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DECISION-MAKING IN CRIMINAL DEFENSE: AN EMPIRICAL STUDY OF INSANITY PLEAS AND THE IMPACT OF DOUBTED CLIENT COMPETENCE

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I. INTRODUCTION

This Article presents an empirical study of attorney-client decision-making in a sample of 139 criminal cases in which the key decision was whether to pursue a clinically supported insanity defense. The study is of interest for two reasons: first, it augments the general literature on attorney-client interactions in criminal defense;[1] second,

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[1] There have been several qualitative studies of relationships between criminal defendants and their attorneys, usually in the context of large public defender organizations. *See, e.g.*, MILTON HEUMANN, PLEA BARGAINING (1978); LISA MCINTYRE, THE PUBLIC DEFENDER (1987); Abraham Blumberg, *The Practice of Law as Confidence Game: Organizational Cooptation of a Profession*, 1 L. & SOC'Y REV. 15 (1967). These studies have highlighted institutional factors that provide incentives for plea bargaining, and that can erode the defense attorney's ethical commitment to the interests or wishes of individual clients. The present study does not arise out of this empirical tradition and does not view the attorney's role from an organizational perspective. Instead, employing a case-centered, quantitative approach, we seek to identify patterns of attorney-client interaction in relation to a particular type of

it sheds light on the relation between client involvement in decisions regarding the defense or disposition of criminal cases and defense attorneys' perceptions of their clients' competence.

The competence of criminal defendants to make decisions is of particular importance in the wake of the Supreme Court's 1993 decision in *Godinez v. Moran*.[2] In holding that the constitutional standard for competence to plead guilty is the same as the standard for competence to stand trial, the Court pointed out that defendants are called upon to make numerous decisions in the course of a criminal case, whether or not the case is tried.[3] To our knowledge, this article presents the only systematic study of the relation between client competence, as perceived by their attorneys, and decision-making participation.

A. PREVIOUS RESEARCH

In previous studies, we have investigated attorney-client interactions in random samples of criminal prosecutions and in a sample of tried cases.[4] Three main findings emerged from these studies. First, more than half of the defendants are described by their attorneys as passive participants in the overall defense,[5] with about one in ten described as uninvolved or "extremely passive."[6] Second, about ten percent of clients are described by their attorneys as recalcitrant, i.e., as rarely or never accepting the attorneys' advice.[7] Interestingly, passivity and recalcitrance are reported less frequently when attorneys are asked to focus specifically on situations in which the law requires personal client participation, such as the decision to plead guilty or, in tried cases, the decision to waive a jury trial, than when attorneys are asked to characterize clients' overall participation in decision-making.[8] The third main finding emerging from our previous research is that attorneys have some doubt about the mental capacity of their clients in eight to fifteen percent of felony cases, although mental health

decision. As explained below, see *infra* text acccompanying note 14, the cases studied comprise a sample of defendants referred for forensic evaluation by attorneys throughout the state of Michigan. Most of the referring attorneys were not public defenders.

2 509 U.S. 389 (1993).

3 *Id.* at 398-99.

4 Norman Poythress et al., *Attorney-Client Decision Making in Criminal Cases: Findings from Three Studies*, 18 LAW & HUM. BEHAV. 437 (1994); Steven K. Hoge et al., *Attorney-Client Decision-Making in Criminal Cases: Client Competence and Participation as Perceived by Their Attorneys*, 10 BEHAV. SCI. & L. 385 (1992).

5 Hoge et al., *supra* note 4, at 390.

6 Poythress et al., *supra* note 4, at 442.

7 *Id.*

8 *Id.*; Hoge et al., *supra* note 4, at 390.

assessments are sought in less than half of these cases.[9] The prevalence of reported client passivity is substantially higher among clients whose competence is doubted than among clients whose competence is unquestioned by their attorneys.[10]

B. THE PRESENT STUDY

The rate of perceived mental impairment in the general defendant populations sampled in our previous studies was too low to permit a thorough examination of the relation between client mental impairment (as perceived by their attorneys) and attorney-client interaction. Because the rate of perceived impairment is likely to be substantially higher in a population of defendants with clinically supported insanity claims, these cases present an opportunity to study the impact of perceived impairment on the decision-making process.[11]

