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ISSUES OF CAPACITY IN THE CONTEXT OF IMMIGRATION LAW PART I: EVALUATION AND ETHICS

by

SANA LOUE, J.D., Ph.D., M.P.H., M.S.S.A. [FNa1]

The majority of immigration attorneys likely never consider whether the client sitting before them has sufficient capacity to consent to representation or to participate in the preparation of his or her own case; indeed, capacity is presumed. [FN1] Even when the level of the client's capacity is impaired, the issue may not be obvious, absent an already-diagnosed mental illness or minority age. Additionally, even when there is such a diagnosis, the parameters of a client's capacity and its relevance and impact on the attorney-client relationship and the preparation of the client's case may be far from clear. Consider the following examples, each of which reflects an actual situation, although the names of the individuals have been changed to protect their identities.

• Reynaldo, a self-identified young gay man from a Latin American country attempted to enter the U.S. illegally following the murder of his lover by a vigilante group seeking to eradicate gays from the small community in which he lived. He was discovered after he had crossed into the U.S. and has been detained. During his initial interviews with you, he indicated that he has been unable to sleep and has recurring nightmares of the slaughter of his lover in front of his eyes. He confides that he feels guilty because he was able to escape and that he believes he should have done more to save his lover. Despite the relatively brief period of detention, it appears to you that he has become increasingly depressed as well as almost completely mute and motionless, spending vast amounts of time face down on his bed. In what way, if any, have your responsibilities as Reynaldo's attorney been modified as a result of his mental state? How does Reynaldo's state of being affect your strategy of representation? What, if any, additional obligations do these circumstances impose on the Immigration judge?

• Teresa, a 16-year old girl from an Eastern European country, had responded to an internet-posted advertisement soliciting young girls to work as nannies or housekeepers in the U.S. and U.K. She had dutifully supplied all of the requisite information to the agency in her country that was listed for the processing of these applications. The agency made all of the necessary travel arrangements for her. On arrival into the U.S., she was met at the airport by a man purporting to be the father of the children she was to care for, only to later find that he was her captor. He and his wife kept her as a prisoner in their home, forcing her to attend parties with them and to participate in sexual activities with men and women in their social circuit, in exchange for money paid to them by the patrons of the sex services. She was able to escape from one of the parties and was brought to your office by a middle-class woman she had approached on the street in her search for help following her escape. To what extent can you engage as her attorney, in view of the fact that she is a minor? Is she presumed to lack capacity because of her minority? What are the effects of her experiences on her mental state and how does this impact both your representation and the legal strategy that you might pursue?

• John, a U.S. citizen by birth, has consulted you with respect to the filing of an I-130 petition for his wife. Following his consultation with you regarding the preparation of the petition, but prior to its adjudication, he is in a serious motor vehicle accident and suffers a traumatic brain injury. It appears that there may be some question regarding the validity of the marriage for immigration purposes in light of his previous marriages to wives who had obtained their permanent residence on the basis of their marriage to John. It is now extremely difficult for him to communicate his thoughts, and it is unclear how much he is able to understand of what is communicated to him. [FN2] What is the effect of his current mental state on the attorney-client relationship or on the viability of an as-yet-unadjudicated petition for his wife?

• Francoise, a French citizen and lawful permanent resident alien, has decided at the age of 50 to apply for U.S. citizenship and has retained you to assist in the preparation of her application. At first blush, Francoise seems to be highly energetic, but somewhat scatterbrained and forgetful. Even though your contact with her is not extensive because of the seeming simplicity of the legal matter before you, it becomes apparent that Francoise is becoming increasingly forgetful. In a somewhat lighthearted and offhanded manner, in an effort not to offend, you joke with your client about the toll that increasing age is taking on your own memory. She suddenly confides to you that she has been diagnosed with early onset Alzheimer's disease. In view of the continuing lengthy delays from the time of filing to the time of swearing in, you wonder if Francoise will be able to understand the oath that is normally required for naturalization. You do not know whether her husband is aware of this diagnosis.

This *Briefing* is the first of a two-part series that addresses issues related to an assessment of client capacity and ethical implications for the attorney-client relationship when client capacity is impaired. Part I begins with an examination of the meaning of capacity and incapacity and factors that may lead to an erroneous conclusion of limitations on client capacity. This Part then examines strategies for maximizing client understanding and participation in situations in which capacity is impaired, and the attorneys' ethical obligations in such situations. Part I relies primarily on the Model Rules of Professional Conduct as the basis of this discussion. Although many states have adopted the same or similar provisions in their codes of professional conduct, there may be notable differences. Accordingly, each attorney should review the rules that guide attorney conduct in his or her respective state. Part II of this *Briefing*, to appear next month, focuses on strategies for handling specific types of cases in which client capacity presents as an issue in the immigration case itself: asylum, waiver and naturalization applications, and removal proceedings.

DEFINING AND DISCERNING INCAPACITY

The Nature of Incapacity

First, it is important to distinguish between the concepts of incompetence and incapacity. Although the terms are often used interchangeably, the concepts are quite distinct. The concept of incompetency refers to a judicial or legal determination to the effect that an individual is unable to care for him- or herself and/or his or her property, either temporarily or as permanently as one can discern. [FN3] The definition of incompetence offered by *Black's Law Dictionary* may have added to the confusion by incorporating within its earlier definition of competency a reference to incapacity:

> Lack of ability, knowledge, legal qualification, or fitness to discharge the required duty or professional obligation. A relative term which may be employed as meaning disqualification, inability or incapacity

and it can refer to lack of legal qualifications or fitness to discharge the required duty and to show want of physical or intellectual or moral fitness. [FN4]

The current definitions of competency and capacity are also likely to engender confusion. “Competency” is defined as “the mental ability to understand problems and make decisions.” [FN5] In contrast, the definitions of “capacity” refer to specific contexts. As an example, “diminished capacity” is used to refer to an impaired mental condition that prevents an individual from having the requisite mental state to be held responsible for a crime, [FN6] while the term “decreased capacity” refers to only a diminution in an individual's physical abilities, rather than mental abilities. [FN7] Although some clients who have been found to be incompetent may present to the immigration attorney, it is much more common, in this writer's experience, to be confronted by situations in which no such determination has been made and questions of capacity are raised at the commencement of or during the course of representation.

Previous understandings of capacity allowed for only two possibilities: that capacity was either present or absent. [FN8] In the immigration context, nationality was once judged to be indicative of and equated with mental defect, thereby providing the basis for the exclusion and deportation of those who were deemed to be ethnically undesirable. As an example, debates relating to immigration restrictions during the 1920s focused on “slow-witted Slavs,” “the neurotic condition of our Jewish immigrants,” and “the degenerate and psychopathic types, which are so conspicuous and numerous among the immigrants.” [FN9] One expert had proclaimed that fully one-half of the immigrants from southern and eastern Europe were feeble-minded. [FN10] Fiorello H. LaGuardia, who worked his way through law school by serving as an interpreter at Ellis Island, suggested later that “over fifty percent of the deportations for alleged mental disease were unjustified,” and had resulted from “ignorance on the part of the immigrants or the doctors and the inability of the doctors to understand the particular immigrant's norm, or standard.” [FN11]

It is now understood, however, that capacity exists along a spectrum and that incapacity may vary with respect to both its scope and duration. The Third Restatement of the Law Governing Lawyers recognizes as much in noting that clients' disabilities in making decisions may range from mild to totally incapacitating; these disabilities may impair a client's ability to decide matters generally or only with respect to some decisions and on some occasions. [FN12] An individual who has sufficient capacity to make decisions with respect to only some matters has capacity that is limited in its scope. Such may be the case with particular forms of mental retardation, so that individuals are able to participate in decision making as it relates to everyday functions of life, but not in more complex decision making. [FN13] Permanent incapacity is exemplified by mental retardation and some forms of brain injury, while temporary incapacity may result from intoxication due to substance use. Incapacity may be progressive, as is seen with Alzheimer's disease, or fluctuating, as in the case of a mental illness such as bipolar disorder or schizophrenia. Two or more forms of impairment may exist even within the same individual. For instance, an individual may experience fluctuating impairment due to the varying course of his schizophrenia but, as he ages, he may develop Alzheimer's disease, resulting in additional levels of progressive impairment. [FN14]

