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# When Something Is Not Quite Right: Considerations for Advising a Client to Seek Mental Health Treatment

CAROL M. SUZUKI\*

## Introduction

The following vignettes of composite clients illustrate some issues concerning client mental illness that arise during the course of legal representation:<sup>1</sup>

Felix obtains a lawyer to represent him in a removal hearing before the United States Immigration Court. He says he is eligible for political asylum and that he cannot return to his home country. He tells his lawyer that he had been beaten unjustly by government agents for organizing peaceful demonstrations, and if he returned home, he would be killed by his torturers. He fled his home country and came to the United States to stay with extended family members. As part of the fact finding process in support of his claim of persecution and well-founded fear of return to his home country, his lawyer suggests that evidence be gathered through examinations with medical doctors. Felix agrees to the evaluations and extended family members pay for a psychiatrist and a general practitioner to examine Felix. The examinations are a financial strain to the family, but they are willing to pay the fees in order to help Felix prove

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1. In order to respect client confidentiality and client ownership of their stories, the illustrations in this Article are each drawn from a number of clients' stories.

his case. Felix is diagnosed with post-traumatic stress disorder (PTSD), which supports his claim of past persecution. He does not seek or get any treatment for his PTSD. The lawyer does not counsel him or his family to seek treatment for his condition, and it goes untreated.

Mental health and other medical evaluations to gather proof that an asylum seeker had been tortured is an established method for gathering evidence where a client seeks asylum on the basis of past persecution.<sup>2</sup> Now that Felix has been diagnosed as suffering from PTSD, should his lawyer refer Felix to a mental health services provider for treatment? Should she wait until Felix's asylum claim is resolved? Does it matter how mental illness is perceived in the country from which Felix has fled? Or whether Felix has the resources to pay for treatment?

Julian seeks legal representation in an appeal of the denial of his application for Social Security benefits. Julian says he wishes he were healthy enough to work, but he claims that he cannot work and is permanently disabled because he is physically and mentally disabled by symptoms related to being HIV-positive. Julian has hospital records showing some medical diagnoses related to his physical health. Julian has no psychiatric or psychological records and he says that he has never met with a therapist but knows that something is not right with him mentally.

In Julian's case, where he claims to have a mental disability but apparently no evidence of such, a mental health evaluation may result in a diagnosis of a mental disorder that may support his claim of a permanent disability, inability to work, and entitlement to Social Security benefits. Beyond an evaluation, if there is a disorder mental health treatment may help Julian in his day-to-day life, and may even alleviate the symptoms of mental illness in order to help him return to work. If the lawyer agrees to represent Julian, should she advise him to get a mental health evaluation? To get treatment for any disorders diagnosed? How would treatment align with the client's goals?

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2. See 8 C.F.R. § 208.13(a), (b)(1) (2008) (burden of asylum applicant to prove asylum eligibility, which may be done through showing past persecution); see, e.g., DEBORAH ANKER, *LAW OF ASYLUM IN THE UNITED STATES* 104-05 (3d ed. 1989) (use of mental health experts in asylum claims).

Angela seeks an order of protection against her abusive boyfriend. She has photographs of her physical injuries from a recent beating by her boyfriend and a copy of a police report that she filed about the incident. This beating precedes Angela's third visit to the attorney's office seeking help. The other two times she came in she did not follow through with seeking the order of protection, so no petition has been filed on her behalf. Angela says that this time she really wants the order from the court. Angela has declined victim's counseling offered by the victims' advocate who works with the police department to obtain counseling and other services.

To support Angela's petition for an order of protection, a mental health evaluation may provide evidence of severe emotional distress or imminent fear of bodily injury to sustain a finding that domestic violence has occurred and supply a basis for the order.<sup>3</sup> Beyond the evaluation and the order of protection, mental health treatment may help Angela to cope with being a survivor of domestic violence and to move past this relationship.

Sam seeks a landlord/tenant lawyer for representation in a dispute involving non-payment of his rent. He says he withheld his rent because he felt the apartment was not worth the amount he was paying. He adds that he no longer has the rent money because he spent it on other necessary living expenses. It is clear to the lawyer after speaking with Sam and looking at photographs of the terrible conditions in the apartment, with a hole in the roof and ceiling in the bathroom, and the presence of nesting birds, mice and cockroaches, that she can argue for a decrease or total elimination of rent arrears based on the landlord's violation of the implied warranty of habitability.<sup>4</sup> She might be able to get Sam's rent arrears reduced or waived. She might even be able to work out reduced or waived rent until repairs are made to the apartment. It is also clear that Sam has a drinking problem and that he is very sad, as he reeks of alcohol and is very teary during their meeting.

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3. See, e.g., N.M. Stat. Ann. §§ 40-13-2(C), 40-13-5(A) (LexisNexis Supp. 2008). However, an evaluation may not be supported by the client's goals, as she had declined counseling offered to her.

4. An implied warranty of habitability is defined as a promise from the landlord to the tenant that the apartment is fit to reside in. See BLACK'S LAW DICTIONARY 1619 (8th ed. 2004).

The attorney would like to represent Sam to assist him in negotiating his rent arrears and future rent until the apartment is repaired. Does Sam have a mental disability or drinking problem that has contributed to his inability to pay rent? Assuming the lawyer can help Sam with the current court case will Sam's mental state or drinking lead him to have another non-payment problem in the future? Are these concerns that a lawyer should raise with Sam? Or upon successful resolution of the current court case and reaching Sam's legal goals, should she hope for the best and close Sam's file with her office?

This Article advocates that a lawyer should consider counseling a client to seek mental health treatment where the lawyer has concerns about the client's behavior, emotional state, or cognition. This Article stresses that mental health counseling should be presented within ethical bounds and only after adequate consideration is given to the legal matter, to the client's goals, and to factors relating to identification of an appropriate mental health referral.<sup>5</sup> Focus on the legal problem is a lawyer's professional responsibility, and concern for a client's mental health is part of a humanitarian function of lawyering. Advising a client to seek treatment should be considered supportive of the ethical and social values of the legal profession, part of what develops as part of a lawyer's professional identity.<sup>6</sup>

This Article recognizes that a lawyer might choose to remain silent about her client's apparent mental health problem for many reasons. She may believe that she is inadequately trained in a given area to give any mental health referral; that a suggestion regarding the client's behaviors would negatively affect the attorney/client relationship; that she is out of her professional purview to discuss the matter; or that she does not have time to research and refer the matter if she raises it. However, a lawyer's concern to not stigmatize or label a client may prevent her from making a suggestion that could

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5. This Article does not discuss a lawyer's duty to warn or protect a third party from a client's potential harmful conduct based on mental illness, which may be found based on law or case law after *Tarasoff v. Regents of University of California*, 551 P.2d 334 (Cal. 1976). See Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165 (1978). This Article is targeted toward the lawyer who sees mental health counseling as a benefit to the client's well-being. Duty to warn is beyond the scope of this discussion.

6. See WILLIAM M. SULLIVAN ET AL., EDUCATING LAWYERS: PREPARATION FOR THE PROFESSION OF LAW 129-31 (2007) [hereinafter CARNEGIE REPORT] (a report on the two-year evaluation of legal education in the U.S. and Canada conducted by the Carnegie Foundation for the Advancement of Teaching).

result in great benefit to her client. The lawyer may be the only professional who is in a position to give such advice to a client during the time of a legal crisis. A lawyer should consider the benefits of making a referral and, if she chooses to remain silent, it should be a conscientious choice. Unfortunately, advising a client regarding mental health services is not a basic tenet of traditional legal education or practice.<sup>7</sup> Lawyers have no specific guidance on what to say to the client with a mental health problem about seeking its resolution.

In the course of her work representing clients in legal matters, a lawyer is likely to encounter clients who suffer from mental illness, even if her work is not focused in the area of mental health.<sup>8</sup> This is not because mentally ill people generally seek legal help, but because mental illness is prevalent in the United States. In a one-year time span, almost one of every five people will suffer from a "clinically significant psychiatric disorder,"<sup>9</sup> as defined and classified by mental health professionals in the U.S. using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.<sup>10</sup> Mental illness is the leading cause of disability in the

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7. See Jane Aiken & Stephen Wizner, *Law as Social Work*, 11 WASH. U. J.L. & POL'Y 63, 73 (2003) ("Legal training has little to do with fostering a passion for social justice. The law school curriculum is designed to neutralize that passion by imposing a rigor of thought that divorces law students from their feelings and morality.").

8. There were 1,162,124 active lawyers in the U.S. as of December 31, 2007. See AMERICAN BAR ASSOCIATION, NATIONAL LAWYER POPULATION BY STATE (2008), [http://www.abanet.org/marketresearch/2008\\_NATL\\_LAWYER\\_by\\_State.pdf](http://www.abanet.org/marketresearch/2008_NATL_LAWYER_by_State.pdf). Given the prevalence of mental illness, it is inevitable that lawyers will encounter clients with mental illness.

Arguably, the bifurcation of health into mental health and physical health is a division that is more separate in word than in reality. An affliction to the body can result in a mental disorder or a somatic disorder. A somatic disorder is one in which disturbances in non-mental functions dominate over mental disturbances. See U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 5-6 (1999) [hereinafter SURGEON GENERAL'S REPORT].

9. Alexander S. Young & Jennifer L. Magnabosco, *Services for Adults with Mental Illness*, in MENTAL HEALTH SERVICES: A PUBLIC HEALTH PERSPECTIVE 177, 180 (Bruce Lubotsky Levin et al. eds., 2d ed. 2004) [hereinafter A PUBLIC HEALTH PERSPECTIVE]; William E. Narrow et al., *Revised Prevalence Estimates of Mental Disorders in the United States: Using a Clinical Significance Criterion to Reconcile 2 Surveys' Estimates*, 59 ARCHIVES GEN. PSYCHIATRY 115, 119 (2002). Of the individuals who have a clinically significant disorder, fifteen percent have a concurrent substance use disorder. See SURGEON GENERAL'S REPORT, *supra* note 8, at 45-46. Mental illness affects a large percentage of the worldwide population. See Levin, *Overview of Prevention, Integration, and Parity*, in A PUBLIC HEALTH PERSPECTIVE, *supra*, at 3.

10. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (text rev. 4th ed. 2000) [hereinafter DSM-IV-TR]. The DSM-IV-TR is a valuable clinical tool for psychiatrists, other physicians, psychologists, social workers, nurses, physicians' assistants, therapists, counselors, and other mental and physical health professionals in the U.S. See *id.* at xxiii.

U.S. population among those between the ages of fifteen and forty-four.<sup>11</sup> A poverty lawyer is even more likely to have clients who are mentally ill. Lower socio-economic status is strongly linked to mental illness, resulting from lower income, lower educational level, and decreased occupational availabilities.<sup>12</sup> Furthermore, families of color are more likely than white families to be living in poverty.<sup>13</sup> As a result, people living with a mental illness may not only be of low income but are also often racial minorities. Thus, poverty lawyers, who work both with racial minorities and lower-income individuals are likely to work with clients suffering from a mental health disability.

A mental problem, as referred to in this Article, is a diagnosable mental disorder, or signs and symptoms of mental illness as perceived by the lawyer.<sup>14</sup> If an attorney and her client have had an ongoing relationship the lawyer may have an idea as to what is normative behavior on the part of the client, departure from which may trigger the lawyer's belief that her client has a mental health problem. Or, a lawyer might notice over time that something appears to be abnormal or amiss about a client. Even without an opportunity to observe her client over time, a lawyer may perceive that her client has problems that are not legal concerns, but are signs of a mental problem, disorder, or illness, or a substance abuse/use problem.<sup>15</sup> Even a lawyer with no mental health training may reflect upon a client's behavior, emotional state or cognitive state and make a preliminary assessment that "something is not right"<sup>16</sup> with the

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11. See NAT'L INST. OF MENTAL HEALTH, THE NUMBERS COUNT: MENTAL DISORDERS IN AMERICA (June 26, 2008), available at <http://www.nimh.nih.gov/healthpublications/the-numbers-count-mental-disorders-in-america.shtml>. Mental illnesses (including depression, bipolar disorder, and schizophrenia) account for nearly 25 percent of all disability across major industrialized countries. See WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2001, MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE 27-28 (2001). About 450 million people worldwide suffer from a mental or behavioral disorder. WORLD HEALTH ORG., INVESTING IN MENTAL HEALTH 8 (2003), available at [http://www.who.int/mental\\_health/en/investing\\_in\\_mnh\\_final.pdf](http://www.who.int/mental_health/en/investing_in_mnh_final.pdf).

