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Independent Protection and Advocacy: The Role of Counsel in Institutional Settings

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I. INTRODUCTION

Over thirty years ago, the conscience of America was shocked by media exposés revealing horrific conditions inside institutions housing people with mental disabilities. Congressional hearings later confirmed that people with disabilities—most warehoused in large state institutions—were being systematically abused, neglected, and deprived of basic civil rights.[1] In response, Congress created a nationwide system of organizations with a mandate to provide protection and advocacy for these vulnerable individuals. The statutory framework for this system also insured that a steady light would be cast on facilities that historically had operated largely out of the public view.

This article will focus on the role of counsel in providing institutional advocacy, drawing on the author's thirteen years of experience as an attorney within the federally funded Protection and Advocacy ("P&A") system. Part II will provide an overview of the P&A system, describing its mission and key features, and exploring how these impact the role of counsel. Part III will describe the advocacy model used by the P&A agency in Massachusetts and discuss allocation of resources. Part IV will discuss the substantive areas of facility-based advocacy, including trends and issues in representation. Part V will focus on collaboration and the potential for conflict between P&A facility attorneys and court-appointed counsel. Part VI will discuss the importance of an "empowerment" style of advocacy and its relationship to recovery for mental health consumers.

II. OVERVIEW OF THE PROTECTION AND ADVOCACY SYSTEM

Congress created the P&A system by passing a series of interrelated statutes that set forth the system's key features, beginning in 1975 with the Developmental Disabilities Act. While the core statutes each identified a different group of people by disability, they were substantially similar in describing the manner in which each group's rights were to be protected.[2] More recently, Congress also passed statutes that allocate funding for P&A agencies[3] to work across disabilities in specific substantive areas.[4]

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1. *See, e.g.*, *Examining the Issues Related to the Care and Treatment of the Nation's Institutionalized Mentally Disabled Persons: Joint Hearings Before the Subcomm. on the Handicapped of the S. Comm. on Labor and Human Resources and the Subcomm. on Labor, Health and Human Servs., Educ. and Related Agencies of the Comm. on Appropriations*, 99th Cong., 1st Sess. (1985) (Hr'g No. 99-50, pt. II).

2. The first statute passed by Congress was the Developmental Disabilities Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000–6083 (1994), *repealed by* Developmental Disabilities Assistance and Bill of Rights Act of 2000 ("DDA"), 42 U.S.C. §§ 15001–15115 (2000). Subsequent statutes passed by Congress include the Protection and Advocacy for Individuals with Mental Illness Act ("PAIMI"), 42 U.S.C. §§ 10801–10807, 10821–10827, 10841, 10851 (2000); the Protection and Advocacy for Individual Rights Act ("PAIR"), 29 U.S.C. § 794e (2000); and the Protection and Advocacy for Persons with Traumatic Brain Injury ("PATBI") provision of the Public Health Service Act, 42 U.S.C. § 300d-53 (2000 & Supp. 2008).

3. Protection and Advocacy agencies are commonly referred to as P&As throughout the nationwide system.

4. These include grants for P&A services related to assistive technology under the Assistive Technology Act of 1998, 29 U.S.C. § 3004 (2000), and grants for P&A services to ensure voting access under the

Most of the core statutes are modeled on the Developmental Disabilities Act and share similar statements of mission and key features. For example, the purpose of the Protection and Advocacy for Individuals with Mental Illness ("PAIMI") Act is set forth as follows:

> [T]o . . . establish and operate a protection and advocacy system for individuals with mental illness which will . . . protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and State statutes; and . . . investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.[5]

The P&A mission is operationalized through statutory provisions which, among other things, provide federal funding to the enumerated programs and grant the P&A agencies unique authority to gain access to individuals with disabilities, their records, and the facilities in which they reside. There is one designated P&A agency in every state, and the funding and access authority run only to that agency.

The access authority is one of the most important features of the P&A system. It is broad and relatively unfettered, in keeping with the original Congressional findings concerning abuse, neglect, and rights violations in facilities housing people with disabilities. All three types of access—to individuals, their records, and the facilities or residences in which they live—are key to the day-to-day work of the P&A attorneys.[6]

While an in-depth discussion of these access provisions is beyond the scope of this article, it is worth noting that access to individuals for the purpose of providing outreach and education is almost completely unfettered. This includes initial conversations in facilities that may house juveniles and/or adults under guardianship.[7] P&A agencies also have what is referred to as "probable cause authority," which allows access to records without the specific consent of the individual if the P&A agency makes a finding of probable cause to believe that abuse or serious neglect has occurred.[8] Access authority is an issue that is vigorously litigated by P&A agencies when access is denied. It is critical that they continue to do so, and accept no compromise on this issue, since this access underlies all else in terms of the P&A mission.

Help America Vote Act, 42 U.S.C. § 15461 (effective Oct. 29, 2002).

5. 42 U.S.C. § 10801(b) (2000).

6. *See generally* 42 U.S.C. §§ 10805(a)(1)(B)–(C) & 15043(a)(2)(I)–(J) (2000) (access provisions of the PAIMI and DDA).

7. While accessing records and providing advocacy on behalf of these individuals may require consent of the guardian, talking to the individuals about the role of the P&A and their rights does not.

8. *See generally* 42 U.S.C. §§ 10805(a)(1)(A), (4)(B) & 15043(a)(2)(B), (I) (2000) (probable cause authority provisions). Several courts have ruled on the contours of the probable cause authority. *See, e.g.*, Protection & Advocacy for Persons with Disabilities v. Armstrong, 266 F. Supp. 2d 303 (D. Conn. 2003); Advocacy, Inc. v. Tarrant County Hosp. Dist., No. 4:01-CV-062-BE, 2001 WL 1297688 (N.D. Tex. Oct. 11, 2001); Ariz. Ctr. for Disability Law v. Allen, 197 F.R.D. 689 (D. Ariz. 2000).

Courts have recognized that P&A access is fundamental, and P&A agencies have almost universally prevailed in this type of litigation.[9]

The role of counsel in the P&A system is also shaped to some degree by the unique access authority granted to P&A agencies. When a call about an incident is received, one of the key roles advocates may play is to educate unfamiliar facility staff and administrators about the P&A agency's unique function and access authority. The access then allows the P&A agency to either conduct its own investigation or review an investigation conducted by another entity. Access may also be used to discern whether there is a pattern of violations that requires systemic advocacy. Armed with this information, advocates can more often than not achieve meaningful relief through negotiation.