The concept of capacity, although used most often in the medical context, has significance in the legal arena as well. In general, incapacity refers to an impairment in an individual's ability to make a decision or communicate a responsible decision due to his or her developmental level, symptoms of mental illness, symptoms of a chronic or acute medical condition, intoxication, or other cause. [FN15] The concepts of competence and capacity merge in the context of informed consent: whether a client is able to understand to a degree that is sufficient

for agreement to “a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks and reasonably available alternatives to the proposed course of conduct.” [FN16] Accordingly, informed consent requires both disclosure by the attorney of the services to be provided and their potential impact or significance and the client's cognitive and functional ability to understand the information that is being explained. [FN17] Additionally, the client must be free of duress or coercion in providing his or her consent. [FN18]

It is generally presumed that a client has capacity to provide informed consent, absent some indication otherwise. Although some legal scholars have suggested that attorneys formally evaluate clients who they believe or suspect may suffer from some capacity-limiting impairment, [FN19] both the American Bar Association (ABA) and the American Psychological Association (APA) have advised against the attorney's assumption of this responsibility, noting that attorneys generally possess neither the training nor the experience to perform such psychological-medical assessments. [FN20]

Although discouraged from utilizing formal psychological evaluation tools to assess their clients' capacity, attorneys have been encouraged to remain attuned to signs that may raise questions with regard to their client's ability to understand the information being provided to them and/or to make decisions. The ABA and the APA together have recommended that attorneys “be alert to cognitive, emotional, or behavioral signs such as memory loss, communication problems, lack of mental flexibility, calculation problems,” or other difficulties. [FN21] It is further recommended that the attorney (1) compare the client's understanding with each element of capacity that may be relevant to the legal issue at hand; and (2) consider the nature of the decision to be made, such as its irreversibility and seriousness, the client's level of functioning, and whether the client is able to articulate the reasons underlying his or her decision.

Practice Pointer: Both adults and children are presumed to have capacity to enter into an attorney-client relationship and to make decisions, absent indications to the contrary. Although attorneys are cautioned not to undertake a formal assessment of a client's capacity, it is critical that an informal assessment be made based on the client's interaction with the attorney in order to ensure that the client is able to provide informed consent to representation and to participate in the preparation of his or her case.

The ABA and APA have suggested that the attorney's informal assessment may reveal that the client (1) displays no or minimal signs of incapacity; (2) is experiencing only mild problems, which do not preclude the continuation either of representation or of work on the case at hand; (3) is suffering from diminished capacity to such an extent that consultation with a competent mental health professional may be warranted; or (4) is suffering from an impairment to such a degree that representation may have to be terminated. [FN22] Various factors, discussed below, may lead the attorney to believe that the client's capacity is diminished when, in reality, it is not.

Factors Affecting Capacity and Perceptions of Capacity

A variety of factors may affect a client's interaction with others, leading to an erroneous conclusion about the client's level of capacity when, in fact, the client's capacity is not impaired or is only temporarily impaired. These factors include stress, grief, depression, reversible medical conditions, substance use, hearing or vision loss, socioeconomic status, educational level, and cultural considerations. [FN23] These factors are discussed

here in order to familiarize attorneys with the factors that should be considered as part of their informal assessments of client capacity. However, these same factors may have implications for the legal strategy to be pursued; Part II of this two-part *Briefings* series will address in greater detail the impact of these factors on strategies for handling specific types of cases.

Trauma and Stress. Many attorneys have represented applicants for refugee or asylum status and are familiar with the diagnosis of posttraumatic stress disorder (PTSD). The diagnosis of this disorder requires that the individual have experienced, witnessed, or been confronted with a traumatic event or a series of events that involved actual death or serious injury or the threat of death or serious injury. As a result of these events, the individual experienced feelings of intense fear, horror, helplessness. [FN24] Additionally, for a period of at least one month, the individual re-experiences the event(s), avoids stimuli that are associated with the trauma, and experiences numbing of general responsiveness and increased arousal, resulting in clinically significant distress or impairment in one or more important areas of functioning, such as family life or work. Individuals may attempt to avoid any feelings or thoughts associated with the trauma and, consequently, may suffer "emotional anesthesia" and/or experience amnesia with respect to the triggering event(s). [FN25]

It will come as no surprise to attorneys who have handled asylum applications that numerous studies have reported that refugees and asylum seekers, in particular, may suffer from posttraumatic stress disorder and other mental illness. It has been estimated that in the European Union, two-thirds of all asylum seekers have experienced some mental problems. [FN26] And, not surprisingly in view of how refugee is defined internationally, it has been estimated that 60% of all refugees have experienced war, torture, or imprisonment. [FN27] In a study of 10 detained asylum seekers in the U.K., it was found that 6 had suffered torture, all 10 were suffering from depression, 4 were suicidal, and 2 had attempted suicide while in detention. [FN28] Over one-half of a sample of 33 asylum seekers in Sydney, Australia reported having been subjected to physical torture. [FN29] Researchers who reviewed 20 studies that provided results for 6,743 adults from 7 countries and 5 surveys of 260 refugee children from 3 countries reported that among the adults, 9% suffered from PTSD, 4% had generalized anxiety disorder, and 5% had major depression, while 11% of the children were diagnosed with PTSD. [FN30] The authors concluded that refugees are 10 times as likely to have PTSD compared to age-matched individuals in the native populations of the countries surveyed.

Other studies have also reported high rates of PTSD among refugee children. Almost all of the children in a sample of internally displaced Bosnian children were found to have PTSD. [FN31] Almost one-half of children who had experienced war in Cambodia and the former Yugoslavia and had migrated to the United States were found in one study to be suffering from PTSD. [FN32] A study of refugee children ages 8 to 16 in London found that greater severity of PTSD was associated with pre-migration experiences of the violent death of family members and an unstable or insecure status following migration. [FN33] Another study involving 87 children and adolescents who sought refuge in the United States from Cuba and had been held in refugee camps for up to eight months prior to arrival in the U.S. reported similar findings. [FN34] More than one-half of the children (57%) evidenced symptoms of PTSD. Age and having witnessed violence in the camps were associated with PTSD. Consistent with findings from other studies, the severity of self-reported symptoms increased as the number of stressors experienced increased. [FN35]

Research findings suggest that exposure to war and/or political unrest may heighten the risk of PTSD. A study comparing 258 immigrants from Central America and Mexico to the United States and 329 U.S-born Mex-

ican Americans and Anglo Americans found that 52% of the Central Americans who had migrated because of war and political violence experienced symptoms of PTSD, compared with 49% of Central Americans who had migrated for other reasons and 25% of Mexican immigrants. [FN36]

Refugees who experienced torture appear to be at increased risk of developing psychiatric disorders in addition to PTSD. A study of ethnically Nepalese, religiously Hindu refugees from Bhutan who sought refuge in refugee camps in Nepal found that individuals who had been tortured were 5 times as likely to develop PTSD as those who had not been tortured, and 1.6 times as likely to have any psychiatric disorder. [FN37] Researchers conducting the study estimated the 12-month prevalence of any psychiatric disorder at 74.4% among those refugees who had been tortured, and 48% among those who had not. However, the presence of family and social support from the immigrant community following the individual's arrival in the receiving country may help to alleviate the adverse impact of the torture on the individual's mental health. [FN38]