12. See SURGEON GENERAL'S REPORT, *supra* note 8, at 82.

13. See U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 39-40 (2001).

14. See SURGEON GENERAL'S REPORT, *supra* note 8, at 39-40.

15. Although substance abuse is not the focus of this article, it is raised here because of the high correlation between mental illness and substance use, including alcoholism. See A PUBLIC HEALTH PERSPECTIVE, *supra* note 9.

16. ABA COMM'N ON L. & AGING & AM. PSYCHOL. ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS 125 (2005) [hereinafter ASSESSMENT OF OLDER ADULTS]. The law presumes capacity, with the burden of proving otherwise on the party seeking such ruling. *Id.* at 131.

client.<sup>17</sup> A client's behavior may be a symptom of a mental disorder diagnosable under the *DSM-IV-TR*.<sup>18</sup> Or the behavior may be a sign of a problem which has negative effects on the client's mental state, but which does not rise to a diagnosable mental illness. Even when a lawyer is confident that her client has the mental capacity to understand the legal matters and make decisions in the matter, the client's negative behavior and mental condition may be apparent to the lawyer.<sup>19</sup> The standards for determining one's capacity to make legally binding decisions do not necessarily coincide with diagnosable mental disorders.

This Article explores rules of professional responsibility, theory, and reasoning processes related to advising clients to seek mental health treatment. Furthermore, this Article looks at cultural and financial aspects of treatment, and concludes with recommendations on how a lawyer should counsel her client once she determines that mental health treatment is appropriate. Part I discusses humanitarian reasons that support a lawyer's decision to advise her client to seek mental health treatment. Part II of this Article discusses rules of professional conduct relevant to advising a client to seek mental health treatment. Part III sets out a framework for considering how evaluation and treatment for mental illness might affect the legal matter for which the attorney has been retained. Part IV examines how race, culture and ethnicity affect beliefs about mental illness and

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17. A situation where an attorney believes a client's mental illness may lead to suicide is beyond the scope of this Article. There is no obligation under the Model Rules of Professional Conduct to disclose a client's intent to commit suicide, but disclosure may be made without a client's consent if a client is under a disability. See ABA Comm. on Ethics and Prof'l Responsibility, Informal Op. 83-1500 (1983) (disclosure of client's intent to commit suicide); see also Wesley W. Horton, *Confidentiality and the Suicidal Client*, 74 CONN. BAR J. 238 (June 2000).

18. Using the DSM-IV-TR definitions, anxiety disorders such as panic disorder, phobias, and post-traumatic stress disorder, are the most common adult mental disorders. SURGEON GENERAL'S REPORT, *supra* note 8, at 225 (citing Darrel A. Regier et al., *Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse. Results From the Epidemiologic Catchment Area (ECA) Study*, 264 JAMA 2511 (1990)). Mood disorders, which include major depression and bipolar disorder, are among the most prevalent forms of mental illness worldwide. See SURGEON GENERAL'S REPORT, *supra* note 8, at 226; Christopher J.L. Murray & Alan D. Lopez, *Evidence-Based Health Policy – Lessons From the Global Burden of Disease Study*, 274 SCI. 740, 741 (1996).

19. This Article does not focus on situations where the lawyer believes the client has diminished capacity. Lawyers who focus on the representation of elderly clients, a practice area where questions of decision-making capacity commonly arise, have developed frameworks for assessing whether a client has diminished capacity and for representing such a client. See, e.g., ASSESSMENT OF OLDER ADULTS, *supra* note 16; Peter Margulies, *Access, Connection, and Voice: A Contextual Approach to Representing Senior Citizens of Questionable Capacity*, 62 FORDHAM L. REV. 1073 (1994).



treatment, and how the mental health care system treats patients depending on their perceived race, culture, or ethnicity. Part V describes how patients pay for treatment for mental illness, another factor relevant to appropriateness of treatment. Part VI sets forth recommendations for how a lawyer should advise her client to seek mental health treatment, considering her professional role, the impact of treatment on the legal matter, and the effects of race, culture, and ethnicity and affordability of mental health treatment.

## **I. Humanistic Reasons for Recommending Mental Health Treatment**

Advising a client to seek mental health treatment can advance the client's goals and meet the lawyer's responsibility to her client and to the public. A lawyer provides professional services to advance justice for clients and society.<sup>20</sup> She may at times feel conflicted between her obligations to her client and those to the public at large. Indeed, a concern about the education of lawyers is improving how law schools teach students professionalism, professional responsibility, and public responsibility.<sup>21</sup> With pursuit of justice for a client and the public good as a central mission of this service profession, a lawyer should view the representation of a client on a specific legal matter in a larger context. That context includes providing legal services to a client who is a contributing member of the larger community in which the lawyer and client live.<sup>22</sup>

Advice from a lawyer to seek counseling may often be the conduit through which a client will get treatment. The lawyer may be in a unique position to say something to her client because they are already engaged in a professional relationship where the client's concerns are discussed. Unfortunately, many people who would benefit from treatment do not get any care for their mental problems. For example, of all people who suffer from serious depression or anxiety in the U.S., only one-third of them receive services for their mental disorder.<sup>23</sup> Lawyers who consider their humanitarian

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20. See CARNEGIE REPORT, *supra* note 6, at 21, 126; MODEL RULES OF PROF'L CONDUCT pmbl. ¶ 1 (2002).

21. See CARNEGIE REPORT, *supra* note 6, at 129. The CARNEGIE REPORT authors expressed concern that education on professionalism is undervalued in comparison to academic and cognitive knowledge. See *id.* at 132-33.

22. See *id.* at 126-27.

23. See Young & Magnabosco, *supra* note 9, at 177; see also SURGEON GENERAL'S REPORT, *supra* note 8, at 75-76 (asserting that most people with a diagnosable mental or addictive disorder in the U.S. do not get treatment within a year).

obligations as part of their professional identity see that their role includes helping their client to access mental health treatment.<sup>24</sup>

Beyond as a means for gathering evidence in support of legal relief, a lawyer should consider advising her client to seek treatment for a mental problem because helping another person is a moral and just act. Some lawyers are resistant to considering psychological needs of a client when providing legal counseling, believing that a mental health referral is "social work" that is not appropriate for lawyers.<sup>25</sup> The emotional dimensions of lawyering are generally not emphasized nor cultivated in law school, so many law students will not learn that considering a client's mental health may be an aspect of competent lawyering.<sup>26</sup> Additionally lawyers are generally not rewarded for their emotions, but rather for their reason.<sup>27</sup> A competent attorney should consider other factors beyond the effect of evaluation and treatment of the legal matter in determining what services would be appropriate. The competent, humanistic lawyer will respect the client as a moral actor,<sup>28</sup> one who might welcome appropriate advice.

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24. See CARNEGIE REPORT, *supra* note 6, at 154-55.

25. See Jane Aiken & Stephen Wizner, *Law as Social Work*, 11 WASH. U. J.L. & POL'Y 63, 63 (2003); Dennis P. Stolle et al., *Integrating Preventive Law and Therapeutic Jurisprudence: A Law and Psychology Based Approach to Lawyering*, in PRACTICING THERAPEUTIC JURISPRUDENCE: LAW AS A HELPING PROFESSION 5, 31-32 (Dennis P. Stolle et al. eds., 2000) [hereinafter PRACTICING THERAPEUTIC JURISPRUDENCE] (in the context of preventive law and therapeutic jurisprudence).

26. See Marjorie A. Silver, *Emotional Intelligence and Legal Education*, 5 PSYCHOL. PUB. POL'Y & L. 1173, 1173-74 (1999).

27. See Marjorie A. Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship*, 6 CLINICAL L. REV. 259, 278-83 (1999); David Dryden Henningsen & Ioana Cionea, *The Role of Comforting Skill and Professional Competence in the Attorney-Client Relationship*, 57 J. LEGAL EDUC. 530, 535 (2007) (study indicating that an attorney with a sophisticated client comforting style was perceived to be less competent than an attorney with a less sophisticated comforting style).

28. See THOMAS L. SHAFFER & ROBERT F. COCHRAN, JR., *LAWYERS, CLIENTS, AND MORAL RESPONSIBILITY* 113-14 (1994).

## II. Guidance from Relevant American Bar Association Model Rules of Professional Conduct<sup>29</sup>

The American Bar Association ("ABA") Model Rules of Professional Conduct ("Model Rules") serve as a model for the ethics rules of most states. Although they include a rule regarding representation of a client with diminished capacity, the Model Rules do not provide other specific guidance regarding counseling a client about mental health matters or any other health matter. But some rules are nonetheless relevant to the issues of mental illness.

### A. Model Rule 1.14

ABA Model Rule of Professional Conduct 1.14 is the sole ethical rule that refers to client mental status. Model Rule 1.14 pertains to an attorney's obligation to a client whom the attorney reasonably believes has diminished capacity to make adequately considered decisions in connection with the legal representation.<sup>30</sup> Model Rule 1.14 is relevant where a client might be incompetent to

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29. Lawyers in the U.S. are governed, in part, by rules of professional conduct in the jurisdictions in which they practice. The American Bar Association ("ABA," the largest voluntary professional association in the world, acts as the national representative of the legal profession in the U.S. The ABA provides law school accreditation, continuing legal education, information about the law, programs to assist lawyers and judges in their work, and initiatives to improve the legal system for the public. The ABA Model Rules of Professional Conduct were adopted by the ABA House of Delegates in 1983. Before their adoption, the ABA formal guidance to lawyers regarding ethics was the 1969 Model Code of Professional Responsibility. Preceding the Model Code of Professional Responsibility were the 1908 Canons of Professional Ethics (last amended in 1963).

30.

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

(b) 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.

(c) 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.

make decisions about his legal matter. It does not address the client's mental health where this aspect of mental capacity is not diminished. Comments to the Model Rules provide guidance for interpreting the Model Rules and do not create additional obligations.<sup>31</sup> Comment 1 to Model Rule 1.14 posits that in a "normal" attorney/client relationship, the client is able to make decisions based upon appropriate advice from the lawyer.<sup>32</sup> If there is no "normal" relationship because the client has diminished capacity, a lawyer must represent her client to the extent a normal attorney/client relationship may be maintained.<sup>33</sup>

This Article is directed toward lawyers whose clients may suffer from a mental illness but who have the capacity to appreciate advice about mental health treatment and about the legal matter.<sup>34</sup> Model Rule 1.14 suggests an obligation for a lawyer to make a preliminary determination of client capacity so that she will know when a case requires that she follow the rule.<sup>35</sup> If she determines that the client's mental capacity is diminished, she must, to the extent practicable, maintain a normal professional attorney/client relationship.<sup>36</sup> It is arguable that Model Rule 1.14 imposes no unique burden on the lawyer, as the only mandatory provision is subsection (a), which requires a lawyer to maintain a normal attorney/client relationship. The other subsections of the rule are permissive. Even if Model Rule 1.14 carries no additional obligations, it raises the concern of determining capacity in order to consider when capacity is diminished.<sup>37</sup>

Assuming that Model Rule 1.14 requires a lawyer to make an initial determination of her client's capacity, every attorney, even without training in psychiatry or psychology, must make, at the very least, a preliminary assessment of whether a client suffers from

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31. See MODEL RULES OF PROF'L CONDUCT scope ¶ 14 (2002).

32. See MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. ¶ 1 (2002).

33. See MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. ¶ 2 (2002).

34. Client competence is presumed until a lawyer determines the client is incompetent. A client may be competent for some matters while incompetent for others. Despite this discussion of Model Rule 1.14, the only Rule of Professional Conduct to raise client mental status, this Article does not focus on representation of clients with diminished capacity or who are incompetent. Client competency has been analyzed in a number of scholarly articles. This Article advocates for a lawyer to advise her client to seek treatment where her client has a mental problem and where her client has capacity to make decisions regarding mental health services.

35. Regarding representation of a client incompetent by virtue of immaturity, see Stephen Wizner & Miriam Berkman, *Being a Lawyer for a Child Too Young to Be a Client: A Clinical Study*, 68 NEB. L. REV. 330 (1989); of an older client with diminished capacity, see ASSESSMENT OF OLDER ADULTS, *supra* note 16.