This unique access authority also allows P&A agencies to maintain an ongoing presence at certain facilities, allowing problems to be addressed earlier than they would be otherwise and therefore decreasing the need for litigation. P&A attorneys have timely access to information, including that which could otherwise only be obtained through formal discovery. In some areas, such as access to peer review materials, P&A access yields more information than may be obtained through litigation.[10] As a result, advocates are able to negotiate prospective changes without either party having to incur the costs—both monetary and non-monetary—associated with litigation. When negotiation fails, or is taking so long as to endanger the health, welfare, or fundamental rights of people with disabilities, advocates are in a stronger position to craft a persuasive complaint and request for preliminary relief. This in turn can foster early settlement and thus maximize the efficient use of limited P&A agency resources.

In addition to access authority, a second key feature of P&A enabling statutes is the allocation of federal funding to P&A agencies. This has always been critical, since most facilities and services for people with disabilities tend to be operated or funded by the state. In addition to providing a consistent source of operating income, federal funding keeps P&A agencies financially independent of state government, insulating them from possible negative political and fiscal repercussions as a result of their advocacy.

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9. For an overview of access litigation, see Deborah F. Buckman, *Validity, Construction and Operation of the Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C.A. §§ 10801 et seq.*, 191 A.L.R. Fed. 205 (2004).

10. The peer review process involves care providers taking a critical look at their own performance following an adverse event. The results of this process are generally privileged by state statute. However, courts have found that P&A agencies are entitled to "peer review" information as part of their records access. *See* Ctr. for Legal Advocacy v. Hammons, 323 F.3d 1262 (10th Cir. 2003); Pa. Protection & Advocacy, Inc. v. Houston, 228 F.3d 423 (3d Cir. 2000).

III. ADVOCACY MODEL AND ALLOCATION OF RESOURCES IN THE MASSACHUSETTS PROTECTION AND ADVOCACY AGENCY

The Disability Law Center is the designated P&A agency for Massachusetts. Like all P&A agencies, the Disability Law Center tries to achieve the greatest impact it can with limited resources. As a threshold matter, this means that the Disability Law Center tries not to duplicate the efforts of other agencies and tries to fill advocacy needs that would otherwise be unmet. As a general matter, therefore, the Disability Law Center does not provide representation in matters for which there is a right to court-appointed counsel. These include civil commitment, criminal defense, and court-ordered treatment. However, the P&A attorneys who do facility-based work are certified to handle civil commitment and court-ordered treatment cases if a specific need arises. P&A attorneys also sometimes handle appeals that arise out of these proceedings where the appellate decision may have broader impact.[11] As will be discussed in Section V, *infra*, P&A facility attorneys often collaborate with court-appointed counsel in these types of cases.

Similarly, the Disability Law Center does less prison work than other P&A agencies because Massachusetts has its own prisoners' legal services organization, Massachusetts Correctional Legal Services ("MCLS").[12] In recent years, MCLS has become increasingly well-staffed and effective at representing inmates on a host of civil rights issues, with attorneys on staff offering expertise in working with prisoners who have disabilities. The Disability Law Center works closely with MCLS through referrals and collaboration on projects and litigation.

In the area of abuse and severe neglect, the Disability Law Center uses a model of conducting mostly secondary investigations, in which it gathers facts and reviews records for the purpose of evaluating the quality of a primary investigation conducted by another agency. The agency's decision to conduct secondary investigations is due in part to the existence of a quasi-independent state agency, the Disabled Persons Protection Commission ("DPPC"). The DPPC is charged with investigating abuse and severe neglect allegations that it receives through mandated reporting and calls to a twenty-four hour hotline. DPPC also actively collaborates with the state police and district attorneys' offices, thereby facilitating not only civil enforcement, but also criminal enforcement when criminal prosecution is warranted.[13]

In Massachusetts, complaints of abuse and neglect are also investigated by specialized offices of investigation within the state licensing and service providing agencies, such as the Department of Mental Health and the Department of Mental

11. For example, in *Commonwealth v. Carrara*, 787 N.E.2d 1128 (Mass. App. Ct. 2003), the P&A attorney provided appellate representation in a case addressing the issue of whether a civil commitment order could restrict the client's movement on hospital grounds. In other cases, the P&A may file a brief as amicus curiae. *See., e.g.*, Newton-Wellesley Hosp. v. Magrini, 889 N.E.2d 929 (Mass. 2008).

12. *See generally* Mass. Correctional Legal Servs., http://www.mcls.net (last visited Sept. 7, 2008).

13. *See* Mass. Gen. Laws ch. 19C, § 5 (2008).

Retardation.[14] Given these resources, the Disability Law Center has chosen a model of requesting or initiating investigations, reviewing the investigations for quality and thoroughness, filing agency appeals, and monitoring corrective action. Other P&A agencies have created their own internal investigative capacity and have specially trained staff members who conduct primary investigations.[15] The results of these investigations are often detailed in reports, media stories, and other advocacy efforts seeking systemic change.[16]

Finally, when it comes to litigation resources, the Disability Law Center tends to utilize its limited resources to seek systemic reform on behalf of groups in cases in which counsel might not otherwise be available. Examples include cases seeking discharge of individuals with intellectual disabilities from nursing homes into the community[17] and cases seeking alternatives to segregation for prisoners with mental disabilities.[18] Although the Disability Law Center may seek damages in cases of first impression or to achieve some other law reform purpose, the agency will typically refer "damages only" personal injury type cases to the private bar, with the expectation that personal injury and civil rights attorneys will pursue cases that involve the prospect of a significant damage award.

With regard to institutional advocacy, the Disability Law Center uses a mixed model that includes both regular monitoring at certain facilities and more traditional intake methods to serve people at other facilities. The agency maintains a regular presence at each of the large, state-run psychiatric institutions. Legal advocates go to their assigned facility at least one full day per week. In terms of agency resources, this equates to a little over one full-time equivalent ("FTE") devoted to these institutions. Other individual facility cases come in through more typical forms of outreach and the regular telephone intake process. These cases arise from numerous other types of facilities, including group homes, nursing homes, general hospitals, emergency rooms, private acute care psychiatric hospitals, jails, prisons, and specialized rehabilitation facilities for people with brain injuries.

The model of maintaining a regular presence at designated institutions has advantages and disadvantages. It also raises significant issues in terms of the role of counsel and is thus worthy of an in-depth discussion. One of the most obvious, and

14. *See* Dep't of Mental Health Investigation and Reporting Responsibilities, 104 Mass. Code Regs. § 32.00–32.09 (2008); Dep't of Mental Retardation Investigation and Reporting Responsibilities, 115 Mass. Code Regs. § 9.00–.18 (2008).

15. *See, e.g.*, Protection & Advocacy, Inc., http://www.pai-ca.org (last visited Sept. 9, 2008) (California's P&A agency).

16. *See, e.g.*, Protection & Advocacy, Inc., *Restraint & Seclusion in California Schools: A Failing Grade*, http://www.pai-ca.org/pubs (last visited Nov. 20, 2008).