Individuals who are placed in detention facilities upon arrival at their destination country are often re-traumatized by this experience and suffer a worsening of their mental health in comparison with those who are not detained. [FN39] Researchers conducting the previously mentioned study of 33 asylum seekers in Sydney, Australia found that the asylum seekers, who had been held in detention for an average period of 2 years, suffered a progressive deterioration in their mental health. [FN40] The research team observed that, ultimately, many of these individuals were:

> dominated by paranoid tendencies, leaving them in a chronic state of fear and apprehension and a feeling that no one, including other detainees, can be trusted. Long periods of time are spent alone and some develop frankly psychotic symptoms, such as delusions, ideas of reference and auditory hallucinations. [FN41]

Refugee children in detention may similarly suffer such distress, which often worsens after observing parental distress and suffering, experiencing separation from their parents with or without warning, suffering through repeated interviewing by immigration officials, witnessing violence and self-harm, and experiencing instability due to lengthy delays in processing their claims for refugee status. [FN42] This may become a growing issue, as the number of unaccompanied child refugees to Western countries is rapidly growing; it is estimated, for instance, that fully 2% to 5% of any refugee population is now comprised of unaccompanied children. [FN43]

Attorneys are likely less familiar with the diagnosis of acute stress disorder. This syndrome occurs within four weeks of the traumatic event, with symptoms lasting between two days and four weeks. [FN44] It is triggered by an event or events similar to those that bring about PTSD. Symptoms may include numbing; a lack of awareness about one's surroundings; dissociative amnesia, so that the individual cannot remember an important aspect of the trauma; re-experiencing of the traumatic event, such as through nightmares or flashbacks; and/or symptoms of anxiety. As with PTSD, these symptoms result in clinically significant distress or impairment in one or more important areas of life. [FN45]

An understanding of acute stress disorder may be critical for several reasons. First, because the symptoms of the disorder are relatively short-lived, a client who initially appears to be unable to comprehend the information that is being conveyed to him or her by the attorney may be able to do so at a later date. In such instances, assuming there is no urgency, it may be advisable to wait for a period of time until the client is better able to at-

tend to the matter. Second, acute stress disorder may help to explain why a client's initial account to immigration officers of his or her experiences may differ from later accounts, even in the absence of PTSD. For example, an individual who was smuggled into the United States may have suffered injuries en route at the hands of his or her smugglers that result in acute stress and symptoms; these symptoms, while similar to those of PTSD, are not of sufficient duration to meet the criteria for that diagnosis.

Consider the situations of Reynaldo and Teresa. Each of them has experienced highly traumatic events that involved direct threats to their own lives and safety. Reynaldo also witnessed the brutal killing of his lover. Consistent with PTSD, neither of them had a memory of these events that was chronologically intact, as a movie might be. Rather, they remembered fragments of their experiences--smells, voices, shadows, touch, noise, some visual images, parts of things that happened to them--in a disjointed manner; some portions were not remembered at all. Reynaldo, in particular, suffered from severe dissociation; he was numb emotionally and, for an extended period of time, was unable both to relate coherently any portion of his experience or to participate in decision making of any kind, at any level.

Grief. Individuals who have left their home countries and/or their families may experience what has been called “ambiguous loss.” [FN46] This term refers to a situation in which an individual experiences grief for a loss that is incomplete. The loss of family and homeland through migration is ambiguous because there is no physical contact despite the continuing existence of a strong emotional bond. Some individuals who are experiencing severe grief may not only experience symptoms as severe as hallucinations, but also suffer from severe functional impairment, so that they are unable to make decisions. [FN47] As in the case of acute stress disorder, it is important to determine the extent to which the client's decision making ability and ability to understand are impaired and whether decisions can be made at a later date when the client is better able to participate.

Both Reynaldo and Teresa experienced severe grief, albeit for different reasons. Reynaldo grieved the loss of his former partner and, on some level, the loss of his own idealism and innocence. Teresa had lost not only her childhood, but also hope that anyone would want her as real partner in the future.

Reversible Medical Conditions. Reversible medical conditions that could potentially affect a client's capacity to understand, consent, and/or participate in his or her representation are many and varied; it is beyond the scope of this *Briefing* to review all such possibilities. However, a client's apparent ability to understand and participate adequately in decision making may be temporarily affected by such underlying conditions as diabetes and hypoglycemia, [FN48] among others. The attorney may be unaware of such an underlying condition and difficulties associated with either its treatment or the client's adherence to treatment and may erroneously conclude that the client lacks capacity. Other circumstances may also temporarily affect a client's capacity, leading, again, to an erroneous conclusion of incapacity. These include an adverse reaction to medication, interaction between medications, dietary insufficiency, and persistent pain. [FN49] With an attorney-client relationship that is of longer duration, it may be easier for the attorney to detect variations from the client's normal level of functioning and approach with the client the apparent difficulty.

Intoxication. An individual's ability to provide informed consent and participate in the preparation of his or her own case may be seriously impaired as the result of intoxication. The formal criterion for diagnosis of intoxication is the “development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance.” [FN50] The use of the substance, such as alcohol, cocaine, and amphetamines, may affect the

central nervous system and bring about changes in mood, behavior, cognition, and judgment during or shortly after the use of the substance. The specific effects vary with the substance ingested. In some situations, the symptoms of intoxication, which may temporarily affect capacity, may mimic those of a severe mental illness. As an example, this writer was once asked by an immigration judge to represent a detained individual at a deportation hearing. When the individual was brought to the court, he was severely disoriented and appeared to be severely mentally ill. The hearing was postponed because of his condition; it was later discovered that he had been suffering from intoxication from the use of inhalants which he had obtained while in the immigration detention facility.

Hearing and Vision Loss. A client's inability to understand or to respond appropriately may appear to be a reflection of diminished capacity, but may, instead, be attributable to deficits in hearing or vision. These impediments can be minimized by using strategies that accommodate these limitations, such as minimizing background noise, providing the client with written summaries of discussions, formatting documents in large print, allowing clients additional time to process the information that is provided to them, enhancing lighting, and/or reducing glare. [FN51] Such strategies could potentially be helpful to John who, you may recall, had suffered a terrible motor vehicle accident and whose ability to understand may or may not have been affected.

Socioeconomic and Educational Levels. An individual's socioeconomic level and educational level may impact their seeming ability to comprehend information. This may result from a lack of familiarity with the concepts that are being presented to them. [FN52] Client comprehension can be increased by patiently and slowly building a foundation for the newer concepts that are to be introduced.

Considerations of Culture. “Culture” has been defined as “a common heritage or set of beliefs, norms, and values.” [FN53] Such a definition gives the impression that culture is something that is static and that resides in the individual, however common the particular values may be. Another scholar has defined culture as follows:

> Culture is constituted by, and in turn constitutes, local worlds of everyday experience. That is to say, culture is built up (“realized”) out of the everyday patterns of daily life activities--common sense, communication with others, and the routine rhythms and rituals of community life that are taken for granted--which reciprocally reflect the patterning downward of social relations by shared symbolic apparatuses--language, aesthetic sensibility, and core value orientations conveyed by master metaphors. In these local worlds, experience is an interpersonal flow of communication, interaction, and negotiation--that is, it is social, not individual--which centers on agreement and contestation about what is most at stake and how that which is at stake is to be sought and gained. Gender, age cohort, social role and status, and personal desire all inflect this small universe in different ways. The upshot is culture in the making, in the processes that generate action and that justify practices. Thus the locus of culture is not the mind of the isolated person, but the interconnected body/self of groups: families, work settings, networks, whole communities. [FN54]

It is important to recognize that there are cultural differences in decision making. In the United States, for example, personhood is defined with respect to the singular individual who makes decisions and acts as such. Our conceptualization of informed consent mirrors this approach, so that we expect that an individual will decide for him- or herself whether to seek representation, whether to engage a particular attorney, whether to follow a specific course of action. [FN55] However, many cultures define personhood quite differently, so that one's identity is not independent of all others, but rather is a function of their many roles, relations, and respons-

ibilities. In such cultures, “autonomy” mirrors this “enlarged self” and informed consent may entail a more communitarian process, in contrast to the individualistic approach of the U.S. [FN56]

Accordingly, behaviors that may raise questions of capacity in U.S. culture may not have the same significance in another. In this regard, it is important to recognize that “[t]he norm of one culture [may be] a sign of nervous pathology in the other.” [FN57] A client's reluctance to sign a retainer agreement, to ask questions, to respond to questions, or to engage in discussions related to his or her case may be misinterpreted as an inability to do so when these are actually signs of a need to confer with others who are part of the client's “enlarged self.”