Decisions concerning the insanity defense also provide an interesting context for studying broad questions relating to the allocation of decision-making prerogatives in criminal defense. It is clear, for example, that attorneys are obligated to adhere to the instructions of competent clients who refuse to plead insanity.[12] It is not clear, however, that this norm entails the further obligation to facilitate client participation in decisions to pursue, or not to pursue, the defense. Thus, a study of insanity plea decisions presents a unique opportunity to explore the practical meaning of the legal norm of client autonomy in criminal defense.

II. METHOD

A. SAMPLE DESCRIPTION

The Center for Forensic Psychiatry (CFP) in Ann Arbor, Michigan, is a state-operated forensic hospital that conducts pre-trial evaluations for courts throughout the state. The CFP's computerized database was utilized to identify all cases for calendar years 1990

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9 Hoge et al., *supra* note 4, at 389; Poythress et al., *supra* note 4, at 441.

10 Hoge et al., *supra* note 4, at 388; Poythress et al., *supra* note 4, at 442. The causal relation between perceived incompetence and passivity is not clear. The defendant's passivity could be interpreted, correctly or incorrectly, as a sign of incompetence. Alternatively, attorneys who have doubts about their clients' competence may not seek their involvement in the decision-making process. We suspect that passivity and perceived incompetence are related in both of these ways.

11 *See, e.g.*, Carmen Cirincione, Henry J. Steadman & Margaret A. McGreevy, *Rates of Insanity Acquittals and the Factors Associated with Successful Insanity Pleas*, 23 BULL. AMER. ACAD. PSYCHIATRY & L. 399 (1995) (diagnosis of severe mental illness is best predictor of successful insanity pleas).

12 *See* Treece v. Maryland, 547 A.2d 1054, 1062 (Md. 1988). *See generally* ABA STANDARDS FOR CRIMINAL JUSTICE, Std. 4-5.2 and cmt. (1993).

through 1992 in which the CFP's forensic examiner had returned a clinical opinion supportive of the insanity defense.[13] One hundred seventy-six such cases were identified. Data were retrieved from CFP case records regarding client characteristics (e.g., demographics, diagnostic and treatment information) and historical variables of interest (e.g., prior criminal record, history of prior psychiatric treatment). Information regarding attorney-client interaction and decision-making was obtained by CFP staff members in telephone interviews with the defendants' attorneys.[14]

B. MEASURES

Archival and interview data were entered on an eighteen-page research protocol designed specifically for this study. Two pages were devoted to data from the CFP case record, while the remainder of the protocol recorded attorneys' responses to inquiries about (i) case outcomes; (ii) strategies; (iii) attorneys' perceptions of clients' attitudes, competence, and level of participation in case decisions; and (iv) interactions with clients about whether to pursue the not guilty by reason of insanity (NGRI) defense made available by the CFP examiner's report.

C. PROCEDURES

The telephone interviews were conducted from July 1991 through December 1993. Beginning with cases evaluated at the CFP during the 1990 calendar year, successive waves of about twenty cases each were selected for follow-up. A letter was sent on CFP letterhead to the attorney's office; it described the study and advised the attorney that a CFP staff member would be calling in the near future to conduct a telephone interview about the case. Initial phone contacts attempted either to complete the telephone interview or to set a specific date and time for a subsequent call during which the attorney could be debriefed regarding the case. In most cases, multiple phone calls were required to arrange the interview. As protocols were nearing completion for one wave of mailings, another group of letters was sent

[13] We sampled retrospecitvely to identify recent cases that had reached final disposition, thereby avoiding the ethical difficulties that would arise in investigating "live" cases.

[14] Attorneys' accounts of attorney-client interaction may be biased by the attorneys' imperfect recollections or their self-serving responses. We responded to this concern in one of our earlier studies by interviewing both attorneys and clients in 35 cases. Poythress et al., *supra* note 4, at 446-49. We found that, although the perceptions of attorneys and their clients were not in perfect accord, there was substantial agreement on most measures (e.g. degree of client passivity, ratings of client involvement in decision-making), leading us to conclude that attorneys provide a reasonably reliable account of attorney-client interactions on the measures being employed in our studies.

out.