17. This case settled, but also gave rise to several reported decisions. *See* Rolland v. Patrick, 483 F. Supp. 2d 107 (D. Mass. 2007); Rolland v. Cellucci, 138 F. Supp. 2d 110 (D. Mass. 2001).

18. *See, e.g.*, Complaint, Disability Law Ctr., Inc. v. Mass. Dep't of Correction, No. 07-10463 (D. Mass. Mar. 8, 2007) [hereinafter Complaint], *available at* http://www.masslegalservices.org/docs/Complaint_FINAL.pdf.

most important, advantages to maintaining a regular presence in facilities is the opportunity to interact with clients whose disability might prevent them from independently seeking out advocacy services. Another similar advantage is the ability to uncover, for example, clients in a long-term psychiatric facility may not complain directly about the quality of the medical care they are receiving, but in the course of going through medical records, advocates may discover systemic failings that could have significant adverse or even deadly consequences for the client and others.

Once systemic issues are uncovered, advocates with a regular presence at a facility may be in a better position to effect change. After an initial investment in building relationships with clients and facility staff, established advocates can often accomplish systemic improvements and do so in a relatively efficient manner. This is especially true once facility staff and administrators come to know and respect an advocate's work.

Other advantages to this model include the advocate's ability to become a vital source of independent information that is essential to clients' sense of empowerment and ability to exercise their rights. As opposed to people with disabilities living in the community, institutionalized clients' access to information is severely restricted. Further, the information that *is* available often comes with no small amount of coercion or psychiatric "spin" attached.

In addition to providing needed information, the advocate's regular presence also provides the "backup" necessary for the effective exercise of clients' rights. In other words, if an advocate advises a client that she or he has the right to do or not do something, and encourages the client to exercise that right, the advocate will be there the following week in person (or by phone at any time) to support the client in that exercise. In this way, clients are empowered to speak and advocate for themselves, but they are also not left out on a limb.

In terms of disadvantages, the first and perhaps most obvious disadvantage of maintaining a regular presence at a facility is that advocates run the risk of becoming co-opted. By virtue of being part of the "milieu" on a regular basis and having regular interactions with staff, advocates may subtly (or not so subtly), take on the perspective of the provider, subordinating clients' rights to what is thought to be in the best interests of the client or the treatment environment as a whole.[19] Another disadvantage is that, from an organizational standpoint, a P&A agency is devoting a substantial amount of resources—in the case of our agency, one FTE—to what is a shrinking proportion of the population eligible for the agency's services.[20] Advocates therefore risk failing to address more pressing needs elsewhere. In spite of the careful

19. For further discussion of this issue, see Sections IV(B), V, and VI, *infra*.

20. With fewer people in large state hospitals, more people living in the community, and an expansion of eligibility under the PAIMI statute, this population is now a relatively small percentage of those who are eligible to be served under the PAIMI program.

enumeration of agency-wide advocacy priorities,[21] the pressure always exists to work on issues that arise in the covered facility, although those issues may be less pressing in terms of overall severity. The reasons for this pressure include things such as difficulty in saying "no" when meeting with clients face-to-face on a recurring basis, or a reluctance to turn down staff referrals, out of a fear that this might discourage them from making such referrals in the future. Finally, another disadvantage to having advocates cover facilities regularly is that once they have built effective working relationships, there is potentially more to lose by bringing an action for damages against individual staff members at a facility. While bringing cases like this can send a powerful message, such action can potentially shut down informal avenues of communication and require that all future contacts with facility staff go through counsel.

IV. SUBSTANTIVE AREAS OF REPRESENTATION: TRENDS AND ISSUES IN ADVOCACY

Because the focus of this article is the role of counsel in institutional advocacy, the discussion will be limited to those substantive areas affecting mental health consumers living in institutions. However, most P&A agencies, including the Disability Law Center, also provide legal assistance in the areas of special education, public benefits, health care, housing, employment, and access to places of public accommodation.[22]

In terms of facility work, it is worth noting at the outset that "facility" is defined broadly enough to include group homes of three or more people, general hospitals, nursing homes, rehabilitation facilities, jails, prisons, and state institutions. Again, advocates typically spend one day per week at a large state psychiatric facility and also handle a mix of individual cases and systemic reform litigation arising out of other facilities.

A. Abuse and Neglect—Current Trends and Issues in Representation

1. Abuse

One of the most significant general trends of the last ten or more years has been the downsizing of large state institutions. The population in these institutions, as a percentage of the overall population of mental health consumers, is shrinking. Similarly, the length of stay is shorter, often measured in months instead of years, unless a client has a complex history that makes him more difficult to place. For example, clients with a background that includes arson or sex offending behavior, still stay in these facilities for years, with preventive detention often taking primacy

21. All P&A agencies go through a regular priority setting process, soliciting input from consumers, advocates, and other interested parties in determining what the priorities will be. For work done under the PAIMI Act, the priorities are formally developed and approved by a consumer advisory council. *See* 42 U.S.C. § 10805(a)(6) (2000) (PAIMI provision providing for such council).

22. *See* Disability Law Ctr., the Protection & Advocacy Agency for Mass., http://www.dlc-ma.org (last visited Sept. 9, 2008).

over treatment. In addition, clients with dual diagnoses can also languish, falling victim to a fractured service delivery system. This "dual diagnosis" category is often made up of clients who have a co-existing intellectual disability or a brain injury and have entered the hospital via the criminal justice system. If and when the criminal charges are resolved, and the client is ready for discharge, various state agencies often dispute their responsibility for serving the client in the community. However, as a general matter, the trend is toward shorter-term stays.

Another favorable trend in large psychiatric facilities in Massachusetts is that there appears to be fewer instances of outright physical abuse, in which a client is assaulted by staff and sustains physical injuries. Abuse is more likely now to be psychological or to involve the use of restraint and seclusion. The restraint may be unjustified in its inception, or be excessive in terms of force or duration. Often, it is a combination of all of these. This form of abuse has also become somewhat less common in the last few years, as Massachusetts state hospitals have sought to reduce and eventually eliminate the use of restraint and seclusion. The hospitals have done this with the assistance of a federal grant.[23] P&A advocates assigned to the various hospitals have been an integral part of the restraint and seclusion elimination initiative in Massachusetts.