Culture may also affect how a client and those around the client perceive and interpret the symptoms that the client is experiencing and what is communicated about those symptoms. As an example from U.S. culture, in a study of bipolar disorder among the Amish [FN58] researchers sought to understand bipolar disorder within the context of Pennsylvania Amish culture. In order to do so, they reinterpreted the behaviors indicative of symptoms of bipolar disorder to reflect the nature of that specific culture. The diagnostic criterion of “excessive involvement in activities,” which is indicative of the presence of mania, often encompasses sexual indiscretions, buying sprees, and ill-advised business ventures. However, the researchers reformulated this diagnostic criterion so as to be relevant to Amish culture, referencing instead such things as

> racing one's horse and carriage too hard or driving a car (recklessness not implied), buying or using machinery or wordly items forbidden by church rules (e.g., dressing up in worldly clothes), flirting with a married person (indeed any overt sexuality), treating livestock too roughly, excessive use of the public telephones (telephones are forbidden in homes), going on a smoking binge, and desiring to give gifts or planning vacations during the wrong season (because the agrarian principle and frugality confine these activities to a given time and place).

An attorney confronted with such a situation might not recognize that the client is unable to participate adequately in decision making because of the mania that he is experiencing and that the client's ability to provide informed consent while experiencing such symptoms might be in serious doubt.

Age and Incapacity. Questions relating to a client's capacity may arise as a function of age when the client is a minor. Attorneys may erroneously assume that a young child lacks the capacity to make any decisions or to participate in a meaningful way in the preparation of his or her case. Because of the power differential that exists between the experienced attorney and the young, inexperienced client, the attorney may unilaterally direct the handling of the legal matter at issue. [FN59] One scholar, for example, has argued that children cannot voice their own interests:

> Children need advocates because in most circumstances young persons cannot speak for and defend their own interests. And yet, because children often cannot define their own interests, how can the advocate know for certain what those interests are? More fundamentally, how can there be any assurance that the advocate is responsive to the children's interests and is not simply pressing for the advocate's own vision of those interests, unconstrained by clients? [FN60]

Other scholars [FN61] and child advocates and attorneys [FN62] have disputed this approach, arguing that children are able to speak to their own interests. Additionally, in situations in which the child client is unable to communicate, the attorney remains obligated to provide principled representation of the child's legal interests, rather than relying on their own subjective judgment of the child's best interests. [FN63] The ABA Model Act

Governing the Representation of Children in Abuse, Neglect, and Dependency Proceedings (Model Act), which recognizes the need to represent children in immigration proceedings that may be ancillary to other types of actions, reflects this more expansive view of children's capacity, noting that a child's age is not determinative of his or her capacity and a child may have sufficient capacity to make some decisions and not others. [FN64] This observation is especially critical in the context of immigration, because the age at which a child develops a particular cognitive skill varies considerably across cultures. [FN65] The Model Act recommends that the determination regarding a child's capacity be focused on the child's decision-making process rather than the child's choices themselves. [FN66] A variety of criteria should be considered in assessing the child's capacity, including his or her developmental stage, level of emotional and mental development, ability to communicate, understanding of consequences, consistency of decisions, and the opinions of figures who are significant in his or her life, such as a teacher, parent, or therapist. Attorneys are cautioned to use language in their explanations to the child that are appropriate to the child's level of development. [FN67]

The Jean Kohn Peters Model of Child Representation has been suggested as a mean by which attorneys can better assess their child-client's level of capacity. This method encourages attorneys to develop a “thickly detailed” understanding of the “child-in-context,” that is, the child's entire situation. Three steps are involved in this process: the relationship default, during which stage the attorney attempts to build rapport with the child; the competency default, during which time the attorney attempts to understand the level of the child's capacity as it exists along a spectrum; and the advocacy default, when the attorney defers to the child's expressed wishes unless they are contrary to the child's own interest. [FN68]

This process would be critical to the establishment of an attorney-client relationship with Teresa, and to the development of an understanding of her situation and her wishes. Although Teresa might be eligible for a T nonimmigrant visa as a victim of trafficking, assuming that other requisite elements could be met, she might not wish to remain in the United States and might want, instead, to go home as soon as possible.

The issue of capacity may also arise in the context of representing elderly clients. It should never be presumed that advanced age equates to lack of capacity; all adults are presumed to have capacity in the absence of signs of questionable capacity. [FN69] Nevertheless, the prevalence of dementia among older persons is strikingly high. While dementia is believed to affect 1% of persons 60 years old, it affects between 30% and 45% of individuals aged 85 years. [FN70] Alzheimer's disease is the most common cause of dementia, affecting between 60% and 70% of individuals with dementia. [FN71]

Consider now the situation confronting you with Francoise, who has been diagnosed with early onset Alzheimer's disease and who may or may not have the capacity to understand the oath of allegiance by the time of her naturalization interview. Although some attorneys might consider videotaping their meetings with her as evidence of her current capacity, thinking that this might be useful later to demonstrate that she does understand the nature of the oath, this approach could actually bring about more harm than good. First, the video may actually exaggerate any deficits that she may have in her capacity to understand and make decisions. Second, unless the attorney makes it a practice to videotape all of his or her clients, the fact of the videotaping itself could cast doubt on Francoise's capacity. Finally, the tape cannot be edited later to remove any portions without risking possible ethical or legal violations relating to evidence tampering. [FN72]

PROCEEDING IN THE CONTEXT OF DIMINISHED CAPACITY

Following the consideration of all relevant factors, the attorney may still conclude that the client's capacity is somehow limited with regard to his or her ability to understand and to provide informed consent. Significant ethical implications may follow as the consequence of limitations to a client's capacity.

• **Practice Pointer:** In circumstances in which a client is believed to have diminished capacity, an attorney

• should not withdraw from representation

• should utilize techniques to maximize the client's ability to understand and participate

• should consider one or more of the following courses of action:

• referring the client to a clinician for further evaluation,

• waiting until the client displays greater understanding before proceeding further,

• seeking assent to proceed in lieu of obtaining informed consent, or

• identifying another individual, or other individuals, who may have legal authority to provide consent and make decisions on behalf of the client

Although some attorneys may wish to withdraw representation in such circumstances, this course of action is specifically disfavored, even if it is permissible ethically. [FN73] Rather, Rule 1.14 of the Model Rules of Professional Conduct provides that:

> (a) When a client's capacity to make adequately considered decisions in connection with 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. [FN74]

This, then, raises the question of what constitutes a normal client-lawyer relationship. Model Rule 1.2(a) offers some guidance in this regard, stating that a “lawyer should abide by a client's decision concerning the objectives of representation.” [FN75] Commentary further provides that the normal client-lawyer relationship rests on the assumption that the client is able to make decisions about important matters when appropriately advised and assisted by the attorney. [FN76] The Model Rules recognize, however, that circumstances may present that render this impossible:

> Ordinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity. [FN77]

In situations in which the client is found to have diminished capacity, the attorney remains obligated to “treat the client with attention and respect” and accord him or her the status of client. [FN78] Various techniques may be helpful in maximizing client capacity, depending upon the underlying cause of the limitations. These include:

• using encouragement and verbal reinforcement

• using simplified questions

• conducting business more slowly

• discussing one issue at a time

• breaking information down into smaller component parts

• providing feedback

• allowing time for rest

• scheduling appointments for the time of day when the client is best able to function

• arranging multiple shorter appointments instead of fewer longer ones

• meeting with the client in his or her home or other location familiar to the client and/or

• repeating, paraphrasing, and summarizing to check for accuracy, completeness, and understanding of communication [FN79]

Fortunately, Francoise had only recently begun to experience the symptoms of Alzheimer's disease and its impact at the time of her initial consultation was relatively minimal. Perhaps because of this minimal impact, several of the foregoing strategies were helpful in working with her. Repeated repetition of the same information in a variety of ways reinforced the information. The provision of a handout detailing the application process allowed her the opportunity to review it periodically and repeatedly on her own. The use of simplified questions and a focus on one issue at a time helped to reduce any sense of confusion that she may have been feeling.