36. MODEL RULES OF PROF'L CONDUCT R. 1.14(a) (2002).

37. "Capacity is the black hole of legal ethics." Margulies, *supra* note 19, at 1082.

diminished capacity. This assessment may be more difficult to make when the lawyer has no past relationship with the client, and thus has no baseline of the client's typical behavior, emotions, or cognitive functioning. To help address the gap between a lawyer's ability to assess diminished capacity and the obligations of an attorney subject to Model Rule 1.14, the American Law Institute and the American Bar Association have developed a handbook to assist lawyers to make such an assessment when working with elderly clients.<sup>38</sup> The ALI/ABA handbook may also be informative to lawyers whose clients are not elderly, but who may nevertheless have diminished capacity. The drafters of Model Rule 1.14 demonstrate a confidence that lawyers can make an initial determination of mental incapacity.<sup>39</sup>

## B. Model Rule 2.1

ABA Model Rule of Professional Conduct 2.1 focuses on the role of the lawyer as an advisor: "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."<sup>40</sup> Model Rule 2.1 supports the *Carnegie Report* argument that the lawyer is a moral actor in fulfilling a broad community role,<sup>41</sup> including considerations of a client's health and the impact of the client's health on others.

Model Rule 2.1 permits, but does not require, that a lawyer discuss areas outside of the legal field when offering advice.<sup>42</sup> A lawyer may counsel her client on a client matter that is outside of the

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38. See ASSESSMENT OF OLDER ADULTS, *supra* note 16, at 2; Silver, *supra* note 26, at 1202 (lawyer with emotional intelligence may recommend that her elderly client seek counseling). Elder law attorneys may consider client capacity when representing clients in matters such as estate planning or powers of attorney.

39. Peter Margulies sets forth a model to determine a client's capacity with a model of contextual capacity considering substantive and procedural factors. See Margulies, *supra* note 19, at 1085-90 (providing a framework for representing elderly clients who may have diminished capacity). He suggests that, at times, representation of a client with diminished capacity becomes a de facto guardianship. See *id.* at 1093-98. Under Model Rule 1.14, an attorney may take action to protect a client who suffers from diminished capacity. Protective action may include seeking appointment of a guardian. Appointment would require client consent or a finding that a guardian is necessary. Involuntary guardianship would probably entail a mental health evaluation to determine incompetency. MODEL RULES OF PROF'L CONDUCT R. 1.14 cmt. ¶¶ 5-7 (2002).

40. MODEL RULES OF PROF'L CONDUCT R. 2.1 (2002).

41. See CARNEGIE REPORT, *supra* note 6, at 129-44.

42. A Chicago attorney suggests that the parallel Illinois Rule of Professional Conduct 2.1 may impose duties, despite the use of the word "may." George W. Overton, *Permissive Duties*, CBA REC. (Chi. Bar Ass'n newsletter), June - July 1997, at 46.

confines of the legal matter. Moreover, the rule allows the lawyer to use her professional judgment in determining the parameters of the “client’s situation” that the lawyer will address. Although health-related matters are not an enumerated factor under Model Rule 2.1 to which a lawyer may refer, advice to a client to seek mental health evaluation and treatment may fit within the parameters of a “client’s situation” that a lawyer may consider. Of course, neither Model Rule 2.1 nor any other rule allows a lawyer to practice in the area of mental health and render mental health opinions, advice or diagnoses absent relevant education and licensure.

Comment 4 to Model Rule of Professional Conduct 2.1 includes “Where consultation with a professional in another field is itself something a competent lawyer would recommend, the lawyer should make such a recommendation.” The comment suggests that a lawyer should look beyond the legal matter for which she has been retained and determine if a competent lawyer would refer a client to a non-lawyer professional, and counsel her client accordingly. Comment 1 suggests that a lawyer should consider making recommendations even if the client might find the subject unpleasant.<sup>43</sup> To facilitate a consultation, a lawyer could advise her client to consult with the non-lawyer professional. A consultation could also occur between the lawyer and the non-lawyer professional. If the client’s identifying information is not revealed as part of the request, then the attorney may not need to obtain her client’s consent regarding disclosure of confidential information.

### C. Other Model Rules

ABA Model Rule of Professional Conduct 1.1 requires a lawyer to “provide competent representation to a client.”<sup>44</sup> There is no model rule requirement that requires a lawyer to counsel a client to seek mental health evaluation and treatment. However, there may be an argument that such advice is required if evaluation or treatment would advance a client’s legal goals. If treatment for mental illness would advance a client’s legal goal, then a lawyer should advise her client to seek appropriate treatment. If treatment would not advance the legal goal, then Model Rule 1.1 does not pose a duty in that area. Furthermore, if a mental health evaluation or treatment would

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43. “[A] lawyer should not be deterred from giving candid advice by the prospect that the advice will be unpalatable to the client.” MODEL RULES OF PROF’L CONDUCT R. 2.1 cmt. ¶ 1 (2002).

44. MODEL RULES OF PROF’L CONDUCT R. 1.1 (2002). See MODEL RULES OF PROF’L CONDUCT R. 2.1 (2002) (client goals).

negatively affect the legal goal, then a competent lawyer might not advise her client to seek treatment during the pendency of the legal matter. She might wait until the legal matter is resolved to raise the issue with her client.

A competent attorney might recommend mental health services to a client under Model Rule 1.1 and also pursuant to another Model Rule. An advocate for survivors of domestic violence has asserted that a lawyer representing a survivor of domestic violence has a professional responsibility under Model Rule of Professional Conduct 1.4<sup>45</sup> to recommend that the client become involved in a domestic violence survivors' peer group as a way of finding her voice.<sup>46</sup> Domestic violence representation may be a situation in which mental health services would be recommended.

### III. Effects of a Mental Health Services Referral on the Legal Matter

A lawyer who is considering advising her client to seek mental health treatment should analyze the possible effects of such treatment on resolution of the legal matter for which she has been retained.<sup>47</sup> Treatment that has a negative effect on the legal matter would be contrary to the goals of the legal representation. For example, Julian seeks Social Security benefits due to his mental and physical disabilities. Mental health treatment may alleviate his disabilities to

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45. "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." MODEL RULES OF PROF'L CONDUCT R. 1.4(b) (2002).

46. Peter Margulies, *Representation of Domestic Violence Survivors as a New Paradigm of Poverty Law: In Search of Access, Connection, and Voice*, 63 GEO. WASH. L. REV. 1071, 1100 (1995).

47. The recommendation of this Article to counsel a client to seek mental health services in appropriate situations does not hew to the theory of therapeutic jurisprudence, but some goals are similar regarding provision of competent client services. Therapeutic jurisprudence ("TJ") is a conceptual scheme that views the legal process through its impact on mental health. Proponents of TJ consider the mental health effects of the legal system on clients and other persons involved in it and advocate for law reform to minimize legal system's negative effects on mental health. See generally DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991); *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* (David B. Wexler ed., 1990). This Article considers the effect of a client's mental health treatment on the legal matter, but is not centered on the legal process and its therapeutic impact. Concern for the client's mental health should extend beyond how the client is affected by the legal process. Critics of TJ caution lawyers that zealous client advocacy must be maintained, and that following the principles of TJ may dilute a lawyer's competent legal representation. See Mae C. Quinn, *An RSVP to Professor Wexler's Warm Therapeutic Jurisprudence Invitation to the Criminal Defense Bar: Unable to Join You, Already (Somewhat Similarly) Engaged*, 48 B.C. L. REV. 539 (2007) (rejecting following a therapeutic jurisprudence model in criminal defense representation).

the extent that he would no longer be eligible or able to prove his eligibility for disability benefits. Julian's lawyer should speak with him about these risks. Since Julian would prefer to be healthy and to work than to be too disabled to work and receive Social Security benefits, he may choose to undergo evaluation and treatment for his mental illness. He may also decide that, even if he were mentally fit, his physical disabilities would prevent him from working. He may decide that his benefits claim would be stronger if he were both mentally and physically disabled.

Another part of the calculus is the impact of the evaluation necessary to determine the course of treatment. Even without the treatment, an evaluation should be contemplated in terms of whether it might be deemed evidence that could affect a legal matter.<sup>48</sup> Evaluation and treatment may generate test results, medical records, diagnoses, and other evidence that may be discoverable in litigation. It is possible that the evaluation and treatment records would be covered by and undiscoverable under the attorney work product rule.<sup>49</sup> Treatment may also affect a client's behavior, emotional state, and cognition in ways that affect a client's legal claim. For example, an asylum claimant such as Felix, with untreated post-traumatic stress disorder, may testify differently from a client who has been treated for a mental disorder.<sup>50</sup> This altered testimony may affect his ability to prove his legal claim.<sup>51</sup>

### **A. Treatment should be Recommended When Evaluation and Treatment Support Legal Goals**

A lawyer representing a client with a mental health problem should consider the potential impact of mental health services on the legal matter for which the lawyer has been retained. In working toward accomplishing a client's goal in a legal matter, the reason for

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48. This Article does not analyze strategies and ethics where a lawyer considers having a client evaluated in the course of gathering evidence, with intent to not refer a client to treatment because of a concern that the results might be detrimental to the legal matter. Here, the lawyer believes the client to have a mental problem and the evaluation would be conducted in the course of obtaining treatment.

49. See BLACK'S LAW DICTIONARY 1638-39 (8th ed. 2004) (work product rule).

50. See Carol M. Suzuki, *Unpacking Pandora's Box: Innovative Techniques for Effectively Counseling Asylum Applicants Suffering from Post-Traumatic Stress Disorder*, 4 HASTINGS RACE & POVERTY L.J. 235, 253-64 (2007).

51. Change in affect and ability to relay facts due to treatment may affect credibility and ability to establish well-founded fear. See *id.* at 253-64. In depth analysis of the effect of treatment for PTSD of an asylum seeker is beyond the scope of this Article but will be elaborated on in a future article.



which the client has retained the lawyer, a lawyer may determine that a client should obtain mental health treatment to support his legal claim. Where mental health treatment would be aligned with successful resolution of a legal matter,<sup>52</sup> a competent lawyer might advise treatment, even without regard to the actual therapeutic benefit to the client and the humanistic goals of lawyering.

For example, Angela must support her petition for an order of protection with evidence that she is entitled to have the court restrain her boyfriend's civil liberties because of his bad acts. A mental health evaluation might show that Angela suffered severe emotional distress or imminent fear of bodily injury, which might sustain a finding that domestic violence had occurred and supply a basis for the order. Angela also might receive mental health treatment to deal with the trauma of domestic abuse. The fact that she is participating in treatment supplies consistent evidence to support her claim that she was in an abusive relationship and suffered trauma as a result. Treatment may also provide a means for Angela to resolve her trauma and to learn to establish healthy relationships. In this instance, a treatment referral would be made in the course of rendering competent legal services,<sup>53</sup> to support the legal claim.

As part of the treatment process, the mental health services provider would evaluate the patient in order to determine the appropriate course of treatment. As part of the evaluation, a service provider may inquire into personal topics, including a patient's mental health, physical health, medical history, education, family background, family history of illness, past test results and evaluations, substance use history, social functioning, involvement with the criminal justice system, and juvenile delinquency. Additionally, psychological and psychiatric tests may be administered or systems of measurement employed to evaluate a patient's mental state.<sup>54</sup> The results of the evaluation may include a written report, medical records, test results, or comprehensive psychiatric evaluation that diagnoses a developmental, behavioral or emotional problem.

The fact of having received treatment, or even the client's improved health, may support a legal claim. Treatment may also support the client's health.<sup>55</sup> Where an attorney determines that a

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52. See Quinn, *supra* note 47, at 574 nn.181-82 (discussing proof of rehabilitation as a mitigating factor in sentencing in the criminal law context).

53. See MODEL RULES OF PROF'L CONDUCT R. 1.1 (2002) (attorney competence).

54. See, e.g., DSM-IV-TR, *supra* note 10, at 818 (Social and Occupational Functioning Assessment Scale (SOFAS)).

55. Preventive law provides a framework for preventing controversy and the risk of litigation

mental health evaluation would generate helpful evidence for the legal claim,<sup>56</sup> and that treatment might support a positive legal outcome of the case,<sup>57</sup> then a mental health referral should be considered as part of a lawyer's duty of competence.<sup>58</sup>

## **B. Treatment May Be Required as Part of the Legal Process: An Example of Obligations to Juvenile Clients**

An attorney for a child involved as a respondent in the juvenile justice system may be instrumental in assuring that mental health services put in place for a child are appropriate in terms of the health of the child and the rehabilitative goals of the system. The historical goal of the juvenile justice system was to rehabilitate children and put services in place to help children to develop into adults who will make positive contributions to society.<sup>59</sup> The juvenile justice system is structured to regulate children's conduct<sup>60</sup> and adjudicate minors who are charged with a status offense<sup>61</sup> or an offense that would be a

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while maximizing a client's opportunities. See Edward D. Re, *The Lawyer as Counselor and the Prevention of Litigation*, 31 CATH. U. L. REV. 685, 692 (1995); see also PRACTICING THERAPEUTIC JURISPRUDENCE, *supra* note 25, at 5, 6-7. See generally National Center for Preventative Law, <http://www.Preventivelawyer.org/main/default.asp> (last visited Feb. 11, 2009). Arguably, a lawyer who responds to Sam's obvious drinking problem by suggesting he seek assistance is practicing preventive law, if she believes that drinking has contributed to Sam's inability to pay rent and will lead to future non-payment problems, either by his not paying attention to his financial obligations, or spending the rent money on drinking. The lawyer does not need a check list to determine there is a social or substance use problem that may lead to a legal problem. But advising a client to seek mental health counseling may occur appropriately without the concern for future legal problems.