Protocols were completed for 139 of the 176 cases (77%). Incomplete protocols typically resulted from difficulty reaching an attorney who had changed offices since the CFP evaluation; in a few cases the attorney was contacted but reported little or no memory for specific details and impressions about the case. Based on information recorded in the CFP records (e.g., offense, defendant's diagnosis, demographic characteristics), the completed cases were not significantly different from the uncompleted ones.

III. RESULTS

A. SAMPLE CHARACTERISTICS

The 139 defendants whose attorneys were debriefed were predominately white (69%) males (87%) who were charged with a felony (93%) and were unemployed (77%) at the time of arrest. Most (73%) had been previously convicted of a felony charge and had previously received treatment in a psychiatric hospital (82%) on one or more occasions.

As expected with this sample, the overwhelming majority (n = 118, 85%) received a primary diagnosis of a major psychiatric disorder: schizophrenia (n = 77, 55%); mood disorder (n = 25, 18%); delusional disorder (n = 9, 6%); or other psychosis (n = 7, 5%). Other primary diagnoses included: organic disorders (n = 8, 6%); mental retardation (n = 4, 3%); alcohol/drug abuse or dependence (n = 3, 2%); and autistic disorder, anxiety disorder, adjustment disorder, or organic personality disorder (1 each). Primary diagnosis for one case was missing.

B. THE FORENSIC EVALUATION

These defendants were referred to the CFP for pretrial evaluation of their criminal responsibility (100%) and their competence to stand trial (89%).[15] Of those referred for competence evaluation, more than half (64%) were found by the examiners to be clearly competent, some (6%) were believed to be marginally competent, and the remainder (30%) were found to be incompetent at the time of evaluation. Most defendants had been hospitalized at some point during the pretrial phase of their cases, either to restore competence (37%) or for other psychiatric treatment (32%). Interestingly, most of the defendants (90%) were on medication, usually anti-psychotic drugs, during the evaluation.

[15] Most (87%) of the evaluations were conducted on an outpatient basis.

Based on the written CFP Report, it appears that most (85%) of the defendants cooperated during the evaluation. Among the 21 defendants who were uncooperative, 13 refused to answer any questions, 11 were thought to have concealed pathological symptoms, and 4 were thought to have malingered (i.e., fabricated psychiatric symptoms).

C. CLIENT PARTICIPATION IN THE DECISION TO SEEK EVALUATION

Attorneys were asked to rate the client's participation in the decision to seek the CFP evaluations. In most cases, the client willingly followed the attorney's recommendation to participate in the evaluation, but the attorneys sometimes made the referral without consulting the client (11%) or over the client's objection (8%).

D. CLIENT COMPETENCE AS PERCEIVED BY THEIR ATTORNEYS

Not surprisingly, attorneys reported that they had "doubts about [their] client's mental capacity to participate in his/her own defense" at some point during the litigation in almost three-fourths (72%) of the cases.[16] These doubts pertained to most competence-related abilities, as shown in Table 1. Of particular interest is the fact that the clients' ability to make rational decisions was more often perceived to be impaired (63%) than their ability to understand the charges (37%) or the nature and purpose of a criminal prosecution (44%). Doubts about clients' decision-making ability often led the attorneys to seek consultation or proxy decision-making from third parties: in 45% of the cases, attorneys reported they consulted parents, spouses, or other relatives in making case decisions.

E. CASE DISPOSITION AND OUTCOME

Table 2 reveals case disposition and outcome. Complete information was available for 123 cases.[17] In 14% of the cases, all charges were dismissed. Forty-one percent of the cases (n = 51) were resolved by plea or stipulation; stipulated findings of NGRI accounted for about one half of the non-tried dispositions (n = 25). Where the defendant pleaded guilty (n = 21) or guilty but mentally ill (GBMI) (n = 5), the plea was usually (63%) to reduced charges.[18] In the cases (n = 55) that went to trial, the insanity defense was raised in 96% of cases and

[16] Attorneys were not asked to rate the "degree of doubt" or the intensity of their concern about possible client incompetence.