In terms of how to proceed with the legal matter at hand, the attorney may be faced with any of four possible courses of action: (1) referring the client to a clinician for further evaluation, (2) waiting until the client displays greater understanding before proceeding further, (3) seeking assent to proceed in lieu of obtaining informed consent, or (4) identifying another individual, or other individuals, who may have legal authority to provide consent and make decisions on behalf of the client, such as a guardian ad litem or conservator. [FN80] Each of these options is discussed in greater detail below in examining the implications of incapacity.

Referral for Evaluation

Rule 2.1 of the Model Rules of Professional Conduct, addressing the role of the attorney as advisor, provides:

> In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors that may be relevant to the client's situation.“ [FN81]

Comment 4 further advises that:

> Matters that go beyond strictly legal questions may also be in the domain of another profession. Family matters can involve problems within the professional competence of psychiatry, clinical psychology,

> or social work... Where consultation with a professional in another field is itself something a competent lawyer would recommend, the lawyer should make such a recommendation.... [FN82]

These statements suggest that not only *may* an attorney consult a professional regarding the mental capacity of a client if the attorney believes that there are capacity-related issues that will affect representation, but that the attorney *should* consult with a professional under such circumstances. However, the mere fact of doing so raises additional ethical issues.

First, the attorney must continue to safeguard the confidentiality of his or her communications with the client, unless disclosure is required in order to protect the client's interests. Model Rule of Professional Conduct 1.14 provides that:

> Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests. [FN83]

Model Rule of Professional Conduct 1.6 sets forth the basic requirement of confidentiality:

> A lawyer shall not reveal information relating to representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation, or the disclosure is permitted by paragraph (b). [FN84]

Paragraph (b) specifies that an attorney may disclose information to the extent that he or she reasonably believes necessary only in specified circumstances. These circumstances include the prevention of reasonably certain death or substantial bodily harm, the prevention of the client's commission of a crime or fraud with specified consequences, the receipt of legal advice about the attorney's compliance with the Model Rules, the establishment of a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, and compliance with a law or court order. [FN85]

Second, the attorney must consider the potential effect of the evaluation. Will it help or impede accomplishment of the objective? A comment to Model Rule of Professional Conduct 1.14 provides that:

> Disclosure of the client's diminished capacity could adversely affect the client's interests... Information relating to the representation is protected by Rule 1.6. Therefore, unless authorized to do so, the lawyers may not disclose such information.... [FN86]

For instance, consider the very different situations of Reynaldo, who is applying for asylum as the member of a social group after witnessing the murder of his male lover, and that of Francoise, an applicant for naturalization who has been diagnosed with early onset Alzheimer's disease. In Reynaldo's case, a professional evaluation of his mental state may actually support the attorney's preparation of his application; a finding of symptomatology that is diagnostic of either posttraumatic stress disorder or acute stress disorder may serve as evidence in support of his claim of persecution. However, a finding of symptomatology so severe as to negate decision making capacity would raise additional issues related to his ability to provide informed consent to representation and to assist with the preparation of his case. In contrast, a formal evaluation of Francoise may do more harm than good if the results of the evaluation were to cast doubt on her understanding of the application process and oath.

The attorney must also consider whether there is any chance that, if obtained, the evaluation might become discoverable. It could be argued that the referral to and consultation with a professional could be considered part

of attorney work product in that it reflects the attorney's strategy of the case.

It may also be important to consider the potential effect that a referral might have on the client and on the attorney-client relationship. In some situations, referral might prove to be traumatic to the client, and it would be important to weigh the potential benefits to the preparation of the case against the potential adverse consequences. Consider, for example, the situation involving Teresa, who unwittingly became the sex slave to a couple's social network rather than a nanny to their children. In this situation, a professional evaluation of her capacity and her mental state could be critical to the preparation of her application for relief because the findings could potentially support her claims of abuse. However, there is also a tremendous risk that she could be retraumatized by an evaluation that requires that she relate in detail what happened to her and her past and current responses to those events. One scholar explained the difficulties that inure for individuals in discussing their experiences of torture and trauma:

> These are not everyday conversations, and it is sometimes difficult to find the words, not to mention the will, to explain the requisite historical conditions, perceptions, meanings and actions. It is retraumatizing for the patient to be asked to describe such private events to a stranger, even in a clinical setting, especially if the conversation brings back painful recollections of shame, loss, and deep grief. [FN87]

Accordingly, these potential benefits and risks should be addressed with the client prior to making a referral and the client should be provided with an opportunity to voice any concerns and to indicate agreement or disagreement with a decision to move forward with a referral.

Some clients may have had adverse experiences with the medical and/or mental health professions as a result of poor care or politically motivated, potentially harmful treatment in their home countries. [FN88] In such instances, a client may be reluctant or fearful to discuss his or her situation with the professional and may withdraw from the questions put to them. This creates further difficulties because the professional may be led to conclude on the basis of the client's demeanor that there are greater limitations on his or her capacity than actually exist.

Assuming that the client agrees to proceed with an evaluation of his or her capacity, there are additional potential difficulties with evaluation that may have to be addressed. It will be important to identify a provider who is familiar with the client's culture and language or, if the provider cannot speak the language of the client, an interpreter who can perform “quality interpretation.” Quality interpretation requires that the interpreter:

• monitor him- or herself to avoid role conflicts, such as advocating for the client (inappropriate) rather than interpreting for the client;

• replicate the style, tone and register of the client's speech; and

• maintain confidentiality, except where disclosure is required by law. [FN89]

Ad hoc interpreters, such as family members, friends, or passers-by, are to be avoided. Numerous studies have demonstrated that interpretation services provided by ad hoc interpreters are often fraught with serious errors, including the omission of information; the addition of editorial comments; the interpreters' provision of responses to questions posed to patients, without transmitting the questions to the patient; and the revision of content that is to be interpreted. [FN90]

The identification of an appropriate professional to conduct an evaluation of the client's capacity will not be problematic if the attorney has been able to develop an extensive network of professionals to whom he or she can refer. However, identification of an appropriate referral may be a time-consuming endeavor if the attorney does not have such a network or if the client speaks a language that is not reflected within the attorney's network of professionals. It may not be advisable to have the client select an individual to conduct the evaluation because he or she may not be able to judge whether the provider's credentials are sufficient should testimony or an affidavit be necessary. In such instances, the attorney will likely have to do some research to identify an appropriate professional. This raises the issue as to whether the attorney should be able to bill for the time invested in identifying an appropriate referral.