56. For example, a diagnosis of PTSD may be evidence in support of an immigration client's claim he suffered trauma at the hands of his government in his home country. See, e.g., DEBORAH ANKER, *LAW OF ASYLUM IN THE UNITED STATES* 104-05 (3d ed. 1989).

57. For example, a mother trying to get her child out of foster care and back home may be able to show that, with treatment, she has been able to stabilize her mental illness and has established a safe home environment for her child.

58. See MODEL RULES OF PROF'L CONDUCT R. 1.1 (2002). A more complicated situation may arise where a lawyer determines that a mental health evaluation, depending on its outcome, would generate evidence supportive of the client's legal goals, but that treatment, based on the attorney's legal assessment, would be detrimental to the legal case. Where treatment might be beneficial for the client's mental health, but detrimental to the legal matter, a lawyer should consider whether to advise her client about the potential legal detriments and health benefits. If that situation were to arise, the lawyer would need to consider how to speak to the client about getting the evaluation, but not treatment.

59. See Jeffrey Fagan, *Punishment or Treatment for Adolescent Offenders: Therapeutic Integrity and the Paradoxical Effects of Punishment*, 18 QUINNPIAC L. REV. 385, 385 (1999) (regarding treatment and punishment in the juvenile justice system).

60. See, e.g., *Hutchins v. District of Columbia*, 188 F.3d 531 (D.C. Cir. 1999) (en banc) (discussing juvenile curfew).

61. A non-criminal act that is considered an offense due to the child's minor status. See Lee

crime if committed by an adult.<sup>62</sup> Because children do not have the requisite intent to commit crimes, due to young age and immaturity, children are generally not charged as adults and do not suffer adult criminal penalties if found to have committed delinquent acts.<sup>63</sup>

As they mature into adults, children are malleable and undergo physical and mental developmental changes. Preventive intervention can help to decrease the effect of risk factors for adult mental disorders.<sup>64</sup> A child charged with committing or found to have committed an act of juvenile delinquency may be offered or required to receive mental health services by the state as a part of the rehabilitative efforts. Mental health treatment might be ordered by the court prior to adjudication in order to bring a child to competence in order to stand trial.

Some children who are involved in the juvenile justice system suffer from mental illnesses that would be more appropriately treated in the mental health system.<sup>65</sup> Children who enter the juvenile justice system have a high rate of abuse and neglect in their families,<sup>66</sup> and they often suffer from diagnosable mental illnesses.<sup>67</sup> Despite the rehabilitative goals of the juvenile justice system, it is difficult for children who are under the care of the state to obtain appropriate mental health, medical, and educational services.<sup>68</sup> The rehabilitative goals of the juvenile justice system suggest that mental health

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Teitelbaum, *Status Offenses and Status Offenders*, in A CENTURY OF JUVENILE JUSTICE 158, 161-64 (Margaret K. Rosenheim et al., 2002).

62. See 18 U.S.C. § 5031 (2006); *In re Gault*, 387 U.S. 1, 8-9 (1967) (juveniles are entitled to constitutional procedural safeguards).

63. See MICHAEL A. CORRIERO, JUDGING CHILDREN AS CHILDREN 35-37 (2006); Franklin E. Zimring, *The Common Thread: Diversion in the Jurisprudence of Juvenile Courts*, in A CENTURY OF JUVENILE JUSTICE 142, 142-50 (Margaret K. Rosenheim et al. eds., 2002). There has been a movement toward increasing the punitive element of juvenile detention, however. See Jeffrey Fagan, *supra* note 59, at 386-89.

64. See SURGEON GENERAL'S REPORT, *supra* note 8, at 17-18.

65. See *id.* at 23. About one in five children annually in the U.S. as a whole could be diagnosed with a mental disorder under the DSM-IV-TR. *Id.* at 123-24. Diagnosis of children under the DSM-IV-TR must take into account a child's developmental stage. See DSM-IV-TR, *supra* note 10, at 9.

66. See JANET K. WIIG & JOHN A. TUELL, JUVENILE JUSTICE & CHILD WELFARE SYSTEM COORDINATION AND INTEGRATION xiv (2004), available at <http://www.cwla.org/programs/juvenilejustice/jjguidebook08.pdf>.

67. See Linda A. Teplin et al., *Psychiatric Disorders in Youth in Juvenile Detention*, 59 ARCHIVES GEN. PSYCHIATRY 1133, 1137 (2002) ("Even after excluding conduct disorder, nearly 60 percent of male juvenile detainees and more than two thirds of females met diagnostic criteria and had diagnosis-specific impairment for one or more psychiatric disorders."); Joseph J. Cocozza & Kathleen R. Skowrya, *Youth With Mental Disorders: Issues and Emerging Responses*, 7 JUVENILE JUSTICE 3, 5-6 (2000).

68. See April Land, *Dead to Rights: A Father's Struggle to Secure Mental Health Services for His Son*, 10 GEO. J. ON POVERTY L. & POL'Y 279, 293-327 (2003).

services should be routinely contemplated by the prosecutor, judge or child's attorney. An attorney who represents children who are respondents in juvenile delinquency cases should understand the unique mental health and educational needs of her clients so that the services are appropriate for the client's treatment goals and are not overwhelming.<sup>69</sup>

### **C. Treatment Should Not Be Recommended When Mental Health Treatment and Evaluation Negatively Affect Resolution of the Legal Matter**

Unfortunately, mental health treatment does not always support the client's legal goals. A lawyer with a client suffering from a mental problem may determine that mental health evaluation and treatment might be detrimental to her client's legal case. If the lawyer determines that having an evaluation conducted, even without treatment, would be contrary to obtaining the client's goals in the legal process, then the attorney and client should discuss whether the client should elect to not be evaluated. They should also discuss the risks involved in not undergoing treatment. Lack of treatment could affect the client's credibility as a witness or as a party to an agreement. The client should make an informed decision regarding what is more important.<sup>70</sup> If the client is not evaluated the client cannot be treated, as there would be no evaluation on which to base the treatment and no recommendation of services would be made by the lawyer to her client. Even if a client does not elect to undergo evaluation, rules of discovery may permit examination and evaluation of a party by the opposing party where a party's mental status is at issue.

A lawyer should consider whether documentation regarding mental problems, if discoverable by the other party, would hamper the client's interests in terms of his goals in the legal matter.<sup>71</sup> The fact that the client has received mental health treatment may be detrimental to the client's case. For example, evidence of treatment

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69. See Patricia Puritz & Katayoon Majd, *Ensuring Authentic Youth Participation in Delinquency Cases: Creating a Paradigm for Specialized Juvenile Defense Practice*, 45 FAM. CT. REV. 466, 475-76 (2007); see also A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 3, 8. (Children are more difficult to diagnose with mental illness because they are still developing on many levels.)

70. See MODEL RULES OF PROF'L CONDUCT R. 1.4(b) (2002).

71. There is a question as to whether a lawyer in that instance should stop her inquiry at that point, or whether she should discuss with her client the benefits of treatment on the client's mental health and the risks of potential adverse effects on the legal matter.

or evaluation or attempts at treatment may be viewed as an admission that a client is mentally ill. It may be used against a parent trying to maintain custody of her child in a custody matter related to a domestic violence case.<sup>72</sup> As another example, a diagnosis of mental incompetence may affect a client's liberty interest or ability to make decisions in his legal case.

#### **D. Services Should Be Recommended When Mental Health Treatment and Evaluation Have No Effect on the Resolution of the Legal Matter**

There are instances where undergoing mental health treatment, including evaluation, would have virtually no effect on the legal matter. Certainly it is somewhat unrealistic to think that mental health treatment of a client would have absolutely no impact on the case in which the client is involved. Even if evidentiary issues were not relevant, treatment would probably affect the attorney/client relationship.<sup>73</sup> But, using Sam's non-payment of rent case as an example, the lawyer may be able to resolve Sam's current legal problem regardless of Sam's sobriety and depressed mental state. While determining that a client's mental problem has no material effect on the legal matter, a lawyer may decide that the problem may be appropriate business to which a competent attorney would attend.<sup>74</sup> A referral might be made out of a humanistic concern for the client's mental health, with consideration to issues discussed in the next Part.

### **IV. Cultural Differences in Mental Illness and Treatment Among U.S. Populations**

Advising a client to seek mental health counseling should be viewed as a sound step of client-centered lawyering. However, to be truly client-centered, the advice must be appropriate in the context of the client's values, priorities, culture, and life situation. It is vital to

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72. A lawyer may determine a client is fit and appropriate to parent his child despite concerns about a client's mental health. She might advise her client to seek treatment upon resolution of the court case.

73. Moreover the effect on the attorney/client relationship is more likely to be positive than negative.

74. Some clinical law scholars refer to this distinction as case-related and client-related referrals. See DAVID A. BINDER ET AL., *LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH* 445 (2d ed. 2004) [hereinafter *LAWYERS AS COUNSELORS*].

consider a client's belief system in recommending a mental services provider.<sup>75</sup> "Culturally competent services incorporate respect for and understanding of, ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems."<sup>76</sup> A lawyer should focus on advising her client to seek a mental health services provider competent in relation to the client's race, ethnicity and culture. This Part highlights the prevalence of mental illness and its impact among diverse populations in the U.S., cautioning that mental illness is not defined, diagnosed and treated equally across race, ethnicity or culture. A client and lawyer might differ in their race, culture, ethnicity, gender, and many other important characteristics. There exist too many possible points of difference to expose all the possibilities. But discussion of some may help to understand the basis of a client's values in regard to possible mental health referrals.

### A. The Need for Appropriate Services for Diverse Populations

Cultural differences in attitudes about symptomatology and illness may induce stigma surrounding mental illness and affect treatment seeking behavior.<sup>77</sup> At the same time, cultural habits will not necessarily stay fixed. They are influenced by the context in which the client finds himself,<sup>78</sup> so it cannot be assumed that a person will react to a mental health referral in a way that might be considered common for his cultural background, assuming there is a common response. Mental health services directed toward a patient's cultural background have been found to be more effective in fulfilling the relevant patient's needs than services that do not adapt to the patient's culture.<sup>79</sup> Unfortunately for members of minority populations who prefer a provider of the same race, culture or ethnicity, most mental health services providers are not minorities.<sup>80</sup>

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75. For example, among the Zulu, an indigenous South African culture, a healer may be sought out to heal a person whose spirit is thought to be possessed by a witch. See Leslie Swartz, *The Politics of Culture and Mental Illness: The Case of South Africa*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS: AN INTERNATIONAL PERSPECTIVE 73, 74-75 (Ihsan Al-Issa ed., 1995) [hereinafter HANDBOOK OF CULTURE AND MENTAL ILLNESS].

76. SURGEON GENERAL'S REPORT, *supra* note 8, at 81.

77. See Ihara & Takeuchi, *Racial and Ethnic Minorities*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 310, 320-21; SURGEON GENERAL'S REPORT, *supra* note 8, at 6-9.

78. See Kevin Avruch, *Culture as Context, Culture as Communication: Considerations for Humanitarian Negotiators*, 9 HARV. NEGOT. L. REV. 391, 400-01 (2004).

79. Derek Griner & Timothy B. Smith, *Culturally Adapted Mental Health Interventions: A Meta-Analytic Review*, 43 PSYCHOTHERAPY: THEORY, RES., PRAC., TRAINING 531, 541 (2006) (meta-analysis of culturally adapted mental health interventions).