[17] Cases for which complete dispositional information was available did not differ in any significant way from cases in which dispositional information was incomplete.

[18] In cases resolved by plea, 76% involved plea agreements.

TABLE 1
ATTORNEY DOUBTS ABOUT CLIENT COMPETENCE (n = 139)

Percent of cases in which attorneys had doubts about client's ability to:	
Understand charges	37
Understand nature of criminal prosecution	44
Understand role of defense att'y	32
Recognize and relate relevant facts	53
Trust defense attorney	22
Understand decision s/he was called upon to make	57
Make rational decisions	63

was successful in 91% of the cases in which it was raised.[19] Overall, the insanity defense was successfully pursued in 71% of the non-dismissed cases, representing 61% of the cases in which the CFP had reached an opinion supporting such a defense.

TABLE 2
DISPOSITION OF CASES WITH AVAILABLE NGRI DEFENSE (%) (n = 123)

All Charges Dismissed	13.8	
Resolved by Plea	41.5	
Guilty		17.1
GBMI		4.0
NGRI		20.3
Resolved by Trial	44.7	
Guilty		1.6
GBMI		2.4
NGRI		40.6

F. DEFENDANTS' REACTIONS TO CFP EVALUATION

Curiously, in 4% of the cases the attorney did not even advise the client of an available NGRI opinion.[20] Most defendants (60%) were receptive to the idea of asserting an insanity defense and to an explanatory formulation that attributed their offense to symptoms of their illness. Of particular interest, however, is the finding that 10% of defendants resisted an insanity plea and another 15% were unreceptive to the attribution of mental illness. The remaining defendants were indifferent. To our knowledge, this is the first empirical estimate of the frequency with which defendants who have an available insanity

[19] The trial cases were almost always (91%) before a judge sitting without a jury.

[20] In these six cases, two were dismissed, three were resolved by GBMI pleas and one was resolved by a trial finding of NGRI.

defense are likely to voice opposition to some aspect of the opinion.

G. OVERALL PARTICIPATION IN DECISION-MAKING

Attorneys were asked to rate their clients' overall participation in decision-making. The sample was about evenly split between those who were viewed generally as being passively (46%) versus actively (54%) involved in case decision-making. About 25% were regarded as uninvolved or "extremely passive," while on the other extreme, 13% were rated as "extremely active." Most defendants were characterized as generally willing to follow counsel's recommendations, but 9% were described as "rarely" or "never" accepting their attorney's advice.

TABLE 3
RELATION BETWEEN CLIENT PARTICIPATION AND CLIENT COMPETENCE, AS PERCEIVED BY THEIR ATTORNEYS

	General Population of Criminal Defendants (Tampa)[1]		Defendants with Clinically Supported Insanity Claims (Michigan)[2]	
	Competence Doubted $n = 32$ (8%)	Competence Not Doubted $n = 368$ (92%)	Competence Doubted $n = 95$ (72%)	Competence Not Doubted $n = 36$ (28%)
Accepting Advice				
Always	41	45	62	75
Usually	31	32	19	19
Sometimes	6	17	7	3
Rarely	9	4	7	3
Never	12	2	4	0
Client Participation				
Active	41	59	27	42
Passive	25	32	43	46
Extemely Passive	34	9	30	14

[1] Combined samples of defendants described in Study 1 and Study 1 in Poythress et al., *supra* note 4.
[2] Total N = 131, rather than 139, due to missing data.

As Table 3 shows, however, attorneys' perceptions about client participation were related to whether they expressed doubts about their clients' competence, a finding that also emerged in our studies of a general defendant population. The data in Table 3 compare attorney perceptions about client participation compiled in our Tampa study of a general population of criminal defendants with attorney perceptions from the present sample of Michigan defendants with clinically supported insanity claims. The data show that in both samples defendants whose competence is doubted were perceived to be

markedly more passive in decision-making, and somewhat less "compliant," than clients whose competence was not doubted. The key difference between the two samples is that attorneys expressed doubts about the competence of 72% of the Michigan defendants with clinically supported insanity claims, compared with only 8% of the general population of criminal defendants in Tampa.