If a fee is to be charged for the time spent searching for an appropriate referral, the attorney may be ethically obligated to first discuss the fee with the client; [FN91] cost may well be a consideration for the client. However, this will not be necessary if the research involved in locating a provider is covered by the scope of the original agreement for legal representation. As an example, a lawyer handling Reynaldo's case may well have discussed from the outset the need for a professional evaluation of Reynaldo's mental state and capacity and indicated at the time that Reynaldo retained him or her that research for an appropriate referral for the evaluation would be necessary. Conversely, it is unlikely that the attorney handling Francoise's application for naturalization would have contemplated her diminishing capacity. Alternatively, the time invested in searching for an appropriate referral could be considered to fall within the ambit of the attorney's pro bono commitment. [FN92] Although a lawyer is prohibited from subsidizing lawsuits or administrative proceedings on behalf of a client, [FN93] he or she may lend the client the fees necessary to obtain a medical evaluation. In situations in which the client is indigent, the lawyer may pay the costs associated with litigation regardless of whether the funds will be repaid. [FN94]

The Waiting Game.

In some situations, it may be advisable to simply wait to proceed until such time as capacity appears less problematic. This situation is illustrated by the previously mentioned situation involving the client who appeared in immigration court shortly after having used inhalants in the detention facility. The apparent limitations on his capacity to understand the proceedings were time-limited. As indicated previously, this may also occur in situations involving lack of adequate hydration or nutrition, as a response to medication, or as the result of an underlying medical condition. In such situations, the wait is of relatively short duration.

Seeking Assent

The issue of assent, in lieu of informed consent, occurs most frequently in the context of representation of young children. It is generally presumed that a child has the ability to direct his or her own representation, and that an attorney may determine and advocate for the child's legal interest only if the child does not or will not express a preference regarding a particular issue. [FN95]

Consider, as an example, the situation involving Teresa. Despite her relatively young age, she may well be able to voice her preference as to whether she wished to remain in the U.S. for as long as possible, or whether she wished to return to her home country. In this regard, it will be important for the attorney to understand the “child-in-context,” as indicated previously, in order both to understand what Teresa wants and to advocate appropriately for her. There are numerous factors that may affect Teresa's decision including, but not limited to,

her relationship with her family members, if any, in her home country; her economic situation if she were to return or if she were to remain in the U.S.; her potential living situation in the U.S. if she were to remain, even temporarily, and her living situation in her home country if she were to return there; the likelihood that she would be called as a witness in a criminal proceeding against the couple who enslaved her; and the possibility that she might wish to initiate a civil suit against her captors for her imprisonment and enslavement.

Identifying a Legally Authorized Representative

As indicated previously, it may be advisable in some circumstances in which the client is experiencing diminished capacity to have a third party appointed as the client's guardian ad litem, guardian, or conservator. The Model Rules of Professional Conduct explicitly recognize this possibility:

> When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial, or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian. [FN96]

As an example, the attorney handling Teresa's immigration matter may come to believe that the appointment of a guardian ad litem would be helpful to both Teresa and to the conduct of her application. It is possible that Teresa is so traumatized that she is unable to understand the process, to make a decision, or to understand the consequences of a decision. Alternatively, she may not be able to comprehend because of limited education and/or her level of cognitive development. In such circumstances, it may be helpful to have a guardian ad litem appointed for her. In deciding whether to seek a guardian ad litem, the attorney must consider whether this is the least restrictive alternative under the circumstances. [FN97]

Protective Action on the Client's Behalf

The Model Rules of Professional Conduct permit an attorney to take protective action on behalf of a client even in those situations in which a "normal" attorney-client relationship cannot be maintained due to a lack of capacity to communicate or to make considered decisions relevant to representation, if the attorney "reasonably believes that a client is at risk of substantial physical, financial or other harm unless action is taken." [FN98] Permissible protective measures relevant to the immigration context might include consultation with family members, use of a reconsideration or waiting period that would permit clarification or improvement of circumstances, and consultation with other professionals. Attorneys are cautioned to consider the wishes and values of the client and the client's best interests, while maximizing client capacities. [FN99] At least some states have recognized that conferral with family members may be inadvisable, noting that unmarried heterosexual, gay, or lesbian partners may be as important as members of the client's family of origin and that there may be conflict between the client's birth family and his or her nontraditional partner. [FN100]

Unfortunately, such risk-laden circumstances may arise much more frequently than might be supposed. As an example, this writer was consulted by a client who, through another attorney, had filed an application for asylum on the basis of persecution for his political opinion. The initial application had been denied based on a finding that the gentleman, who will be called Ali here, had participated in the torture of political prisoners of the previous regime, which had been overthrown. Ali had fled his home country with his family following the overthrow of that government and his escape from imprisonment under the new regime. His family members' in-

dividual applications for asylum had been approved. Ali's inability to obtain asylum status was perceived by his family as a failure and his involvement with the previous political regime of his country was now a source of shame for them, where it had once been a source of pride. His eldest son, who towered above him in height, had begun to beat him physically in a struggle for status and control within the family. Ali had disclosed these problems during his several visits to the office to discuss the denial of his asylum application. On several such occasions, his face showed clear signs of the battering he had received.

Ali appeared late one afternoon without having arranged an appointment. He was clearly distraught, actually crying and sobbing. It was at the end of the day and everyone else had already left or was in the process of leaving. Without warning, Ali informed this writer that he was carrying a gun and that he intended to blow his brains out in the office as a solution to his misery. Clearly, Ali was in no state to make decisions or to process information; this writer's focus became intervening to prevent his suicide.

A lawyer may even act on behalf of a non-client who has diminished capacity, but in very limited circumstances. In situations in which an individual does not have the capacity to have established an attorney-client relationship, the lawyer may act on behalf of that individual if (1) it is an emergency situation, and (2) the attorney was consulted by the individual or another person acting on behalf of that individual. [FN101] The Model Rules define an emergency as a situation in which the individual's health, safety, or financial interest “is threatened with imminent and irreparable harm.” [FN102] Accordingly, the attorney may “take legal action on behalf of the person only to the extent reasonably necessary to maintain the status quo or otherwise avoid imminent and irreparable harm” and only if the attorney “reasonably believes that the person has no other lawyer, agent, or other representative available.” [FN103] The lawyer in such circumstances is cautioned to maintain the confidences of the client, disclosing them “only to the extent necessary to accomplish the intended protective action.” [FN104]

CONCLUSION

An understanding of client capacity in the immigration context is particularly challenging because of the nature of many clients' immigration experiences, cultural variations, and differences in language. When a client's capacity is actually diminished, the attorney must address numerous ethical issues, including the nature and extent of the client's impairment and how best to maximize the client's capacity in the context of the representation. Additional issues relating to the strategy of the case must also be addressed and will provide the basis for discussion in Part II of this *Briefing*.

[FN1]. The discussion of capacity in this *Briefing* is not be confused with the concept of capacity as it is understood in the context of criminal defense: whether, as the “result of mental disease or defect” the defendant lacked “substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.” American Law Institute, Model Penal Code § 4.01 (1955). *See also Durham v. United States*, 214 F.2d 862, 874-875 (D.C. Cir. 1954).

[FN2]. Vehicular accidents account for one-half of all cases of traumatic brain injury (TBI). Rehabilitation of Persons with Traumatic Brain Injury, National Institutes of Health Consensus Development Conference Statement, 2, 5, 9 (October 1998). Almost one- third of all individuals with TBI suffer serious neurologic sequelae, which commonly involve the brain stem, the frontal lobes, and/or the temporal lobes. Fernando G. Diaz,

"Traumatic Brain Injury and Criminal Behavior," Med. Law 131, 133 (1995). Injury to the frontal lobes, which control the executive functions of the brain, often results in emotional disturbances, personality changes, and difficulties with decision making, planning, focusing, and self-monitoring. Donald T. Stuss & Catherine A. Gow, "'Frontal Dysfunction' After Traumatic Brain Injury, Neuropsychiatry, Neuropsychology, and Behavioral Neurology 272, 273 (1992).