80. Ihara & Takeuchi, *Racial and Ethnic Minorities*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 310, 318.

Because there are distinct racial, ethnic and cultural variations in rates of diagnosis of mental disorders in the U.S., these variations should be considered in the context of the changing population.<sup>81</sup> As the population increases from domestic births in and immigration to the U.S., it also shifts in its demographic makeup to become more diverse in terms of culture, race and ethnicity. The U.S. population in late 2008 was approximately 306 million people.<sup>82</sup> The U.S. Census Bureau estimates that by 2050 the population will increase by over forty percent.<sup>83</sup> The current minority population will become the majority by 2042.<sup>84</sup> As the population changes, attorneys need to better understand different concepts of mental illness and its treatment and disparate diagnoses depending on client race, ethnicity and culture.

## B. Defining and Diagnosing Mental Illness

### *i. Global Differences*

In preparation for advising her client to seek services, a lawyer should understand that there are differences in defining and diagnosing mental problems around the world. The conditions that the *DSM-IV-TR* defines as mental illness exist worldwide, but there are symptomatological and incidental differences in other cultures.<sup>85</sup> Even among Western countries, differences can be observed in diagnostic concepts of mental disorders.<sup>86</sup> As culture structures what is normal and deviant,<sup>87</sup> it defines illness and available remedies.

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81. See SURGEON GENERAL'S REPORT, *supra* note 8, at 81.

82. POPULATION DIVISION, U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, U.S. POPCLOCK PROJECTION, <http://www.census.gov/population/www/popclockus.html> (last visited Feb. 25, 2009) (305,799,680 U.S. resident population projected for February 11, 2009).

83. See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, 2008 NATIONAL POPULATION PROJECTIONS tbl.1 (Aug. 14, 2008) (based on 2000 census), available at <http://www.census.gov/population/www/projections/summarytables.html>.

84. Press Release, U.S. Census Bureau, U.S. Dep't of Commerce, An Older and More Diverse Nation by Midcentury (Aug. 14, 2008), available at <http://www.census.gov/Press-Release/www/releases/archives/population/012496.html>.

85. The *DSM-IV-TR* is acknowledged worldwide as a diagnostic tool for mental illness. Its authors note that symptoms of mental illness may be culturally specific to a locality. See *DSM-IV-TR*, *supra* note 10, at App. I; see also Al-Issa, *supra* note 75, at 7 ("Since normality and abnormality are defined within a social and cultural context, they cannot be considered medical or scientific concepts but rather moral, religious, or political ones.").

86. See Al-Issa, *Culture and Mental Illness in an International Perspective*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 7 (schizophrenia and affective psychoses in the U.S. versus England and Wales).

87. *Id.*

Culture provides a framework for interpreting motives and behaviors.<sup>88</sup> The causes of mental illness are also not shared globally. In the United States, mental illness is believed to be caused by biological, psychological, social, cultural and environmental factors.<sup>89</sup> These bases for mental illness are not shared by all cultures and communities. For example, some cultures believe mental illness is caused by spirits.<sup>90</sup>

Some symptoms of a *DSM-IV-TR*-defined mental disorder may not be considered as negative or abnormal in non-Western cultures.<sup>91</sup> For example, depression is not universally recognized as an emotional state.<sup>92</sup> The *DSM-IV-TR* definition of depression includes helplessness and loss of a sense of pleasure as symptoms. Among Buddhists, these conditions may not be considered abnormal,<sup>93</sup> and therefore not symptoms of illness. Schizophrenia is *DSM-IV-TR*-defined mental disorder with cultural characteristics that must be considered.<sup>94</sup> In some cultures, the symptoms of schizophrenia, such as hallucinations and delusions, are normal, accepted, and not considered indications of a mental problem.<sup>95</sup>

## ii. Domestic Diagnostic Differences

A lawyer considering referring a client to treatment should also be aware that, even with the adherence to the *DSM-IV-TR* diagnostic framework, differences persist in the U.S. in the diagnosis and treatment of mental illness that are based on race and ethnicity.<sup>96</sup> For

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88. See Avruch, *supra* note 78, at 395-96.

89. See SURGEON GENERAL'S REPORT, *supra* note 8, at 49-57.

90. See Raquel C. Andrés-Hyman et al., *Culture and Clinical Practice: Recommendations for Working with Puerto Ricans and Other Latinas(os) in the United States*, 37 PROF. PSYCHOL.: RES. & PRAC. 694, 700 (2006) (recommendations for mental health professionals treating patients of Hispanic heritage); Luh Ketut Suryani, *Cultural Factors, Religious Beliefs, and Mental Illness in Bali: Indonesia*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 203, 205 ("Bali Illness" is a disorder caused by supernatural forces, such as spirit possession or curses. Bali illness does not carry with it shame and is considered curable, unlike insanity, which is considered genetic in cause and incurable); DERALD WING SUE & DAVID SUE, COUNSELING THE CULTURALLY DIVERSE: THEORY AND PRACTICE 214-15 (5th ed. 2008) [hereinafter COUNSELING THE CULTURALLY DIVERSE] (discussing spirit possession).

91. See Al-Issa, *Culture and Mental Illness in an International Perspective*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 3, 9.

92. The Chinese and Yoruba (Nigerian) languages have no term equivalent to "depression." See *id.* at 21.

93. See *id.* at 20.

94. See *DSM-IV-TR*, *supra* note 10, at 297-311.

95. See *id.* at 306 (behaviors may be a part of a religious experience); SURGEON GENERAL'S REPORT, *supra* note 8, at 272-73.

96. To assist in the diagnosis of individuals from diverse cultures and to counter possible



example, a study of bipolar patient records suggests that African-American and Hispanic bipolar patients are more likely than white bipolar patients to be misdiagnosed as schizophrenic, a psychotic disorder.<sup>97</sup> Other studies show that African Americans and Hispanics tend to be over-diagnosed with schizophrenia but under-diagnosed for affective disorders, such as depression,<sup>98</sup> that may be considered less stigmatizing and serious, such as depression. The under-diagnosis for affective disorders also occurs among African-American children.<sup>99</sup> Although allegations of misdiagnosis of African-American patients by white psychiatrists have been supported only by a few examples, there is circumstantial evidence that suggests that African-American patients are more likely to be misdiagnosed than white patients by white psychiatrists.<sup>100</sup> Although there tend to be similarities when looking at all white patients versus all Asian patients, there are significant differences among Asian populations when comparing diagnoses of patients in these groups.<sup>101</sup> Minority groups overall are overrepresented in inpatient treatment and underrepresented in outpatient treatment.<sup>102</sup> Cultural differences in attitudes about symptomatology and illness may affect diagnosis,

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clinician bias, the DSM-IV-TR contains a section outlining cultural considerations and containing a glossary of culture-bound syndromes. See DSM-IV-TR, *supra* note 10, at xxxiii-xxxiv, 897-903.

97. See Sukdeb Mukherjee et al., *Misdiagnosis of Schizophrenia in Bipolar Patients: A Multiethnic Comparison*, 140 AM. J. PSYCHIATRY 1571 (1983); cf. Victor R. Adebimpe, *Race, Racism, and Epidemiological Surveys*, 45 HOSP. & COMMUNITY PSYCHIATRY 27 (1994) (describing how sociodemographic and experiential differences between African American patients and white patients affect data collection and analysis). But see D.A. Regier et al., *One-Month Prevalence of Mental Disorders in the United States and Sociodemographic Characteristics: The Epidemiologic Catchment Area Study*, 88 ACTA PSYCHIATRICA SCANDINAVICA 35, 39, 44-45 (1993) (Studies which indicate a higher rate of overall mental illness prevalence among African Americans and Hispanics than among whites in the U.S. may be a result from those demographics having an overall lower economic status.).

98. See Will M. Aklin & Samuel M. Turner, *Toward Understanding Ethnic and Cultural Factors in the Interviewing Process*, 43 PSYCHOTHERAPY: THEORY, RES., PRAC., TRAINING 50, 51 (2006); Victor R. Adebimpe, *Overview: White Norms and Psychiatric Diagnosis of Black Patients*, 138 AM. J. PSYCHIATRY 279 (1981). The differences in prevalence by race are found in other countries. For example, in Britain, African and other ethnic minorities are diagnosed as schizophrenic more often relative to white people. SUMAN FERNANDO, CULTURAL DIVERSITY, MENTAL HEALTH AND PSYCHIATRY: THE STRUGGLE AGAINST RACISM 30 (2003).

99. See Aklin & Turner, *supra* note 98, at 51 (suggesting that symptoms of mental illness are deemed more serious when patients are minorities).

100. Adebimpe, *supra* note 98.

101. See Nolan Zane & Herbert Hatanaka, *Ethnic-Specific Mental Health Services: Evaluation of the Parallel Approach for Asian-American Clients*, 22 J. COMMUNITY PSYCHOL. 68, 74-75 (1994) (summary of diagnostic differences among Asian groups).

102. SURGEON GENERAL'S REPORT, *supra* note 8, at 84.

which is generally in part based on patient reporting.<sup>103</sup>

### C. Differences in Service Provision Depending on Patient Characteristics

A lawyer attempting to refer a client to appropriate treatment services should know that mental health services providers acknowledge that overall, ethnic and racial minority groups are underserved.<sup>104</sup> The mental health services field is in the nascent stages of studying the effects of culturally appropriate services<sup>105</sup> and how these services can help to meet the needs of targeted populations. The impacts of culture, ethnicity, and race in diagnosis and provision of mental health services have been recognized as needing further study to address the needs of patients of color.<sup>106</sup> There is an acknowledgment among psychologists that their profession must develop systems to meet the increasing need for professionals who are adept at working with patients of different races, cultures and ethnicities.<sup>107</sup> Professionals in the mental health field point out the need for practitioners who are part of the communities which they serve,<sup>108</sup> and they advocate for cultural education for those working in the field.<sup>109</sup> The barriers to mental health services should be eliminated to make appropriate treatment available to members of diverse communities.

When they do access formal traditional Western mental health treatment, patients of color are more likely to terminate treatment

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103. See Aklin & Turner, *supra* note 98, at 50 (analyzing the effects of ethnicity and culture on the clinical assessment interview).

104. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 64-66 (discussing the need for multicultural mental health education); Ihara & Takeuchi, *Racial and Ethnic Minorities, in A PUBLIC HEALTH PERSPECTIVE*, *supra* note 9, at 310, 318 (most mental health professionals are white, a barrier to minorities who seek providers of the same race or ethnicity); SURGEON GENERAL'S REPORT, *supra* note 8, at 80-81.

105. Griner & Smith, *supra* note 79, at 541.

106. See U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 159-62 (2001). See generally COUNSELING THE CULTURALLY DIVERSE, *supra* note 90.

107. See Derald Wing Sue et al., *The Diversification of Psychology: A Multicultural Revolution*, 54 AM. PSYCHOLOGIST 1061 (1999). In 2002, the American Psychological Association approved of guidelines on multicultural education for psychologists, but they are set to expire in 2009. American Psychological Association, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (Aug. 2002), available at <http://www.apa.org/pi/multiculturalguidelines/references.html>.

108. See, e.g., SUMAN FERNANDO, CULTURAL DIVERSITY, MENTAL HEALTH AND PSYCHIATRY: THE STRUGGLE AGAINST RACISM 174-75 (2003).

109. See generally *id.*

early than white patients.<sup>110</sup> There is a significantly higher rate of terminating treatment after one session among patients of color compared to white patients.<sup>111</sup> The mental health system would benefit from professionals from diverse racial and ethnic groups,<sup>112</sup> as mental health professionals of color are more likely to accept and retain patients of color.<sup>113</sup>

There are deep-rooted racial, cultural and ethnic reasons that people do not access mental health services or do seek non-normative treatment providers. Members of minority groups are less likely than the overall population to seek help with a mental problem. Perceived racism, biases, stereotypes, and differing cultural values and beliefs affect whether a person attempts treatment and stays in treatment.<sup>114</sup> Studies show that the mistrust of the mental health system by minority populations may not be misplaced. Mistrust of the mental health system by African Americans may exist because of experienced and historical discrimination including slavery,<sup>115</sup> racism and segregation,<sup>116</sup> disparities in diagnosis, and misdiagnoses. Also, bias against African American and Hispanic patients has been found among mental health services providers, negatively affecting the diagnostic process.<sup>117</sup> Compared to white patients, African Americans are more often misdiagnosed and overrepresented among patients in involuntary inpatient services.<sup>118</sup>

When a minority group member seeks assistance to cope with a problem, the person consulted may be someone who is associated with spirituality, such as a minister or tribal traditional healer.<sup>119</sup> As

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110. Ihara & Takeuchi, *Racial and Ethnic Minorities, in A PUBLIC HEALTH PERSPECTIVE*, *supra* note 9, at 310, 318 (citing studies comparing treatment dropout rates among cultural groups).