H. THE DECISION WHETHER TO PURSUE AN NGRI DEFENSE

Attorneys described the process by which they and their clients decided whether or not to pursue the insanity defense in 134 cases.[21] It was ultimately decided that the NGRI defense would not be pursued in twenty cases, while the decision was made to enter an insanity plea in 114 cases. Table 4 summarizes data provided by the attorneys regarding discussions with their clients about this important decision.

In the twenty cases in which the defense was not pursued, the decision-making process usually followed one of two expected patterns. In seven of the cases, the case had already been dismissed or the defendant had already decided to plead guilty before the report was received. In eight of the cases, the attorney discussed the report with the client, and recommended that the defense not be raised, and the client followed the recommended advice. (In three cases the attorney discussed the report with the client but made no recommendation, leaving it to the client to decide how to proceed.) Two of these twenty cases are of special interest because they involved disagreements between the attorney and client—the attorney recommended that the defense be raised and the client rejected this advice; in one of these cases, the attorney unsuccessfully sought the court's permission to advance the defense over the client's objection.

In 85% of the cases, an insanity plea was pursued. In more than half (53%) of these cases, the decision was made with full client participation: in 43% of the cases, the attorney received the report, discussed it with the client, recommended that the defense be pursued, and the client followed the attorney's recommendation without objection; and in another 10% of the cases, the attorney entered an insanity plea based on an implicit delegation of authority from the client—either pursuant to a previous understanding with the client on the course of action to be followed upon receipt of the report or in anticipation of client ratification at a later time.

In only two cases did the attorney and client have an overt disagreement. In one case the client decided to raise the insanity defense in the face of the attorney's contrary advice; in this case, the client

[21] Inadequate information was available in 5 cases.

TABLE 4
ATTORNEY-CLIENT INTERACTION IN INSANITY DEFENSE DECISIONS (%)

	All cases (n = 134)	Defense Not Raised (n = 20)	Defense Raised (n = 114)
Disposition Arranged Before Report Received	10	35	6
Client Followed Attorney Recommendation	51	40	53
Client Decided without Attorney Recommendation	5	15	3
Client and Attorney Disagreed	3	10	2
Attorney Made Decision Without Consulting Client	31	—	36

eventually decided to plead guilty. In a second case, a client who strongly resisted the insanity plea eventually decided to pursue the defense due to pressure from his family; in this case, the defendant was eventually found NGRI at trial.

In more than one-third (36%) of the cases in which the insanity defense was pursued the attorneys appear to have pre-empted their clients' participation in the decision-making process. That is, the attorneys made the decision to pursue the insanity defense on their own, without meaningful client participation—they did not discuss the matter with the client at all or they presented a negotiated insanity plea to the client as a *fait accompli.*

I. EXPLANATION FOR ATTORNEYS' PREEMPTIVE BEHAVIOR

Among the cases in which the attorneys preempted client participation (n = 41), the attorneys were asked to explain their reasons for not discussing the decision with the client. In response, they usually indicated either that the insanity defense was the only real choice and that there was nothing to discuss (50%), or that they doubted their clients' competence to participate meaningfully in the decision-making process (38%).[22] Not surprisingly, preemptive behavior was associated with other indicators of perceived client incompetence, such as whether the client had been hospitalized for treatment before trial ($\chi^2(132.3) = 11.88$, $p = .008$) and whether the attorney expressed doubts about the client's ability to understand important case decisions ($\chi^2(97.1) = 4.07$, $p = .04$). Interestingly, however, the attorneys who preempted client participation in the insanity plea decision were no more likely to seek consultation or proxy decisions from relatives

[22] In the few remaining cases, the attorneys indicated either that they consciously precluded the defendants' involvement due to anticipated disagreement (n = 2) or that they usually make decisions of this nature without client participation (n = 3).

than attorneys who elicited client involvement.