[FN3]. Sana Loue, "Elder Abuse and Neglect in Medicine and Law: The Need for Reform," 22 J. Leg. Med. 159 (2001); Steven Bisbing, Joseph McMenamin, & R. Granville, "Competency, Capacity, and Immunity," in Legal Medicine, 3d ed. (ACLM Textbook Committee ed. 1995).

[FN4]. *Quoted in* A. Frank Johns, "Older Clients with Diminishing Capacity and Their Advance Directives," Real Property, Probate, and Trust J. (2004).

[FN5]. Black's Law Dictionary 302 (8th ed. 2004).

[FN6]. *Id*. at 220.

[FN7]. *Id*.

[FN8]. Charles P. Sabatino, "Determining the Legal Capacity of Elders: Myths and Realities." Presented to the American Psychological Association, August 15, 2008. Retrieved June 18, 2008 from http://www.abanet.org/aging/cle/home.shtml. See, for example, the 1983 version of Model Rule 1.14, which conceives of impairment as either present or absent:

(a) When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability or for some other reasons, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) A lawyer may seek the appointment of a guardian or take other protective action with respect to a client only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest.

[FN9]. Thomas Wray Grayson, "The Effect of the Modern Immigrant on Our Industrial Centers," Medical Problems of Immigration 103, 107-109 (1913).

[FN10]. *See* James W. Trent, Jr., Inventing the Feeble Mind: A History of Mental Retardation in the United States 166-169 (1994).

[FN11]. Fiorello H. Laguardia, The Making of an Insurgent: An Autobiography, 1882-1919, at 65 (1948; reprint 1965).

[FN12]. Restatement (Third) of Law Governing Lawyers § 24 cmt. c.

[FN13]. *See generally* Sana Loue & Earl Pike, Case Studies in Ethics and HIV Research 224 (2007).

[FN14]. *Id*.

[FN15]. As late as the 1970s, an individual in the U.S. who was diagnosed with epilepsy could be involuntarily committed to a mental institution, and many individuals continued to believe that epilepsy was a form of mental

retardation. T.J. Murray, “Epilepsy, the Devil, and Immigration,” 116 Canadian Med. Ass'n J. 963 (1977).

[FN16]. Model Rules of Professional Conduct R. 1.0(E) (2007) (Model Rules). These prerequisites to the establishment of informed consent are analogous to those that have been enunciated in the medical arena: that the patient be provided with information sufficient for decision making; that the patient have capacity to understand the information provided and actually understand the information; and that consent be provided voluntarily. In the context of medical and other health-related research, the requirements for informed consent derive from the principles embedded in several international documents, including the Nuremberg Code and the Helsinki Declarations, and has been incorporated into research guidelines promulgated by the Council for International Organizations of Medical Sciences. Council for International Organizations of Medical Sciences, International Ethical Guidelines for the Conduct of Biomedical Research Involving Human Beings (2002); Council for International Organizations of Medical Sciences, International Guidelines for Ethical Review of Epidemiological Studies (2005). In addition, the provisions of various international conventions and protocols arguably prohibit the conduct of research involving human participants without their informed consent. For instance, the Universal Declaration of Human Rights provides in Article 5 that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

[FN17]. Model Rules *supra* note 16, at R. 1.0 cmt. 6.

[FN18]. Jacqueline Nolan-Haley, “Agents and Informed Consent,” in The Negotiator's Fieldbook: The Desk Reference for the Experienced Negotiator 505, 506 (Andrea Kupfer Schneider & Christopher Honeyman eds. 2006).

[FN19]. *See* Robert B. Fleming, “Lawyers' Ethical Dilemmas: A ‘Normal’ Relationship When Representing Demented Clients and Their Families,” 35 GA.L. REV. 735, 750 (2001).

[FN20]. American Bar Association Commission on Law and Aging & American Psychological Association, Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers 21 (2005) (Handbook).

[FN21]. *Id*. at 21-22. Although this recommendation was made specifically in the context of working with elderly clients, it is equally valid with respect to non-elderly persons.

The concept of incapacity and, accordingly, strategies for its assessment, have evolved over time and place. From the 14th through the 20th centuries, courts in the U.S. and the U.K. used a status-based test to determine incapacity, inquiring whether the individual was non compos mentis, insane, of unsound mind, a spendthrift, or an idiot. Sabatino, *supra* note 5. The status-based test was replaced in the mid-20th century by a medicalized approach, consisting of a two-pronged inquiry: (1) does the individual suffer from a condition that is presumptively disabling, such as mental retardation, mental illness, advanced age, chronic use of drugs or alcohol, or other condition such as epilepsy; and (2) does the disabling condition result in functional disability such that the individual is unable to properly or adequately manage his or her property or person. The 1960s saw a further refinement of “incapacity” through the addition of a third prong: is the individual unable to meet his or her essential needs such as housing and food (“essential needs test”), or does the individual's incapacity endanger his or her safety or welfare (“endangerment test”). Later still, during the 1980s, the concept of capacity evolved to focus on an individual's cognitive capacity: whether, as a result of the presumably disabling condition, the individual was impaired to the extent that he or she lacks a sufficient understanding or capacity to make or communicate responsible decisions.

[FN22]. Handbook, *supra* note 20, at vi.

[FN23]. *Id*. at 16-17.

[FN24]. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition (DSM-IV-TR) 467 (2000).

[FN25]. *Id*. at 464.

[FN26]. Angela Burnett & Michael Peel, "The Health of Survivors of Torture and Organized Violence," 322 Brit. Med. J. 606 (2001).

[FN27]. *See generally* James M. Jaranson & Michael K. Popkin (Eds.), Caring for Victims of Torture (1998).

[FN28]. Patrick Bracken & Caroline Gorst-Unsworth, "The Mental State of Detained Asylum Seekers," 15 Psychiatric Bull. 657 (1991).

[FN29]. Aamer Sultan & Kevin O'Sullivan, "Psychological Disturbances in Asylum Seekers Held in Long Term Detention: A Participant-Observer Account," 175 Med. J. Australia 593 (2001).

[FN30]. Mina Fazel, Jeremy Wheeler, & John Danesh, "Prevalence of Serious Mental Disorder in 7000 Refugees Settled in Western Countries: A Systematic Review," 365 Lancet 1309 (2005).

[FN31]. Richard Goldstein, Nina S. Wampler, & Paul H. Wise, "War Experiences and Distress Symptoms of Bosnian Children," 100 Pediatrics 873 (1997).

[FN32]. Richard Mollica, Charles Poole, Linda Son, Caroline Murray, & Svang Tor, "Effects of War Trauma on Cambodian Refugee Adolescents' Functional Health and Mental Health Status," 36 J. Am. Acad. Child Adolescent Psychiatry 1098 (1997); William H. Sack, Gregory N. Clarke, & John Seeley, "Multiple Forms of Stress in Cambodian Adolescent Refugees," 67 Child Dev. 107 (1996); Stevan Weine, Daniel Becker, Thomas McGlashan, Dolores Vojvoda, Stephen Hartman, & Judith Robbins, "Adolescent Survivors of 'Ethnic Cleansing': Observations on the First Year in America," 34 J. Am. Acad. Child Adolescent Psychiatry 1153 (1995).

[FN33]. Ellen Hepinstall, Vaheshta Sethna, & Eric Taylor, "PTSD and Depression in Refugee Children: Associations with Pre-Migration Trauma and Post-Migration Stress," 13 European Child Adolescent Psychiatry 373 (2004).

[FN34]. Eugenio M. Rothe, John Lewis, Hector Castilo-Matos, Orestes Martinez, Ruben Busquets, & Igna Martinez, "Posttraumatic Stress Disorder among Cuban Children and Adolescents after Release from a Refugee Camp," 53 Psychiatric Serv. 970 (2002).