111. Stanley Sue et al., *Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis*, 59 J. CONSULTING & CLINICAL PSYCHOL. 533, 533 (1991) (showing fifty percent versus thirty percent in a study of patients of color utilizing outpatient mental health services); Stanley Sue, *Community Mental Health Services to Minority Groups: Some Optimism, Some Pessimism*, 32 AM. PSYCHOLOGIST 616, 620-22 (1977) (study of culturally-appropriate service delivery).

112. Ihara & Takeuchi, *Racial and Ethnic Minorities, in A PUBLIC HEALTH PERSPECTIVE*, *supra* note 9, at 310, 318.

113. See Sue et al., *supra* note 111, at 536-37 (study of ethnic and language matching of therapist and client).

114. See SURGEON GENERAL'S REPORT, *supra* note 8, at 81.

115. MARTIN N. MARGER, RACE AND ETHNIC RELATIONS: AMERICAN AND GLOBAL PERSPECTIVES 164-70 (8th ed. 2009).

116. See SURGEON GENERAL'S REPORT, *supra* note 8, at 87.

117. Aklin & Turner, *supra* note 98, at 57.

118. See *id.* at 58.

119. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 219-28, 336 (indigenous healer, church).

another example of selecting non-Western treatment, some people, Chinese or not, may believe in the healing powers of traditional Chinese medicine,<sup>120</sup> as opposed to Western treatments. But the choice of service provider may not simply indicate a preference for assistance outside of the formal mental health profession. People of color may not seek mental health treatment because of historic racial disparities, and the lack of therapists from the same ethnic backgrounds or who speak the same native languages.<sup>121</sup> Also mental health services may not be located in the community where people of color reside.<sup>122</sup>

Furthermore, a racial or ethnic match may not be desired by a patient. When formal mental health treatment is sought by an African-American patient, depending on the patient's racial identity or consciousness, the patient may prefer a white service provider or an African-American service provider.<sup>123</sup> Thus, one patient of color may not attach the same weight to ethnic, racial and cultural match between the provider and the patient as another patient of color might attach.

Although Asian Americans share similarities with other ethnic groups in the U.S. with respect to frequency and severity of mental illness, they tend to underutilize the mental health treatment that is available to them.<sup>124</sup> Among people of Asian origin in the U.S., two-thirds of whom are immigrants,<sup>125</sup> the reasons that they may not seek treatment include stigma about mental illness,<sup>126</sup> the fear of "losing face" within one's family or community,<sup>127</sup> limited English proficiency,<sup>128</sup> differing cultural explanations of causes of mental illness,<sup>129</sup> and inability to find culturally competent services.<sup>130</sup>

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120. See SUMAN FERNANDO, CULTURAL DIVERSITY, MENTAL HEALTH AND PSYCHIATRY: THE STRUGGLE AGAINST RACISM 90, 142-44 (2003).

121. Griner & Smith, *supra* note 79, at 532; Jacquelyn H. Flaskerud & Li-Tze Hu, *Participation in and Outcome of Treatment for Major Depression Among Low Income Asian Americans*, 53 PSYCHIATRY RES. 289 (1994).

122. Griner & Smith, *supra* note 79, at 532.

123. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 337.

124. See Zane & Hatanaka, *supra* note 101, at 68-69 (providing statistics of underuse).

125. See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, THE AMERICAN COMMUNITY-ASIANS: 2004, at 11 (Feb. 2007).

126. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 159, 361. Mental illness may be viewed as deviant and harmful in Korea. See Kwang-iel Kim, *Culture and Mental Illness in South Korea*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 147, 149.

127. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 136, 160, 363-64.

128. *Id.* at 136, 364, 428.

129. See *id.* at 369.

130. See *id.* at 324 (discussing multicultural psychology and ethnic minority mental health);

In a short-term study of treatment effectiveness, when they access services, Asian Americans tend to be less satisfied with the treatment than white patients.<sup>131</sup> Also in the short-term, they tend to have poorer treatment outcomes than white patients.<sup>132</sup> Asian patients and white patients differ in how they are referred to mental health treatment in the U.S. Asians tend to be referred by social services organizations or other family members.<sup>133</sup> White patients in the U.S. tend to be referred by mental health services agencies.<sup>134</sup>

American Indians overall are inclined to mistrust the mental health services system.<sup>135</sup> Mistrust may be a reasonable result of an historical experience of conquest, depopulation, and displacement by European settlers and the American government.<sup>136</sup> The Bureau of Indian Affairs employs mental health professionals, but its responsibility in this area is mainly to provide referrals to mental health treatment providers as opposed to providing the services themselves.<sup>137</sup> Indian Health Services<sup>138</sup> does not have the ability to fulfill the needs of their patients for mental health and substance use treatment.<sup>139</sup>

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Zane & Hatanaka, *supra* note 101; Sue et al., *supra* note 111 (ethnic match between patient and provider increases length of treatment but may not strongly affect treatment outcome).

131. Nolan Zane et al., *Treatment Outcomes of Asian- and White-American Clients in Outpatient Therapy*, 22 J. COMMUNITY PSYCHOL. 177, 185 (1994). "Asian-American clients reported feeling more depressed, more hostile, and more anxious after four sessions of treatment than White-American clients." *Id.*

132. *Id.* at 177, 187. Additionally, at least in short term treatment, therapists see Asian-American patients as less suitable for treatment than White-American patients. *Id.* at 188.

133. Zane & Hatanaka, *supra* note 101, at 75-76.

134. *Id.*

135. See U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 83, 91 (2001); COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 346-47.

136. See SURGEON GENERAL'S REPORT, *supra* note 8, at 87; COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 346; see also MARTIN N. MARGER, RACE AND ETHNIC RELATIONS: AMERICAN AND GLOBAL PERSPECTIVES 138-63 (8th ed. 2009).

137. See Philip D. Somervell et al., HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 315, 323.

138. For background on federal funding for health services for American Indians and the establishment of Indian Health Services, see Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and The Indian Health Care Improvement Act*, 4 DEPAUL J. HEALTH CARE L. 843, 843-48 (1999).

139. See Philip D. Somervell et al., HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 315, 323.

## **D. How Culture, Race and Ethnicity May Affect Mental Health Counseling**

Representation of a client with a mental problem who seeks assistance in an immigration matter raises many issues related to a client's cultural background, race and ethnicity, and provides a setting to reflect on the factors affecting mental health services. Common concerns about immigrants with mental health problems will include cultural views of mental illness in a client's home country;<sup>140</sup> race, ethnicity and culture matching between the client and the mental health services provider;<sup>141</sup> the need for a language interpreter;<sup>142</sup> and mental stressors relating to immigration.<sup>143</sup>

An example may illustrate the importance of considering race, culture and ethnicity in making a mental health referral. In the example in the Introduction to this Article, Felix underwent a mental evaluation and was diagnosed with post-traumatic stress disorder, but received no treatment. Felix sought legal representation to obtain asylum in the U.S. based on torture by the government that was supposed to protect him. The mental health evaluation was completed as part of the evidence-gathering investigation in support of Felix's legal claim.<sup>144</sup> Looking beyond the supportive evidence from the evaluation, his attorney should consider the impact of any potential treatment on the case and Felix's actual ability to access treatment in determining whether to make a referral for mental health services. Treatment might affect Felix's affect, meaning his facial, vocal and gestural behavior, when he talks or testifies about his past torture. The effects may be positive or negative in relation to how credible he appears and sounds before an immigration judge in regard to his claim of well-founded fear.<sup>145</sup>

Assuming treatment is appropriate in light of the anticipated legal resolution, Felix's lawyer should be mindful of referring Felix to a service provider with whom Felix feels comfortable when determining an appropriate referral for treatment of the mental problem. A client may express a preference for a provider of the same race, ethnicity, or culture, which may be difficult when the client is an immigrant. Felix's attorney should consider not only the community and culture in which Felix currently resides, but also the

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140. See *supra* Part IV.B.1.

141. See *supra* Part IV.C.

142. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 428.

143. See *id.* at 430.

144. See Suzuki, *supra* note 50, at 264-65 n.157.

145. See *id.*

culture from which he came, and the facts relating to his emigration to the U.S. (i.e., voluntary or as a refugee).<sup>146</sup> Among immigrant refugees, mental stress related to immigration can be pronounced in the first three years after arrival in the U.S.<sup>147</sup> Immigrants may have a fear of being reported and deported while seeking legal representation in the immigration matter.<sup>148</sup> Lawyers who assist clients like Felix with claims for asylum may be in a unique position to assist their clients with mental health treatment at a time that is particularly stressful for the client. A person seeking asylum assistance may not have support systems in place in his new community. Even in the situation where a client does not appear to be suffering from trauma related to the reason for leaving one's home country, mental health treatment may help to improve the well-being of an immigrant client.

Another dilemma that may arise in finding an appropriate service provider is language difference. Felix may require a language interpreter if he does not speak or is not comfortable speaking about complex issues in English and no service provider is available who speaks Felix's native language. Mental health counseling through an interpreter has been found to be difficult for some patients because not only is there another person who knows of the client's problem, but the counseling through an interpreter means that there is a built-in filter between the client and the provider.<sup>149</sup> Language interpreters may be necessary in legal settings to interview and counsel clients for the legal matter and to refer to mental health treatment,<sup>150</sup> and in medical settings to provide care for patients. Matching the language and ethnicity of the patient and mental health services provider increases the likelihood that the patient will continue treatment.<sup>151</sup>

Beyond concerns arising from a client's race, culture and ethnicity, immigrants may not have the ability to afford mental health

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146. See Al-Issa, *HANDBOOK OF CULTURE AND MENTAL ILLNESS*, *supra* note 75, at 3, 29-31.

147. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY* 30 (2001).

148. See SURGEON GENERAL'S REPORT, *supra* note 8, at 87; COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 427.

149. COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 136.

150. See Angela McCaffrey, *Don't Get Lost in Translation: Teaching Law Students to Work with Language Interpreters*, 6 *CLINICAL L. REV.* 347 (2000); Muneer I. Ahmad, *Interpreting Communities: Lawyering Across Language Difference*, 54 *UCLA L. REV.* 999 (2007) (suggesting a framework for the lawyer/client/interpreter relationship to better manage language and cultural differences that arise in legal representation).

151. See Sue et al., *supra* note 111, at 538-39 (providing a study of patients of color who utilize outpatient mental health services); Griner & Smith, *supra* note 79, at 543 (meta-analysis finding benefits to treatment in a patient's preferred language).

treatment.<sup>152</sup> Depending on his documented immigration status and his living circumstances in the U.S., an immigrant or an asylum seeker like Felix may not have a job or be eligible to work, may not have appropriate insurance, and he may not be eligible for Medicaid and Medicare to pay for treatment. Inability to pay or difficulty in paying for mental health services is a struggle for many people in the U.S. regardless of immigration status, and will be discussed in the next Part.

## V. Covering the Costs of Mental Health Treatment

An attorney who endeavors to refer her client to appropriate mental health treatment should reflect on the client's ability to pay for treatment. A suggestion to seek counseling without having available referral to potential service providers or with no offer to assist the client to locate a provider may be insufficient support to a client with a mental illness. Moreover, a referral with no consideration of whether the client has the means to pay the provider, including the availability of Medicaid, Medicare and employer or group insurance, would be incomplete. This Part summarizes financial aspects of accessing mental health services, as affordability is a crucial aspect of identifying appropriate treatment.<sup>153</sup>

Many people who are aware that they have mental problems do not get treatment because they cannot afford or otherwise lack means to pay for the treatment.<sup>154</sup> Eleven million people in the United States recognized they had mental illness in 2007, and almost half of them expressed that their need for treatment was not met due to the costs of treatment or lack of insurance.<sup>155</sup> Studies show that risk factors for dropping out of mental health treatment include socio-economic disadvantage.<sup>156</sup> Thus, an element of appropriateness in a

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152. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 429.

153. This Part does not focus on costs of a mental health evaluation that is completed as part of a legal case, which raises issues beyond the scope of this Article.

154. See Ronald C. Kessler et al., *The Epidemiology of Adult Mental Disorders*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 157, 168.

155. TAMI L. MARK ET AL., SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL EXPENDITURES FOR MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE TREATMENT: 1993-2003, at iii (2007), available at <http://www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf>.