IV. Discussion

Results from our previous work provide a backdrop for the present findings. Our previous studies of attorney-client decision-making focused on unselected samples of criminal cases. The attorneys in those studies described their clients as somewhat passive in general, but reported a high degree of client involvement in the discrete decisions for which well-established legal norms mandate client participation—e.g., whether to testify at trial, waive a jury and request a bench trial, or plead guilty.

The present study focuses on a single decision—whether or not to pursue a clinically supported insanity defense—in a sample of defendants selected precisely because a favorable clinical opinion had been rendered. Clearly the decision whether to pursue the insanity defense was the pivotal strategic issue in these cases, and the prospect of psychiatric labelling, stigmatization, and indeterminate hospitalization would seem to place this issue squarely within the realm of client autonomy. Not surprisingly, one-fourth of the clients resisted the attributions of mental disorder, insanity, or non-responsibility represented by the forensic findings. Notwithstanding the arguments that can be made against raising the insanity defense, it was pursued in 85% of the cases in this study, including 79% of the cases in which clients had resisted one or more of the clinical findings. Moreover, contrary to our expectations, the rate of reported disagreement between the attorneys and the clients regarding the insanity plea was relatively low.

Surprisingly, the main finding in this study pertains to the *lack* of client involvement: we find that the attorneys made the decision without consulting the defendant in about one-third of the cases in which the defense was raised and that the degree of client participation was relatively low even when the client was consulted.

The key question is, what accounts for the observed pattern of attorney dominance? In our view, this pattern is attributable to two related factors: an ambiguous ethical norm relating to the attorney's obligation to facilitate client participation, and a distinct tendency toward paternalistic decision-making in cases involving defendants with documented histories of serious mental illness.

A. THE AMBIGUOUS LEGAL NORM

It is now well settled that defense attorneys are obligated to adhere to client wishes on basic issues relating to the defense or disposi-

tion of the case, including the "theory of defense" and the plea. Until recently, however, decisions whether to raise the insanity defense were outside the defendant's sphere of control. In many states, the insanity defense could be interposed by the court and, in some states, by the prosecution, without regard to the defendant's wishes.[23] Moreover, the defendant's preferences on this issue probably were not even binding on the defense attorney. Within the past twenty years, however, the governing legal norm has shifted decisively. A line of recent cases, beginning with *Frendak v. United States*,[24] has established not only that the insanity defense may not be interposed by the state, but also that the defense attorney must adhere to the wishes of a competent defendant who declines to raise the defense.[25] Michigan law is in accord with the prevailing rule.[26]

Beyond the duty to adhere to the client's known wishes, however, the attorney's legal obligation is ambiguous. Two key questions presented in this study are whether an attorney is obligated to present to the client the possibility of raising a clinically supported insanity defense and, if so, whether the attorney is obligated to facilitate an informed client decision.[27] Informed client decision-making may be an aspirational ethical ideal but, in Michigan and elsewhere, it is by no means clear that attorneys have a legal obligation to achieve it.[28]

In the absence of any alternative exculpatory claim, the attorney may be justified in assuming, without inviting client participation, that an available insanity plea serves the client's interest in avoiding criminal conviction. If a negotiated insanity plea is entered, or if the defense is raised at trial, the defendant will have the opportunity to object if he wishes to do so.[29] Thus, it can be argued that by deciding

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23 *See, e.g.*, Whalem v. United States, 346 F.2d 812, 818 (D.C. Cir. 1965) (en banc), *overruled by* United States v. Marble, 940 F.2d 1543 (D.C. Cir. 1991).

24 408 A.2d 364 (D.C. 1979).

25 For a full discussion, see Treece v. State, 547 A.2d 1054 (Md. 1988).

26 In *People v. Newton*, 446 N.W.2d 487 (Mich. Ct. App. 1989), the court held that a defense attorney who adhered to a competent client's wishes to forego an available insanity defense provided constitutionally adequate representation, strongly implying that an attorney is obligated to follow the client's instruction or withdraw from the case. This conforms to the prevailing understanding.

27 *See generally* Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 U. MIAMI L. REV. 539, 568-70 (1993).