In the cases of staff on client abuse that do arise, the role of counsel often first involves the preservation of evidence, such as ensuring that pictures are taken and that clients are evaluated medically. It may also involve ensuring that the staff member alleged to have assaulted the client is reassigned or put on leave pending an investigation. If the P&A agency is not one which conducts primary investigations, advocates also need to make sure that the abuse is reported and that the ensuing investigation is closely monitored. If the P&A agency does conduct its own investigations, that agency will often follow specific protocols. In Massachusetts, the advocate's role will typically be to monitor the primary investigation and ensure that the investigation is conducted in a thorough, timely manner. At the conclusion of the investigation, the advocate often appeals for further investigation, or seeks to ensure that appropriate disciplinary or corrective action is taken. An issue for advocates to be aware of is the practice of allowing an abusive staff member to resign in order to avoid a lengthy disciplinary process with the involvement of the union. While resignation may be the quickest and most certain way to remove the staff member from the facility, it does not necessarily prevent the offender from moving on to a similar position at another facility.

23. This was an initiative of the Substance Abuse and Mental Health Services Administration ("SAMSHA") and its Center for Mental Health Services ("CMHS"). The grant was administered by the National Technical Assistance Center for State Mental Health Planning ("NTAC"). For information on the initiative, see Office of Technical Assistance (formerly NTAC), National Association for State Mental Health Program Directors, http://www.nasmhpd.org/ntac.cfm (last visited Sept. 9, 2008).

Facility-based advocates can also assist clients in accessing the courts to pursue criminal charges if they decide to do so[24] and with referrals to a personal injury attorney if damages are sought. *Davis v. Rennie* is an example of a damages case that arose out of a restraint in a state psychiatric facility, Westboro State Hospital.[25] It is one of the relatively few reported cases concerning this substantive area in Massachusetts and the case is instructive because it also addresses issues of supervisory liability.

Another issue that advocates need to be alert to is when clients are charged for assault against facility staff. This often arises as the result of a physical altercation that occurs during the course of a restraint. Many mental health consumers have experienced various forms of trauma and are in the hospital at least in part due to that history. This trauma history may dictate how clients respond when they are surrounded by staff and "taken down" to the floor. Advocates have a role to play in seeking to avoid unwarranted prosecutions that subject mental health clients to all of the devastating primary and collateral consequences associated with entry into the criminal justice system.[26] The first step is to be actively involved in prompting the facility to adopt policies and practices to eliminate or reduce restraint and seclusion. These reduction efforts often go hand-in-hand with implementing trauma-informed and recovery-oriented models of care.[27] Since restraint and seclusion elimination is not often achieved quickly, advocates should in the meantime encourage the facility to adopt a policy that favors informal, facility-based mediation over the filing of a criminal complaint.[28] Finally, if charges are brought, advocates may assist their client's defense attorney by providing information about the restraint incident or the prevalence of post traumatic stress disorder ("PTSD") among mental health consumers. Defense attorneys may need to be educated that PTSD often causes people to automatically resort to a physically defensive mode when surrounded by staff as a

24. This can be an issue if the client has access only to campus security and is deterred from accessing the courts in ways that are available to other members of the community. A recent advocacy example involved ensuring that state hospital clients had the same ability to file an "application for a criminal complaint" as did the general public, and that they were given the opportunity to have the subsequent "show cause" hearing in regular court, as opposed to a court sitting inside the hospital for civil commitment hearings. The Americans with Disabilities Act, 42 U.S.C. §§ 12101–12231 (2000), can be invoked to ensure equal access to the courts.

25. 264 F.3d 86 (1st Cir. 2001).

26. Even if a person escapes the inadequate treatment and often horrific conditions faced by mentally ill inmates in prisons, the collateral consequences associated with a conviction include those related to immigration, public benefits, public housing, and employment.

27. For more information on trauma-informed care, see National Center for Trauma-Informed Care, http://www.mentalhealth.samhsa.gov/nctic (last visited Sept. 9, 2008). For more information on recovery, see Boston University's Center for Psychiatric Rehabilitation, http://www.bu.edu/cpr (last visited Sept. 9, 2008).

28. While most facilities come to the conclusion that they cannot legally prohibit staff members from seeking criminal charges against clients, they can discourage the practice, such as by requiring staff to make court appearances on their own time.

prelude to being "taken down" and restrained. Efforts should be made by advocates to seek defense attorneys who are familiar with mental health issues and mental health facilities. In Massachusetts, the public defender agency has developed a list of attorneys who are certified in both criminal practice and mental health practice so that a client facing charges arising out of these circumstances can be assigned an attorney familiar with these issues.

What appears to be a downward trend in outright physical abuse in large state psychiatric facilities here in Massachusetts does not hold true for jails and prisons. Physical and psychological abuse, particularly of individuals with mental disabilities, appears to be rampant in prisons and jails, where stressful conditions increase the symptomatology of mental health clients and treatment is often severely lacking. The Disability Law Center has filed suit on behalf of prisoners with mental disabilities who are being held in segregation, following an investigation into a number of prisoner suicides in solitary confinement.[29]

Emergency rooms are another arena in which levels of abuse appear to be holding constant, if not growing. It is more common than ever for individuals experiencing a psychiatric crisis to be detained in emergency rooms. They are also being detained for longer and longer periods of time. Abuse takes the form of excessive force, unnecessary restraint, and psychological abuse. Many consumer/survivor organizations are working to improve the environment of care for mental health clients in emergency rooms and are developing alternatives whereby clients can receive peer support or other forms of support that ease the severity of the crisis, rather than exacerbate it. Advocates can support these efforts and file complaints to draw attention to the need for systemic change.[30]

2. Neglect

While outright physical abuse may be less common than it used to be in large state facilities, neglect remains present in many forms, in all types of facilities. One of the more common and troubling forms of neglect is medical neglect of people with mental disabilities. The causes of such neglect are varied. In general hospitals, clients may enter the hospital complaining of a physical ailment, but find themselves diverted to a psychiatric ward once their computerized medical record reveals that they have a psychiatric history. As a result, the physical complaint may or may not

29. *See* Complaint, *supra* note 18. The P&A agency is both counsel and plaintiff in this case, exercising its associational standing on behalf of prisoners. For more information on prison conditions underlying the suit, see a three-part "Spotlight Series" on the issue: Beth Healy et al., *Breakdown: The Prison Suicide Crisis*, Boston Globe, Dec. 9–11, 2007, at 1A. For cases on P&A agency standing, see Or. Advocacy Ctr. v. Mink, 322 F.3d 1101 (9th Cir. 2003); Doe v. Stincer, 175 F.3d 879 (11th Cir. 1999); Risinger v. Concannon, 117 F. Supp. 2d 61 (D. Me. 2000); Trautz v. Weisman, 846 F. Supp. 1160 (S.D.N.Y. 1994).