[FN35]. Zachary Steel, Derrick Silove, Tuong Phan, & Adrian Bauman, "Long-Term Effect of Psychological Trauma on the Mental Health of Vietnamese Refugees Resettled in Australia: A Population-Based Study," 360 Lancet 1056 (2002); Peter Cheung, "Post-Traumatic Stress Disorder among Cambodian Refugees in New Zealand," 40 Int'l J. Soc. Psychiatry 17 (1994); R.C-Y. Chung & Margaret Kagawa-Singer, "Predictors of Psychological Distress among Southeast Asian Refugees," 36 Soc. Sci. & Med. 631 (1993).

[FN36]. Richard C. Cervantes, V. Nelly Salgado de Snyder, & Amado M. Padilla, "Posttraumatic Stress in Immigrants from Central America and Mexico," 40 Hosp. Community Psychiatry 615 (1989).

[FN37]. Mark Van Ommerren, Joop T.V.M. de Jong, Bhogendra Sharma, Ivan Komproe, Suraj Thapa, & Etzel Cardena, "Psychiatric Disorders Among Tortured Bhutanese Refugees in Nepal," 58 Arch. Gen. Psychiatry 475 (2001).

[FN38]. Robert Schweitzer, Fritha Melville, Zachary Steel, & Philippe Lacherez, "Trauma, Post-Migration Living Difficulties, and Social Support as Predictors of Psychological Adjustment in Resettled Sudanese Refugees," 40 Australian & New Zealand J. Psychiatry 179 (2006); Metin Başoğ lu & Murat Paker, "Severity of Trauma as a Predictor of Long-Term Psychological Status in Survivors of Torture," 9 J. Anxiety Disorders 339 (1995).

[FN39]. Bracken & Gorst-Unsworth, *supra* note 28; Zachary Steel & Derrick M. Silove, "The Mental Health Implications of Detaining Asylum Seekers," 175 Med. J. Australia 596 (2001); Maritza Thompson & Patrick McGorry, "Maribyrnong Detention Centre Tamil Survey," in The Mental Health and Well-Being of On-Shore Asylum Seekers In Australia 27-31 (Derrick Silove & Zachary Steel eds. 1998); Rise Becker & Derrick Silove, "Psychiatric and Psychosocial Effects of Prolonged Detention in Asylum-Seekers," in Protection or Punishment: The Detention of Asylum-Seekers in Australia 46-63 (Mary Crock ed. 1993).

[FN40]. Sultan & O'Sullivan, *supra* note 29.

[FN41]. *Id*.

[FN42]. Karen J. Zwi, Brenda Herzberg, David Dossetor, & Jyotsna Field, "A Child in Detention: Dilemmas Faced by Health Professionals," 179 Med. J. Australia 319 (2003).

[FN43]. Wendy Ayott & Louise Williamson, Separated Children in the UK: An Overview of the Current Situation (2001); Simon Russel, Most Vulnerable of All: The Treatment of Unaccompanied Refugee Children in the U.K. (1999).

[FN44]. DSM-IV-TR, *supra* note 24, at 471.

[FN45]. *Id*. at 472.

[FN46]. Pauline Boss, Ambiguous Loss: Learning to Live with Unresolved Grief (1999).

[FN47]. DSM-IV-TR, *supra* note 24, at 741.

[FN48]. Rosebud O. Roberts, Yonas E. Geda, David S. Knopman, Teresa J.H. Christianson, V. Shane Pankratz, Bradley F. Boeve et al., "Association of Duration and Severity of Diabetes Mellitus with Mild Cognitive Impairment," 65 Arch. Neurology 1066 (2008); Sang Won Suh, Koji Aoyama, Yongmei Chen, Philippe Garnier, Yasuhiko Matsumori, Elizabeth Gum et al., "Hypoglycemic Neuronal Death and Cognitive Impairment Are Prevented by Poly (ADP-Ribose) Polymerase Inhibitors Administered After Hypoglycemia," 23 J. Neurosci. 10681 (2003); Robert Stewart & D. Liolitsa, "Type 2 Diabetes Mellitus, Cognitive Impairment and Dementia," 16 Diabetes Med. 93 (1999).

[FN49]. Handbook, *supra* note 20, at 17.

[FN50]. DSM-IV-TR, *supra* note 24, at 201.

[FN51]. Handbook, *supra* note 20, at 28.

[FN52]. *Id*. at 17.

[FN53]. United States Department of Health and Human Services, Mental Health: A Report of the Surgeon General (1999).

[FN54]. Arthur Kleinman, "How Is Culture Important For DSM-IV?" in Culture & Psychiatric Diagnosis: A DSM-IV Perspective 16 (Juan E. Mezzich, Arthur Kleinman, & Horacio Fabrega, Jr. eds. 1996).

[FN55]. *See* Ruth R. Faden & Thomas L. Beauchamp, A History of Informed Consent 238 (1986).

[FN56]. Keymantrhi Moodley, "HIV Vaccine Trial Participation in South Africa--An Ethical Assessment," 27 J. Med. & Philosophy 197 (2002).

[FN57]. Nicole A. King, "Comment, The Role of Culture in Psychology: A Look at Mental Illness and the 'Cultural Defense,"' 7 Tulsa J. Comp. & Int'l L. 199, 212 (1999).

[FN58]. Janice A. Egeland, Abram M. Hostetter, & S. Kendrick Eshleman, "Amish Study, III: The Impact of Cultural Factors on Diagnosis of Bipolar Illness," 140 Am. J. Psychiatry 67, 68 (1983).

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[FN74]. Model Rules, *supra* note 16, at R. 1.14 (a).

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[FN76]. *Id*. at R. 1.14, cmt. 1.

[FN77]. *Id*. at R. 1.4, cmt. 6.

[FN78]. *Id*. at R. 1.14 cmt. 2.

[FN79]. Handbook, *supra* note 20, at 29. Colorado's Code of Professional Conduct Rule 1.14 (1993) provided even at a relatively early date that: "Not only can the mental, physical, or other condition of the client impose additional responsibilities on the lawyer, the fact that a client is impaired does not relieve the lawyer of the obligation to obtain information from the client to the extent possible."

[FN80]. Handbook, *supra* note 20, at vii.

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[FN96]. Model Rules, *supra* note 16, at R. 1.14 (b).

[FN97]. Comments to New Hampshire Rules of Professional Conduct underscore the need to pursue the least restrictive alternative in situations involving a client with diminished capacity. New Hampshire Rules of Professional Conduct R. 1.14 cmt 3.

[FN98]. Model Rules, *supra* note 16, at R. 1.14 cmt. 5.

[FN99]. *Id*.

[FN100]. *E.g.*, New Hampshire Rules of Professional Conduct, R. 1.14 cmt 2.

[FN101]. Model Rules, *supra* note 16, at R.1.14 cmt. 9.

[FN102]. *Id*.

[FN103]. *Id*.

[FN104]. *Id*. at R. 1.14 cmt. 10.

[FNa1]. Sana Loue is a Professor and the Director of the Center for Minority Health in the Department of Epidemiology and Biostatistics at Case Western Reserve University School of Medicine in Cleveland, Ohio. Previously, she served as Senior Attorney of the Aliens' Rights Unit of the Legal Aid Society of San Diego, Inc., where she also supervised the HIV Legal Hotline. She received her J.D. in 1980 from the University of San Diego Law School, her Ph.D. in epidemiology from UCLA in 1993, and her Ph.D. in medical anthropology from Case Western Reserve University in 2004. Dr. Loue, who has served as chair of the San Diego chapter of the American Immigration Lawyers Association, is the author of numerous articles on the health aspects of immigration law, including Access to Care and the Undocumented Alien, Representing HIV-Positive Clients, Health-Related Issues in Immigration Practice, and The Role of the Physician in Political Asylum Proceedings, and has spoken at many seminars and conferences on the subject. She is also the author of the treatise, Immigration Law and Health (Thomson/West). Her current research addresses HIV prevention, family violence, and mental illness among minority and marginalized populations.
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