28 There appear to be no Michigan cases directly on point—i.e., cases in which an attorney decided to pursue an insanity defense without consulting the defendant. However, in one recent case, the court characterized the attorney's decision to invoke the defense as a defensible exercise of trial strategy because it presented the best chance for acquittal, adding only as an afterthought the defense attorney's testimony that the defendant had consented to this strategy. People v. Edward, MICHIGAN LAWYERS' WEEKLY, Oct. 18, 1993, at 23A (Mich. Ct. App. 1993).

29 In the present study, for example, the outcomes in the "pre-empted" cases were as

to pursue the defense, the attorney does not preclude a client's subsequent veto.

In sum, it is possible that the governing legal norm reflects a "weak" conception of client autonomy. Under a "strong" conception, the attorney would be obligated to present the issue to the client in all cases and to facilitate informed client participation. However, under the weaker conception that appears to prevail in practice, the attorney is expected to adhere to the known wishes of the client but has no affirmative duty to secure the client's involvement.

In light of the high prevalence of attorney preemption in decisions *to pursue* the insanity defense revealed in this study, it is interesting to note that a similar pattern did not emerge in the twenty cases in which the insanity defense was *not* pursued. It appears that clients participated in all of these decisions. In this context, however, the legal norm is not ambiguous: when the attorney decides to forego an available insanity defense, the attorney is probably obligated to elicit client participation, especially if the attorney advises the defendant to plead guilty.[30]

B. ATTORNEY PATERNALISM

It also appears that the attorneys' paternalistic intuitions play a significant role in explaining their behavior. The attorneys explicitly linked their preemptive behavior with perceived client incompetence in 38% of the cases, and responses to other questions about client competence showed that 91% of the attorneys who preempted client participation had doubts about their clients' capacity "to understand the decisions they were called upon to make." In addition, decisions to preempt client involvement were associated with the clients' hospi-

follows: dismissal of case (n = 6); NGRI plea (n = 10); G or GBMI plea (n = 2); NGRI at trial (n = 18); and G at trial (n = 2).

[30] The usual cases in Michigan, as elsewhere, involve post-conviction claims that the defense attorney should have raised the insanity defense. In these cases, the Sixth Amendment claim usually turns on whether the attorney made an informed professional judgment. Convictions are sometimes set aside. *See, e.g.*, People v. Hunt, 427 N.W.2d 907 (Mich. Ct. App. 1988); People v. Snyder, 310 N.W.2d 868 (Mich. Ct. App. 1981). For our purposes, the key question is whether a conviction will be set aside, even if the attorney made an informed professional judgment, on the ground that he did not present the matter to the client for decision. In cases which went to trial, no rulings setting aside convictions have been identified. However, in *People v. Nyberg*, 362 N.W.2d 748, 751 (Mich. Ct. App. 1984), the court set aside a GBMI verdict (and a life sentence) because the defendant had not been informed "that he had a reasonable likelihood of successfully interposing a valid and complete defense to the charge." *Nyberg* stands at most for the proposition that an attorney should inform the defendant of any potentially successful defense before advising him to plead guilty.

talization for treatment during the pre-trial phase.[31]

The tendency of attorneys to take a paternalistic stance in dealing with mentally ill clients has been well-documented in the context of civil commitment, where aggressive advocacy against commitment is often forsaken in favor of a role resembling that of a guardian ad litem.[32] Even in customary representational contexts, codes of ethics are remarkably ambiguous regarding the allocation of decision-making responsibility. In fact, the codes imply that attorneys are ethically permitted to make decisions on behalf of impaired clients, even in the absence of a legal determination of incompetence.[33] In short, the behavior of the Michigan attorneys in this study appears to reveal an unambiguous instance of "soft" paternalism in legal representation.[34]

V. CONCLUSION

The findings of this study show why it is desirable, as one of us has previously suggested,[35] to conceptualize competence in criminal adjudication as two separable constructs: a foundational requirement of "competence to assist counsel" which refers to the minimum condi-

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[31] It is possible that the very fact of client hospitalization impeded client consultation, and that the attorneys' preemptive behavior reflected logisitical difficulties rather than paternalistic decision making. For example, we wondered whether the attorneys may have been required by statute to file notice of a possible insanity plea before they had the opportunity to meet with their clients. This explanation seems unlikely, however. The procedural clock would not have been running during the period of pre-trial hospitalization for competence restoration. Moreover, even if attorneys decided on their own, due to logistical difficulties, to give notice of a planned insanity plea, they still had plenty of time to discuss the issue with their clients before the scheduled trial.