30. *See* Susan Stefan, Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements (2006); Liz Kowalczyk, *Psychiatric Patients Feel Strain: State Investigates Complaints at ERs*, Boston Globe, July 15, 2007, at 1A.

be adequately followed up on by staff. Similarly, psychiatric facilities may deliver substandard medical care for a host of reasons. The focus may be on psychiatric issues rather than physical issues, and client complaints may be labeled as delusional. The role of the psychiatrist is often a factor. If the model of care is such that the psychiatrist acts as a primary care clinician and gatekeeper, limited or outdated knowledge, limited time, and psychiatric bias may act to prevent access to needed care. If the model is that the psychiatrist focuses primarily on treatment of mental illness, with medical care being provided by a separate clinic or offsite provider, the care may be fractured. Under these conditions, lack of communication and inadequate coordination of care may contribute to the neglect. These problems are exacerbated by current trends toward greater "co-morbidity" in this population. In other words, people with mental illness are trending toward more, and more severe, medical conditions.[31] People are on ever greater numbers of medications, including psychiatric drugs that may cause or contribute to a high risk for diabetes, heart disease, obesity, and other illnesses. The risk of medical neglect is also heightened by the severe, long-term, nationwide nursing shortage, as nurses traditionally have played a critical role in medical monitoring and patient education. Whatever the causes of the medical neglect, advocates must be proactive. While many clients would approach an attorney with a more typical rights violation—such as being held in the hospital too long or having access to visitors restricted—it is much less common for clients to suspect medical neglect and approach advocates about this issue. Advocates therefore need to be aware of these issues when reviewing records, talking to clients, and meeting with facility administrators.

Information on medical neglect and adverse medical events is also available through monitoring and accreditation reports issued by the Center for Medicaid Services ("CMS"), a federal agency which sets conditions of participation in order to receive Medicaid, and the Joint Commission (formerly JCAHO), a not-for-profit national organization which accredits most healthcare facilities. Advocates should also keep in mind that improving medical care can be an issue that hospitals are willing to work on proactively and cooperatively. Such an approach can avoid adverse outcomes that lead to potential liability and/or being found in violation by CMS, the Joint Commission, or other licensing authority. The threat of a complaint to one of these monitoring agencies is taken very seriously. A final point to keep in mind is that, to be effective in this area, advocates may need to familiarize themselves with medical issues and standards of care. They may need to have access to a medical expert who can offer an opinion and make recommendations on quality of

31. *See* Am. Diabetes Ass'n et al., *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes*, 27 Diabetes Care 596 (2004); Marilyn Elias, *Mentally Ill Die 25 Years Earlier, on Average*, USA Today, May 3, 2007, *available at* http://www.usatoday.com/news/health/2007-05-03-mental-illness_N.htm; Michael Smith, *APA: Schizophrenia Patients Go Untreated for Comorbidities,* MedPage Today, May 24, 2006, *available at* http://www.medpagetoday.com/MeetingCoverage/APA/tb/3385; Timothy B. Wheeler, *Healing the Mind, Punishing the Body; Doctors Beginning to Warn Mental Patients About Drug Side Effects,* Balt. Sun, July 8, 2005, at 1C.

care. If resources do not permit this, then advocates may request a higher-level internal review, a peer review, or an outside consultation conducted at the hospital's expense.

Issues of medical neglect are of critical importance and occur in all of the facilities in which our agency works. In group homes, untrained staff may fail to recognize the need for medical attention and follow up. Nursing homes are often understaffed and loathe to pay for sufficient physician time or access to specialists. Not surprisingly, medical neglect is rampant in prisons, where access to care is restricted for a myriad of reasons that range from budgetary constraints, to perceived security concerns, to staff indifference.

Again, where neglect results in injury, advocates need to be cognizant of the potential for damages. Whether the P&A agency undertakes such a case itself or refers it to a medical malpractice attorney, clients should have litigation available as a remedy and should be advised of all relevant timelines.[32]

Other forms of client neglect that facility advocates may encounter include the failure to engage in adequate treatment planning and/or the failure to include clients in their own treatment planning. Advocates continue to be astonished by the extent to which clients are excluded from meaningful participation in treatment planning and the limited access clients often have to their psychiatrists. Even where there appears to be a treatment plan that was developed with some level of client participation, advocates often see abject failure to provide active, individualized treatment that is truly geared toward recovery and progress toward discharge. These issues can be dealt with by providing individual advocacy but also by seeking systemic or policy changes that help to usher in best practices in client-centered treatment planning. Advocates should keep several strategies in mind when dealing with this issue. These strategies range from stating the obvious—that reducing the length of stay by providing more active treatment benefits everyone—to filing complaints with CMS or the Joint Commission, to bringing a lawsuit under the constitutional right to treatment if the neglect is serious enough to warrant this. Advocates need to always keep in mind that clients who are involuntarily committed have a constitutional right to treatment.[33] A person cannot be deprived of liberty in exchange for warehousing that does little to advance her treatment and return her to the community.

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32. For example, Massachusetts has two procedures in addition to the ordinary statute of limitations that can act as a bar to damages actions involving medical neglect. In addition to a medical malpractice tribunal that must screen all claims prior to their being filed in court, there is a two year presentment requirement if the defendant is the state. *See* Mass. Gen. Laws ch. 258, § 4 (2008); Mass. Gen. Laws ch. 231, §§ 60B–E (2008).

33. For a thorough discussion of the right to treatment, see Michael Perlin, Mental Disability: Law Civil and Criminal § 3A (2d ed. 2002).

B. Civil Rights in Facilities

Unfortunately, deprivation of basic civil rights is still a routine occurrence in all types of facilities housing people with disabilities. Denial of access to telephones, mail, and visitors routinely takes place, with little or no due process. This is in spite of a Massachusetts statute protecting these rights that was premised on a finding that these rights are "fundamental."[34] While advocates have sometimes been successful in getting favorable decisions as the result of a human rights complaint or appeal under the Department of Mental Health or Mental Retardation administrative complaint procedures,[35] these procedures are not always timely, and favorable findings do not always result in effective corrective action or widespread dissemination that would prevent the practice from recurring. Thus, advocates use limited resources to file the same type of complaints against the same facilities over and over again. Advocates in Massachusetts are currently supporting legislation that would give clients a right to an administrative hearing, as opposed to a strictly paper review, for these types of complaints.[36] Denial of such an appeal after a hearing would then trigger a right to court review.[37]

Another important role for facility-based advocates in protecting civil rights is to insure that clients have access to the courts. In violation of their rights, clients are often not present at hearings involving guardianship and review of court-ordered treatment plans. If advocates find that this is a pattern at a particular facility, they may seek to address it with hospital counsel, appointed counsel for clients, and, if need be, the courts.