156. Alan E. Kazdin et al., *Risk Factors for Dropping Out of Treatment Among White and Black Families*, 9 J. FAM. PSYCHOL. 402, 413 (1995) (discussing a study of differences in factors for dropping out of treatment between white children and African-American children. Factors shared between the groups also included stress of the parent, antisocial behavior of the child, history of antisocial behavior of a parent, and adverse child-rearing practices.).



mental health services provider is one who a client can afford to see for treatment.

While many people with mental illness do not receive treatment or receive inadequate treatment, expenditures for mental health services are significant. In the U.S. in 2003, 100 billion dollars was spent on mental health services.<sup>157</sup> Most of that treatment was financed through public sources, including Medicaid, Medicare and other federal monies, and state and local government funding.<sup>158</sup> Twenty-one billion dollars was spent on substance abuse treatment in 2003 in the U.S., the majority of which was paid for through public funding.<sup>159</sup> Despite all of the public financing for mental health services, Medicare and Medicaid recipients often have difficulty accessing appropriate treatment because providers could get paid at higher rates for treating patients with other sources of payment. Beyond government financing of mental health care, mental illness places a larger economic burden on society. Among all human diseases, mental illness, including ideations that lead a person to commit suicide,<sup>160</sup> is the second most burdensome disease in established market economies such as the U.S.<sup>161</sup> Mental health services under Medicare and Medicaid have traditionally been under-financed. Recent changes in federal law may help eligible patients to access affordable treatment.

### A. Medicare

Medicare is a federal program that provides health insurance coverage for Americans and permanent residents who are 65 years of age or older and those under 65 with a qualifying disability.<sup>162</sup> Based

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157. See MARK ET AL., *supra* note 155, at 7, 13, 20-21 (public funding accounted for 58 percent of the total mental health expenditures).

158. *Id.* at 7, 13, 20-21 (public funding accounted for 58 percent of the total mental health expenditures). In comparison, looking at all healthcare in 2003, public funding paid for 45 percent of the expenditures. *Id.* at 20.

159. *Id.* at 7, 38-39 (public funding accounted for 77 percent of the total substance abuse treatment expenditures).

160. See *supra* note 17.

161. See SURGEON GENERAL'S REPORT, *supra* note 8, at 4 (citing CHRISTOPHER J.L. MURRAY & ALAN D. LOPEZ, THE GLOBAL BURDEN OF DISEASE (1996)). Mental illness in 1990 cost 63 billion dollars in loss of productivity due to illness, 12 billion dollars in indirect costs from premature death and 4 billion dollars in loss of productivity due to incarceration of the mentally ill and for the loss of productivity for the time family members cared for the mentally ill. SURGEON GENERAL'S REPORT, *supra* note 8, at 411. In 1996, the direct costs of mental health treatment were 99 billion dollars, including treatment for Alzheimer's disease and substance use. See *id.* at 412.

162. See 42 U.S.C.A. § 1395c (2008); EARL DIRK HOFFMAN, JR. ET AL., OFFICE OF THE

on projections from the 2000 census, thirteen percent of the population residing in the U.S. in 2010,<sup>163</sup> or 40 million people,<sup>164</sup> will be at least 65 years old. However, Medicare provides only limited coverage for mental health care. In terms of inpatient care, mental health services are limited to 190 days total during a patient's life,<sup>165</sup> while inpatient coverage for general health care is not limited during a patient's lifetime.

A client who has Medicare may be able to access mental health treatment, but may need to pay for a share of the services. The patient's share of the costs and out-of-pocket expenses for mental health services can be a burden on patients with limited or fixed incomes. Mental health treatment may not be a financial priority for Medicare recipients who must pay a portion of the expenses, so recipients who might benefit from treatment may not receive it due to its costs.

## B. Medicaid

Medicaid is a federally-funded, state-administered, medical insurance program for poor and disabled Americans and other eligible persons who do not otherwise have access to medical services.<sup>166</sup> Fifty-nine million people were enrolled in the Medicaid program in 2005.<sup>167</sup> The payment rate for services is lower under Medicaid compared to other insurance plans, and providers may find that the burden of the paperwork involved outweighs the value of the payment for the services.<sup>168</sup> Thus, even if it is a high priority, people who rely on Medicaid for health coverage may have difficulty finding mental health services providers willing to accept them as patients.

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ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T HEALTH & HUMAN SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID 5 (2007), [http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/Medicare\\_MedicaidSummaries2007.pdf](http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/Medicare_MedicaidSummaries2007.pdf).

163. See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, 2008 NATIONAL POPULATION PROJECTIONS chart 6 (Aug. 14, 2008), available at [http://www.census.gov/population/www/projections/tablesandcharts/chart\\_6.pdf](http://www.census.gov/population/www/projections/tablesandcharts/chart_6.pdf).

164. See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, 2008 NATIONAL POPULATION PROJECTIONS chart 5 (Aug. 14, 2008), available at [http://www.census.gov/population/www/projections/tablesandcharts/chart\\_5.pdf](http://www.census.gov/population/www/projections/tablesandcharts/chart_5.pdf).

165. 42 C.F.R. § 409.62 (2007).

166. See 42 U.S.C.A. § 1396 (2008). For a discussion of the failure of the juvenile justice system to provide medically necessary services under Medicaid to a child under its "protection," see Land, *supra* note 68.

167. See THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID, A PRIMER, at 16 fig.10 (2009), available at <http://www.kff.org/medicaid/upload/7334-03.pdf>.

168. See *id.* at 12-13.

### C. Mental Health Parity

Because of the difference in coverage between mental health and other medical care, there have been ongoing attempts to achieve parity of payment for all types of medical care under Medicare, Medicaid, and employer and group health plans. Advocates claim that parity, where health benefit coverage for mental disorders and general other medical disorders would be equal, would increase availability of mental health care.<sup>169</sup> However, achieving parity has been difficult in part because the public is less willing to pay for treatment of mental disorders than for treatment of somatic disorders through increases in insurance premiums for all plan members or through tax increases that would provide increased mental health treatment coverage for recipients of publically-financed healthcare.<sup>170</sup> As of 2004, advocates for parity had been successful to varying degrees in thirty-three states and had achieved partial parity on the national level with the Mental Health Parity Act of 1996.<sup>171</sup>

Advocates for people with mental illness are hopeful that recent changes in federal law will increase access to mental health treatment and insurance coverage for treatment. On October 3, 2008, as part of the federal economic bailout plan,<sup>172</sup> President Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Wellstone-Domenici Act").<sup>173</sup> The Wellstone-Domenici Act should help patients to receive better insurance coverage for mental health treatment, as it requires equal coverage of mental and physical illnesses for 113 million people,<sup>174</sup> which was not previously mandated. Pursuant to the Wellstone-Domenici Act, businesses with fifty-one or more employees are required to provide equal coverage for mental and physical illnesses in their insurance plans.<sup>175</sup> The date by which most health plans must

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169. Levin et al., *Overview of Prevention, Integration, and Parity*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 3, 8.

170. See SURGEON GENERAL'S REPORT, *supra* note 8, at 8; Kristina W. Hanson, *Public Opinion and the Mental Health Parity Debate: Lessons from the Survey Literature*, 49 PSYCHIATRIC SERVS. 1059 (1998).

171. See 29 U.S.C.A. § 1185a (2008); 42 U.S.C.A. § 300gg-5 (2008); Petril & Levin, *Mental Disability Law, Policy, and Service Delivery*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 42, 54-55 (discussing the Mental Health Parity Act of 1996, which focused on annual and lifetime benefit amounts.).

172. Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008) (codified as amended in scattered sections of 26, 29, and 42 U.S.C.).

173. *Id.*

174. See AM. PSYCHOL. ASS'N PRAC. ORG., SUMMARY OF THE WELLSTONE-DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (Oct. 2008).

175. 26 U.S.C.A. § 9812 (2008); see Robert Pear, *Bailout Provides More Mental Health*

make the Wellstone-Domenici Act changes is January 1, 2010.<sup>176</sup>

#### **D. Care for Uninsured Persons**

Despite the advances in parity for mental health treatment, many people in the U.S. will continue to find that treatment is beyond their financial means. Such persons will include those who do not qualify for Medicaid or Medicare and who do not have private or group insurance. In 2007, there were 45.7 million uninsured people residing in the U.S.<sup>177</sup> One source for health care for an uninsured person is the local emergency hospital. Many people who do not have insurance and are not eligible for Medicare and Medicaid use the emergency room as their primary medical care facility, even where the care needed is not urgent.<sup>178</sup> Federal law requires hospitals that provide emergency services and receive Medicare monies to render emergency screening and care or facility transfer to Medicare and Medicaid recipients and uninsured or underinsured persons.<sup>179</sup> However, mental health services available through an emergency room are inadequate and patients with serious mental illnesses are putting a strain on emergency care facilities.<sup>180</sup>

### **VI. Referring a Client to an Appropriate Mental Health Treatment Provider<sup>181</sup>**

When a lawyer determines that mental health treatment would be appropriate for her client, she should be deliberate in her approach to counseling her client in this matter. She should provide referrals or offer to help her client find an appropriate mental health services provider. A lawyer who considers her client's best interests in

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Coverage, N.Y. TIMES, Oct. 6, 2008, available at <http://www.nytimes.com/2008/10/06/washington/06mental.html>.

176. See Pub. L. No. 110-343, 122 Stat. 3765 (2008).

177. Ian Urbina, *A Decline in Uninsured is Reported for 2007*, N.Y. TIMES, Aug. 26, 2008, available at <http://www.nytimes.com/2008/08/27/washington/27census.html>. (U.S. Census Department officials reported that a decline in the number of uninsured from 2006 occurred because of the growth of government-sponsored health insurance programs.)

178. ANN S. O'MALLEY ET AL., THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE, RISING PRESSURE: HOSPITAL EMERGENCY DEPARTMENTS AS BAROMETERS OF THE HEALTH CARE SYSTEM, ISSUE BRIEF 2-3 (2005).

179. Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, 100 Stat. 165 (codified as amended at 42 U.S.C.A. § 1395dd (2008)).

180. O'MALLEY ET AL., *supra* note 178, at 2-3.

181. This Part does not focus on a mental health evaluation completed as part of a legal case, which raises issues beyond the scope of this Article.

suggesting treatment must maintain a trusting attorney/client relationship and credibility in her work on the client's legal matter. She should be thoughtful about how she will speak with her client about this subject.<sup>182</sup> As she researches and investigates providers, she should consider potential benefits, pitfalls, and alternatives,<sup>183</sup> and be mindful that mental illness can be a sensitive discussion topic because of the stigma and negative aspects of behavior and character that it raises. Treatment that is contemplated to advance a client's legal goals will bring to bear many other variables related to the legal matter, including timing, service provision through the court system, and voluntariness on the part of the client, that will not be discussed in this Part. A lawyer's advice would have a different focus when treatment is part of case strategy or if it is recommended after an evaluation completed as part of a court case. However, some of the suggestions for client counseling in this Part may be useful to lawyers who make referrals with the legal goal in harmony with the treatment objective.

The lawyer's advice should be substantive and not end with a general recommendation to get help. Vague advice about mental health treatment may be viewed as unhelpful to a client. Reasons why people do not seek help include that they do not have "help-seeking behavior,"<sup>184</sup> or they do not know that treatment exists or where to go.<sup>185</sup> Raising the issue of mental illness with her client without specific suggestions, such as names of potential service providers or how to find some referrals, or without an offer to help find appropriate treatment, may not provide enough assistance to a client, even one who is receptive to mental health counseling. Prior to discussion with a client, a lawyer may wish to research potential providers and plan the client interview.<sup>186</sup> She may know or have a sense of the client's priorities, values and needs. But she should be prepared to do more research based on client input and reactions to the attorney's suggestions.

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182. See ROBERT M. BASTRESS & JOSEPH D. HARBAUGH, INTERVIEWING, COUNSELING, AND NEGOTIATING: SKILLS FOR EFFECTIVE REPRESENTATION 237-38 (1990) [hereinafter BASTRESS & HARBAUGH].

183. See *id.*

184. S. Sheikh & A. Furnham, *A Cross-Cultural Study of Mental Health Beliefs and Attitudes Towards Seeking Professional Help*, 35 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 326, 331 (2000) (cultural background is not a good predictor of a mental health patient's attitude toward seeking help).

185. Ronald C. Kessler et al., *The Epidemiology of Adult Mental Disorders*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 157, 171.