[32] *See, e.g.*, Norman G. Poythress, Jr., *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 18 (1978).

[33] *See, e.g.*, MODEL RULES OF PROFESSIONAL CONDUCT, Rule 1.14 cmt. (1992) ("When the client . . . suffers from a mental disorder or disability . . . maintaining the ordinary client-lawyer relationship may not be possible in all respects . . . . If the person has no guardian or legal representative, the lawyer often must act as de facto guardian."; MODEL CODE OF PROFESSIONAL RESPONSIBILITY EC 7-12 (1978) ("If a client under disability has no legal representative, his lawyer may be compelled in court proceedings to make decisions on behalf of the client.")

[34] An instance of "hard paternalism" is when one overrides the wishes of a competent actor who has made a voluntary choice on the ground that what the person wants to do is not in his or her best interests. Libertarians who object to hard paternalism will usually accept some form of "soft" paternalism under which the intervention is made because the subject is not competent to decide what is in his or her best interests or because of some other defect of voluntariness. The residual controversies relate to the definition of the conditions which justify paternalistic interventions (e.g., impairment of decisional abilities). *See generally* 3 JOEL FEINBERG, HARM TO SELF 12-16 (1986).

[35] Bonnie, *supra* note 27; Richard J. Bonnie, *The Competence of Criminal Defendants: A Theoretical Reformulation*, 10 BEHAV. SCI. & L. 291 (1992) [hereinafter Bonnie, *A Theoretical Reformulation*]. For a generally supportive critique, see Bruce J. Winick, *Reforming Incompetency to Stand Trial and Plead Guilty: A Restated Proposal and a Response to Professor Bonnie*, 85 J. CRIM. L. & CRIMINOLOGY 571 (1995).

tions required for participation in one's own defense; and a contextualized concept of "decisional competence" which has independent legal significance only in cases in which the defendant is competent to assist counsel. If a defendant lacks the abilities required to understand the proceedings and assist counsel, the dignity and reliability of any ensuing adjudication cannot be assured; this is why a defendant's lack of "competence to assist counsel" precludes conviction. However, if the defendant is competent to assist counsel, a discrete defect of decisional competence can be addressed through remedies other than barring adjudication, such as default rules or surrogate decision-making.

As previously noted,[36] decisional impairments relating to pleas of insanity have arisen with sufficient frequency to lead courts to subdivide competence in a manner which tracks the distinction between decisional competence and "competence to assist counsel." The reported cases involve defendants who refuse to plead insanity; in these cases—in which the defendant is regarded as competent to undersand the charges and assist counsel, but not competent to make a rational decision regarding the insanity plea—courts have sometimes allowed the defense to be raised by a surrogate decision-maker: the defense attorney, a guardian, or the court. As the present study shows, however, "refusing" defendants represent only a small fraction of defendants who have clinically supported insanity claims, and the typical case involves an "assenting" defendant whose decision-making ability is questionable. In practice, it appears, attorneys serve as surrogate decision-makers in these cases.

Some would argue that a disposition which deprives the defendant of liberty should not be arranged in the absence of an autonomous decision by the defendant him or herself. From this perspective, the results of this study are disturbing because they reveal that most defendants who are acquitted by reason of insanity are perceived by their lawyers as having significant impairments of decisional competence, and that one-third of them play no meaningful role in the decision to seek this disposition. Even if surrogate decision-making is regarded as an acceptable response in these cases, as we believe it is, attorneys should take appropriate steps to invite and facilitate the maximum feasible participation of which the defendant is capable. This should be an ethical imperative even if it is not a legal one.

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[36] Bonnie, *A Theoretical Reformulation*, *supra* note 35, at 308-11.