Other civil rights issues that arise involve freedom of association, sexual expression, marriage, the right to informed consent, and the right to make "bad" choices. This latter category might include whether to smoke, what to spend money on, and dietary choices. While these rights are ill-defined and there is often little or no case law in the way of guidance, these rights are of great importance to clients. When it comes to protecting these rights, advocates are likely to come into direct conflict with facility staff and administration who believe that they are acting in the client's best interest or protecting the client from harmful influences. While there may be a duty to protect clients from serious and imminent harm, an advocate's role should be to break down the alleged threat and focus attention on whether it truly meets that

34. *See* Mass. Gen. Laws ch. 123, § 23 (2008) (as amended by the Act to Protect Five Fundamental Rights, 1997 Mass. Legis. Serv. ch. 166 (West 2008) (expanding the guarantee of these rights to individuals receiving psychiatric treatment in private, as well as public, hospitals)).

35. *See generally* Dep't of Mental Health Regulations, 104 Mass. Code Regs. § 32.03 (2008); Dep't of Mental Retardation Regulations, 115 Mass. Code Regs. § 9.06–.11 (2008).

36. *See, e.g.*, H.B. 1895, 185th Gen. Ct., Reg. Sess. (Mass. 2007) (setting forth avenues of redress for individuals "receiving services from programs or facilities of the Department of Mental Health").

37. *See* Mass. Gen. Laws ch. 30A, § 14 (2008) (providing Superior Court review of final agency adjudications).

standard—in terms of gravity, the likelihood of the harm occurring, and less restrictive alternatives.

Sometimes, when the layers are peeled back, a knee-jerk paternalism on the part of the facility staff is revealed. In these cases, advocates may want to initiate a discussion with staff, encouraging a different perspective while acknowledging that the intent may have been to act in the "best interest" of the client, the advocate can convey the ways in which such paternalism in and of itself is harmful to the client's autonomy and recovery. A better approach is to empower clients to make healthy choices and to educate facility staff that everyone is entitled to the "dignity of risk." This is shorthand for the right to be given the opportunity to make bad choices and learn from one's mistakes. A helpful way to have this dialogue is to get the staff to acknowledge their own behaviors that may not be healthy or advisable—they may eat too much pizza and ice cream, spend too much money on "frivolous" items, or maintain relationships with people who cause them stress. The fact that someone is in need of treatment and residing in a facility does not mean they give up the rights and choices all adults get to make. Reminding staff of the freedoms they routinely exercise—and the bad choices we all make—may be an effective way to break down the paternalism at the root of many of these restrictions.

C. Community Integration

The work of advocates in seeking discharge for clients unnecessarily institutionalized received a significant boost in 1999 when the U.S. Supreme Court issued its opinion in *Olmstead v. L.C.*[38] In *Olmstead*, the Court ruled that the anti-discrimination provisions of the Americans with Disabilities Act mandate that care be provided in the least restrictive setting that is appropriate to an individual's needs. The Disability Law Center, like most other P&A agencies, has sought to use *Olmstead* on a scale both large and small to foster community integration. On the psychiatric disability side, the threat of *Olmstead* class action litigation led to a decreased length of stay and a higher rate of community placement for people who would have otherwise languished for years in state hospitals. The threat of litigation enabled state agencies to seek additional funding from the legislature for the purpose of creating more community placements. On the intellectual disability side, Massachusetts advocates have brought cases pre-dating *Olmstead* that sought to discharge people from large state facilities.[39] In fact most individuals with intellectual disabilities are in community-based care. However, *Olmstead* has provided a powerful tool to continue this trend in the face of renewed legal challenges and/or budgetary constraints.

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38. 527 U.S. 581 (1999).

39. The case of *Ricci v. Okin* is an ongoing, decades-long class action. For the "final order" (later re-opened) and a brief recitation of the prior litigation, see *Ricci*, 823 F. Supp. 984 (D. Mass. 1993). For the most recent (and possibly final) chapter, see *Ricci v. Patrick*, 544 F.3d 8 (1st Cir. 2008).

Another group in need of advocacy under *Olmstead* are those individuals who primarily have an intellectual disability or a brain injury but are inappropriately placed at state psychiatric facilities, often having entered through the criminal justice system. The Department of Mental Retardation, which has responsibility in Massachusetts for dually-diagnosed clients, often claims that it does not have the capacity to serve them. Our agency has prepared for multiple plaintiff or individual *Olmstead* suits on behalf of these individuals, and has been successful in getting them community-based services. However, this is likely to be a struggle that continues. Another group of individuals in need of *Olmstead* advocacy is made up of people with brain injuries who are stuck in nursing homes, with very little access to community-based care.[40] Post-*Olmstead* litigation has been robust across the country and the case law on claims and defenses in various contexts is fairly well developed. Advocates working in facilities have a powerful tool in the *Olmstead* decision and the body of case law that has grown up around it. They should not hesitate to benefit from the collective experience of other advocates across the country when contemplating litigation in this complex area.

V. COLLABORATION WITH COURT-APPOINTED COUNSEL

Interaction and collaboration with court-appointed counsel is most often an outgrowth of a P&A agency's regular presence in state hospitals. The fact that P&A agencies have a regular presence at facilities allows advocates to spend a great deal of time with clients and to observe facility-wide trends. In the best of circumstances, advocates can offer unique observations and provide helpful collaboration to court-appointed counsel.

However, this is also an area that can be fraught with difficulty. Advocates need to be cautious to avoid the ethical problem of advising or counseling a client on a matter in which he or she is represented by counsel. Advocates need to take their cues from court-appointed counsel and advise clients that while the facility-based advocate can offer assistance, it will be up to the court-appointed attorney to decide whether or not to accept this assistance. While it is often difficult to do so, the advocate also needs to avoid getting drawn into a conversation in which the client asks the advocate to second-guess what the court-appointed attorney is doing.

With all of these cautions in mind, facility-based advocates can often provide assistance that enhances the case presented by court-appointed counsel. This collaboration and the potential for conflict will be discussed in more detail below. However, it is worthwhile to note that the advocate can also play another role that is less fraught and is tremendously helpful to clients.

Clients who find themselves in a facility facing civil commitment, court-ordered treatment, or evaluation in connection with a criminal case often have questions

40. The Center for Public Representation recently brought suit on behalf of this class in Massachusetts. *See* Complaint, Hutchinson v. Patrick, No. 07-30084 (D. Mass May 17, 2007), *available at* http://www.centerforpublicrep.org/uploads/vt/p7/vtp7pMAR1QawjxehmE69lQ/Hutchinson-Complaint.doc.

about the process. They often do not know what to expect, what the timeframes are, and what their rights are with respect to these proceedings. Taking the time to sit down with a client, answer these questions, and provide moral support is a routine part of facility-based advocacy. Although it can sometimes lead to a situation in which a client seeks legal advice in connection with the proceeding—or attempts to get the advocate's opinion about what court-appointed counsel did, did not do, or might do—this is a line advocates need to walk, and one that can be walked effectively. Listening to client concerns and providing information about the legal process the client is embroiled in can be enormously helpful and comforting. Clients often express gratitude and relief at having gained a better understanding of a legal process that has made them feel confused and powerless.

In terms of collaboration, commitment cases are one area in which the facility advocate may be of assistance to the court-appointed attorney.[41] The advocate may have had more time to talk to the client, review records, and meet with the treatment team relative to the time the appointed counsel has prior to a hearing. Advocates may have seen things in a client's record that could be useful at a hearing but are not readily apparent. Advocates with a regular presence at a facility may be familiar with weaknesses in a particular doctor's testimony. It may also be the case that certain staff members or disciplines are more likely to note the client's strengths, and advocates can point the attorney in that direction.[42] Further, advocates may be familiar with the direction that the hospital administration or the mental health authority is moving, in terms of best practices, and may point out if a doctor is out of step with those trends or best practices. For example, a doctor may be an outlier in not moving clients toward discharge, or in believing that all clients should be sent to group homes as opposed to being discharged to their individual homes or apartments with needed support. Finally, advocates may also be more familiar with community-based resources that can serve as alternatives to hospitalization.

In the context of court-ordered treatment cases,[43] advocacy can start during the period when a petition for treatment is being contemplated, but has not yet been filed. In certain Massachusetts probate courts, there can be a gap of several months between the time when the petition is filed and counsel is appointed. Advocacy can be provided during this period as well. Prior to the petition being filed, advocates can meet with the treatment team to try and avoid the petition by highlighting less intrusive alternatives or other mediated solutions. The advocate can also seek a review of the proposed petition by the facility medical director or an independent consultant. Once a petition has been filed, but before counsel has been appointed, advocates can often attend treatment team meetings with their clients so that a bal-

41. For an excellent resource on these proceedings in Massachusetts, with helpful practice pointers, see Stan Goldman, Mental Health Proceedings in Massachusetts (2001).

42. For example, occupational therapists or other rehabilitation specialists may take a more positive approach with clients, and their training may lead them to have a more strength-based focus.

43. For a resource on court-ordered treatment advocacy, see Goldman, *supra* note 41, at pt. 4.

anced and accurate picture of a client's competencies, and the reasons for a client's treatment choices are documented in the record.[44] This is important, since a petition is often initiated only when a client disagrees with the treatment being proposed, in spite of the fact that the focus should be on the legal issue of whether the client is competent, not the extent to which he or she disagrees with the treatment being recommended.[45] In cases where client refusal of medication is cited as evidence of incompetence and as justifying forced treatment, it can be helpful to have clients articulate whether they are opposed to particular medications, as opposed to all medications, and the reasons for that opposition. Similarly, if clients have had negative experiences with the treatment being proposed, this should also be documented.

When a petition for court-ordered treatment is brought forward, facility-based advocates can often provide information that is based on their long-standing and in-depth knowledge of the facility, the staff, and particular clients. There may also be trends which are relevant, but which the court-appointed attorney would otherwise be unaware. For example, petitions for court-ordered electroconvulsive therapy ("ECT") may have more to do with which doctor is assigned to the client than pure clinical indications for that type of treatment.

In the context of criminal evaluations and commitments, advocates can often provide useful information to a client's defense attorney.[46] Defense attorneys may be unfamiliar with mental health issues in general, or with certain types of mental disabilities, and may have had little or no opportunity to get to know the client. Oftentimes, defense attorneys have seen their mentally-ill clients for only a few minutes, in a lockup, before the client is ordered to the hospital for a competency evaluation. If that is the case, then the default is often for attorneys to postpone further advocacy until the client is found competent and returned to court.

In some instances, the facility advocate works with the client during this time and more in-depth discussions with the client and/or record reviews indicate that the client could not have committed the offense charged. Two advocacy examples help to illustrate this type of scenario. In one case, an individual awaiting trial for five years for masked armed robbery turned out to have a physical impairment that made it impossible for him to have done what the police report described the suspect as doing. In another case, a record review indicated that the client was actually hospitalized at the time of the alleged offense. Providing this information to the defense attorney prevented the needless further detention of the clients. In these cases, in-

44. For example, an advocate was brought into the treatment planning meeting by a client who would not otherwise participate. She was afraid—rightly so—that anything she said would be used against her in support of a petition for forced ECT. The advocate's assistance helped her articulate her views on various forms of treatment and the client was discharged before the petition was heard.

45. While there may be a valid relationship between these two things, they should not, as a legal matter, be equated.

46. *See generally* Goldman, *supra* note 41, at pt. 3.

formation was also provided to the defense attorneys about a procedural mechanism for review of these cases. The mechanism is one that many defense attorneys are not familiar with, since it is rarely invoked and is found in the mental health code, as opposed to the criminal code.[47]

In other circumstances, advocates may provide a critical link between the other attorneys involved in the case. In Massachusetts, a mentally ill defendant is represented by a criminal defense attorney as to the criminal charge and the competency to stand trial determination. However, the defendant is then entitled to be represented by mental health counsel in any subsequent commitment or court-ordered treatment proceeding. If the defense attorney is certified to accept mental health cases, it can be the same attorney. More often than not, however, it is a different attorney.

A recent case example illustrates the critical role played by a facility advocate in securing the client's freedom and achieving systemic change to a practice that contributed to the needless detention of the client. A client charged with a minor offense was sent to a facility for a competency-to-stand-trial evaluation, and was subsequently committed and ordered to receive forced medication. The client told anyone and everyone at the facility that the charges had been dismissed and that she should no longer be at the hospital. It was only the facility advocate who took the time to listen and research the issue. It turned out that the charges had indeed been "filed." This was equivalent to a dismissal insofar as there were no further proceedings for which she was required to be competent. However, the charges were "filed" toward the end of a hearing at which the client was not present. During the first part of the hearing, the facility had recommended that the client be found incompetent, had filed a petition for commitment, and moved for a change of venue—to the hospital—for the convenience of the parties. These motions were allowed first and then the charges were "filed" at the request of defense counsel. Several days later, the client—assisted by a different mental health certified attorney—was committed to the facility by a different court, holding hearings at the hospital. An order for medication over the client's objection was also entered.

In this case, the facility advocate was able to pull the disparate pieces of the story together and work with the defense attorney to get the charges docketed as an outright dismissal. The advocate also worked with the mental health attorney to file a motion to vacate the commitment and treatment orders, and contacted the Mental Health Litigation Unit of the public defender's office to handle an appeal in the

47. Massachusetts law allows for a hearing to test the sufficiency of the state's evidence. *See* MASS. GEN. LAWS ch. 23, § 17 (2008). The client does not have to be competent for the hearing and, while the charges can be dismissed as the result of the hearing, the client is put in no other legal jeopardy. The hearing is best suited for cases in which the defendant has a strong defense, such as a solid alibi or an impossibility defense.

event that the motion to vacate was denied.[48] The advocate in this case then worked with the hospital's counsel to discontinue the practice of routinely seeking a change in venue in these cases. To that attorney's credit, he did so willingly after an open and honest discussion of the consequences this practice could have for clients caught up in a fractured system. The ability to parlay the result in an individual case into a systemic change, without resorting to litigation, was based on the advocate's good working relationship with the hospital staff and illustrates one of the more powerful advantages of maintaining a regular presence in a facility.

This case example shows successful collaboration, where the facility-based advocate's vantage point—and relative luxury in terms of time to listen to the client and review records—was the key. Also, due to a positive working relationship with hospital counsel, the advocate was able to achieve system changes that make the situation less likely to reoccur.

It must be said, however, that advocates will not always be able to work collaboratively with court-appointed counsel. Facility-based advocates will often be in a position to hear complaints about court-appointed counsel and/or to actually observe deficient performance by counsel. This raises a host of difficult ethical issues and uncomfortable feelings. For seasoned advocates who have become comfortable advocating for clients' expressed interests in an oftentimes coercive, paternalistic system, these are perhaps the most awkward situations they can encounter. Advocates are faced with clients who may be vulnerable and unable to effectively advocate for themselves, and who also have a great deal to lose—including their freedom, the right to be free from forced treatment, and/or their broader autonomy as the result of being placed under guardianship. These risks and vulnerabilities must be balanced with the acknowledgment that the appointed counsel may be trying to do his or her best under difficult circumstances. If an advocate believes that a client's interests are in jeopardy, the advocate should first attempt to work with the court-appointed attorney, taking a collaborative approach and offering information and resources. If this is unsuccessful or not well-received, the advocate may need to inform the client of the avenues available to seek alternate counsel. These include requesting that the attorney withdraw, lodging a complaint with the agency responsible for overseeing court-appointed counsel, or bringing the issue before the judge. If the client is incapable of pursuing these avenues on his or her own, advocates may need to assist with this process. Where there is an agency charged with investigating complaints about court-appointed counsel, it is often best to make a simple referral to this agency. The agency will then conduct its own review and can appoint successor counsel if appropriate. This also avoids a situation in which a judge refuses to allow an attorney to withdraw because successor counsel is not readily available.

48. This office trains and certifies mental health attorneys, and assists defense attorneys on issues related to mental health. *See generally* Comm. Pub. Counsel Servs., http://www.publiccounsel.net (last visited Sept. 9, 2008).

If advocates find themselves in this difficult situation, they should also seek advice from colleagues, mentors, and supervisors about how best to handle it. The aim is to protect the client's interests when they are in serious jeopardy from ineffective assistance of counsel, while not unduly interfering with the attorney-client relationship and not putting the chances for future collaboration with court-appointed counsel at risk.

VI. EMPOWERMENT MODEL OF REPRESENTATION

The concept of this model is simple. Advocacy on behalf of clients with disabilities should foster empowerment. Rather than simply taking up the mantle and speaking for clients, advocates should take the time to educate clients about their rights so that they can become effective self-advocates. Facility advocates can discuss with clients not only their legal rights in a particular situation, but also the larger systemic issues, and the political landscape in which the advocacy is taking place. They can provide clients with information about mental health consumer groups that they might want to connect with once they are out of the hospital. In Massachusetts, our agency has also provided training on substantive legal rights and advocacy methods for peer advocates. Facility-based advocates can also push for and support the employment of peer advocates in the mental health system.[49]

This model of representation can not only help clients become effective self-advocates and move the cause of mental health clients' rights forward, but it can also speed and promote recovery. The traditional thinking—rooted in paternalism and the medical model—has been that clients' rights are at odds with treatment and medical recovery. While this type of thinking can still be found in most facilities operating today, the more enlightened view is that clients who feel empowered to help themselves and who play a role in helping others often take greater responsibility for their own recovery. Becoming an empowered self-advocate fosters social support and provides the purpose and hope that is critical to sustaining treatment gains and long term recovery. From the standpoint of facility advocates, helping clients become effective self-advocates is probably one of the most rewarding things they can do. Clients then become colleagues with a shared mission and a passion that cannot be matched.

VII. CONCLUSION

The role of counsel in institutional settings is a complex but rewarding position. The facility-based advocate works in a "total environment" in which the facility administration and staff have a great deal of power relative to the client. Moreover, these providers often believe that their view of what is in the client's "best interest" should carry the day in all circumstances. In contrast, advocates need to assist their

49. For further information about peer support, including a description of the role of a hospital peer-specialist in Massachusetts, see Gayle Bluebird, *Paving New Ground: Peers Working in In-patient Settings*, http://www.nasmhpd.org (last visited Nov. 20, 2008).

clients according to each client's "expressed interest" to the extent that there is any legally supportable basis for doing so—even if such legal theories are new and evolving. While this type of advocacy often brings advocates into direct conflict with facility staff and administration, advocates with a regular presence in a facility can often build relationships and educate staff in a way that fosters collaboration in even the most difficult cases. Today's advocates can also frame their arguments in terms of best practices—seeking common ground—now that the recovery movement has become mainstream and "best practices" have caught up with human rights advocacy favoring autonomy.

Facility-based advocates will also routinely be interacting with clients who are involved in other legal proceedings and who may be represented by court-appointed counsel. The advocate may be called upon to provide critical information to clients about court procedures. In addition, advocates may offer assistance to court-appointed counsel. In both of these activities, however, advocates must ensure that they do not jeopardize the existing or developing relationship between the client and court-appointed counsel. If appointed counsel is putting clients' interests at risk, advocates may need to take appropriate steps to assist their clients.

Given the landscape in which they practice, facility-based advocates can sometimes feel alone and at odds with everyone they encounter on a given day. This can even include being at odds with their clients, who may feel that the advocate cannot do enough to remedy their predicament of being detained against their will under difficult conditions. The role of a legal advocate is not a position for those who want to be liked by everyone, at all times. However, it is possible and necessary in this complex role to forge relationships without compromising clients' interests. If advocates can strike that balance, they will be able to persevere in their roles, becoming better and more trusted resources for clients and facility staff alike. Having access to experienced, competent advocates can make a tremendous difference to clients in facilities, who are often otherwise marginalized, alone, and disempowered. Advocating for these clients and empowering them to become effective self-advocates is a role that brings deep rewards in spite of its many challenges.