186. See BASTRESS & HARBAUGH, *supra* note 182, at 235-54.

## A. Defining an Appropriate Treatment Provider

In developing a treatment referral, the lawyer should consider what her client might want and need in a service provider, as well as what the client may want to avoid in treatment. The range of mental health resources includes traditional western treatment for mental disorders that is psychosocial (i.e., therapy, counseling), or psychopharmacological (i.e., medication), or a combination; and includes non-traditional services.<sup>187</sup> Fifteen percent of U.S. residents each year seek from health professionals, social services agencies, schools, religious organizations or support groups.<sup>188</sup> Of those who seek or undergo treatment, many encounter barriers while trying to obtain services and find gaps in the services they receive.<sup>189</sup> People who are aware of the existence of treatment may not seek help for various reasons, including: mistrust of service providers;<sup>190</sup> belief that treatment will not be effective;<sup>191</sup> concerns about racism and discrimination;<sup>192</sup> concerns about racial bias;<sup>193</sup> concerns that there is no provider with language competence,<sup>194</sup> cultural competence,<sup>195</sup> or shared race or ethnicity;<sup>196</sup> lack of means to pay for services;<sup>197</sup> impracticality/non-accessibility (i.e., transportation, childcare, office hours, waiting list);<sup>198</sup> lack of confidentiality;<sup>199</sup> and concerns about the stigma of being labeled as mentally unfit.<sup>200</sup> Each client brings with him many variables for the attorney to weigh in determining what services might be appropriate for him. Among other factors, an

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187. See SURGEON GENERAL'S REPORT, *supra* note 8, at 15.

188. See *id.* at 75.

189. See *id.* at 455-56.

190. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 100-03.

191. Ronald C. Kessler et al., *The Epidemiology of Adult Mental Disorders*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 157, 168, 170-71 (even if financial and situational problems are resolved, some mental health treatment needs will remain unmet because of the psychological barrier of lack of confidence in the treatment).

192. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 84.

193. See *id.* at 84-88.

194. See *id.* at 151-53.

195. See *id.* at 136.

196. See *id.* at 322-24.

197. SURGEON GENERAL'S REPORT, *supra* note 8, at 73.

198. See Andrés-Hyman et al., *supra* note 90, at 699 (recommending that mental health programs for women consider the socioeconomic situations of the clients when setting up meeting hours); see also Ronald C. Kessler et al., *The Epidemiology of Adult Mental Disorders*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 157, 171 (discussing inconvenience).

199. See SURGEON GENERAL'S REPORT, *supra* note 8, at 440-41 (research on confidentiality in the mental health treatment setting); COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 435 (discussing refugees).

200. See SURGEON GENERAL'S REPORT, *supra* note 8, at 6-9.

appropriate referral must take into account a client's values and priorities, cultural beliefs about mental illness and treatment, and ability to pay for treatment. In some cases, the best fit may be a service provider who is not considered a member of the traditional western mental health profession.

*i. Cultural, Racial and Ethnic Concerns*

A client will bring to the law office his cultural beliefs and biases surrounding mental health, so an attorney should be mindful that a client may have deep-rooted traditional beliefs that conflict with western science.<sup>201</sup> As set forth in Part IV, there is no universal definition of mental health and no universally accepted belief in the cause of mental illness. A lawyer should research specific information about how mental illness is defined and treated in the client's culture, in order to try to reduce anxiety about the issue.<sup>202</sup> Even if he does agree to, and wants, assistance, a client may be more receptive to treatment that considers his cultural background, race or ethnicity.<sup>203</sup> He may prefer a treatment provider who shares the client's race or ethnicity, set of beliefs, norms and values, and traditions.<sup>204</sup> A lawyer should consider perceived or actual discriminatory treatment in health care when making a referral. For example, many African-American clients may harbor a mistrust of the mental health care system,<sup>205</sup> due to misdiagnoses and historical and current discrimination, racism and stereotyping.<sup>206</sup> The discussion between the lawyer and client must account for the possibility that a client may be resistant to normative western mental health professionals and services, but open to assistance from a spiritual healer such as clergy.<sup>207</sup>

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201. See Paul R. Tremblay, *Interviewing and Counseling Across Cultures: Heuristics and Biases*, 9 CLINICAL L. REV. 373, 403-06 (2002).

202. See Susan Bryant, *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 72-76 (2001).

203. See Zane & Hatanaka, *supra* note 101, at 79 (suggesting that ethnic-specific mental health services can provide effective treatment to Asian patients).

204. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 429-30.

205. Aklin & Turner, *supra* note 98, at 58.

206. See *supra* Part IV; COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 340-41.

207. See COUNSELING THE CULTURALLY DIVERSE, *supra* note 90, at 227, 336-37 (discussing the African-American church); Can Tuncer, *Mental Illness in an Islamic-Mediterranean Culture: Turkey*, in HANDBOOK OF CULTURE AND MENTAL ILLNESS, *supra* note 75, at 169, 176 (patients in Turkey suffering from depression are more likely to seek religious persons and family members for assistance, rather than treatment from the medical profession); Luh Ketut Suryani, *Cultural Factors, Religious Beliefs, and Mental Illness in Bali: Indonesia*, *id.* at 203, 206 (Balinese people may seek medical doctors, traditional healers, priests, or high priests

Then again, there is a danger that the attorney might attribute a value to the client's culture that the client does not bestow. "Cultural differences often cause us to attribute different meaning to the same set of facts."<sup>208</sup> Attorneys must be cognizant of whether they attribute a behavior as cultural when there is a client of color involved.<sup>209</sup> The lawyer should avoid stereotyping her client in the course of identifying an appropriate referral.<sup>210</sup> Related to culture and ethnicity, ideally a provider would be able to speak the client's preferred language. Use of an interpreter in mental health counseling is impractical, and raises issues of costs, availability, confidentiality and misinterpretation.<sup>211</sup>

## *ii. Financial Appropriateness*

A client who seeks legal representation may not place a financial or other priority on advice to seek mental health treatment. Appropriate mental health services must account for the means with which a client would pay for those services. As set forth in Part V, there is a great need for treatment at all levels of affordability. But partly because of the lower reimbursement rates under the Medicare and Medicaid systems, finding providers of mental health services has been difficult for patients reliant on those programs. Also, some people will not seek Medicaid or Medicare coverage because they are not eligible or do not think they are eligible based on their immigration status, or do not want to negatively affect their immigration status.<sup>212</sup> A client's ability to afford treatment until resolution of the problem should be considered as a factor when making a referral. A lawyer may need to research free, low-cost, or sliding-scale-fee services in the client's community.

For clients of limited financial means, access to mental health services may be impeded further by distance that must be traveled if

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for treatment, depending on the symptoms of mental disorder.).

208. Bryant, *supra* note 202, at 42 (teaching students to be prepared for and to deal with difficulties in cross-cultural conversations).

209. *Id.* at 42-43.

210. LAWYERS AS COUNSELORS, *supra* note 74, at 32-40. An example is suggesting yoga as a means for stress release to a client from India. Even if a referral is considered culturally neutral to the referrer, it may not be taken as such by the receiver of the information, so a lawyer should be mindful of the issue.

211. Shared language does not equal shared culture. A refugee from Macedonia may speak Serbian, but may not want to be treated by a Serbian mental health professional because of historic conflicts in the Balkans.

212. See Ihara & Takeuchi, *Racial and Ethnic Minorities*, in A PUBLIC HEALTH PERSPECTIVE, *supra* note 9, at 310, 317.



there is no provider where the client resides, lack of transportation, lack of child care, other expenses,<sup>213</sup> and office hours that conflict with the client's family and work obligations.<sup>214</sup> As a practical matter, mental health services, whether culturally matched or not, may not be located in the community where clients of color reside,<sup>215</sup> so costs of transportation and travel time should be considered.

Advising a client to seek mental health services should be considered even where the lawyer, through her own investigation, cannot identify a provider of free counseling services for a client with limited financial means. The lawyer should not limit her appropriate or necessary legal counseling because of a perceived lack of financial resources. It is possible that the client has access to funds that has not yet been revealed to the lawyer. Or, the client may be aware of counseling services in her community that are free or low-cost of which the lawyer is not aware.

### *iii. Other Concerns*

Besides the factors enumerated above, other influences define appropriate treatment for a particular client and should be taken into account by the lawyer in making a referral.<sup>216</sup> Other considerations may include whether the client would prefer a mental health services provider of a certain gender,<sup>217</sup> which is common for a female victim of sexual assault or domestic violence. Mental health services for people who live in rural areas may also be difficult to obtain.<sup>218</sup> Problems in rural communities include limited provider availability, the related lack of choice and variety of provider and treatment, and lack of anonymity.<sup>219</sup>

## **B. Finding a Provider**

A lawyer should make as specific a referral as possible to her client in order to better assure that a client will access and continue with mental health treatment. A lawyer who has experience with making referrals or who collaborates with mental health professionals

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213. Griner & Smith, *supra* note 79, at 532.

214. SURGEON GENERAL'S REPORT, *supra* note 8, at 73.

215. Griner & Smith, *supra* note 79, at 532.

216. The factors would be determined based on a specific person, so not all variables can be listed here.

217. Andrés-Hyman et al., *supra* note 90, at 699.

218. Griner & Smith, *supra* note 79, at 532.

219. See SURGEON GENERAL'S REPORT, *supra* note 8, at 92.

in legal matters may already have some referrals available. On the other hand, a lawyer may not know of specific providers or know her client's preferences. Not wanting to presume what is best for her client, a lawyer may first discuss with a receptive client his preferences. When she advises her client to seek help, they may have an initial discussion about how best to explore identifying a provider. A client might wish to do his own investigation to find a provider, especially if a client would prefer to see a non-western or non-traditional mental health services provider. It is also possible that a client already has a mental health services provider or support system in place of which the lawyer is unaware.

### C. Counseling the Client

#### *i. Timing*

In general, there is no one optimal time in the attorney/client relationship in which to speak with a client about seeking mental health treatment. However, the posture of the legal case, the lawyer's knowledge about the client's values and preferences, the stage of development of the attorney/client relationship, and the trust developed between the attorney and the client should be factored in determining the best time for client counseling in this matter.

A lawyer may decide to speak with her client about counseling during their first interview, in order to determine the client's receptiveness, to obtain the client's consent to research providers, and to gather information so the lawyer can identify the appropriate provider.<sup>220</sup> Or, a lawyer may wait until she has a better understanding of her client's pattern of behaviors over time, to feel more certain that her client indeed appears to have a mental problem. If treatment might have negative effects on the legal matter or on the attorney/client relationship, the lawyer might wait until the legal matter is resolved before raising the issue of mental health services with her client. What is important about the timing is that the lawyer

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220. However, one study suggests that client comforting by an attorney may be an inappropriate strategy for a first client interview. See David Dryden Henningsen & Ioana Cionea, *The Role of Comforting Skill and Professional Competence in the Attorney-Client Relationship*, 57 J. LEGAL EDUC. 530, 535-36 (2007). On the other hand, some lawyers may make legal representation contingent on seeking mental health treatment.

is thoughtful about it,<sup>221</sup> and mindful that advising a client to seek counseling may be an emotional experience for the client and the lawyer.<sup>222</sup>

## *ii. Client Trust and Confidentiality*

Even without the issue of a client's mental problems, a lawyer should speak with her client about confidentiality maintained within the attorney/client relationship as a matter of legal professionalism. A lawyer's advice to her client to seek mental health services should be maintained as confidential, as this advice is given within the boundaries of the attorney/client relationship.<sup>223</sup> The legal matter itself may raise confidentiality concerns that the attorney and client should discuss. One reason people do not access mental health treatment, even if they think they would benefit from it, is concern about the stigma of mental illness and whether the treatment would be kept confidential. The lawyer should recognize that asserting that she perceives or is aware of a mental problem could also be stressful to the client and raise additional confidentiality concerns.<sup>224</sup>

Mental health services providers maintain codes and rules of professionalism.<sup>225</sup> The codes of ethics for psychiatrists<sup>226</sup> and for psychologists<sup>227</sup> provide for confidentiality of patient information, but disclosure without client consent is allowed under some circumstances.<sup>228</sup> Lawyers should have some basic knowledge about

221. See BASTRESS & HARBAUGH, *supra* note 182, at 237-38.

222. See *id.* at 235.

223. See MODEL RULES OF PROF'L CONDUCT R. 1.6(a) (2002).

224. See generally SURGEON GENERAL'S REPORT, *supra* note 8, at 438-441.

225. Confidentiality laws include the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1997) (codified as amended in scattered sections of 42 U.S.C.).

226. AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS prin. IV (2001), available at <http://www.ama-assn.org/ama/pub/category/2512.html> ("A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law." Adopted by the American Medical Association's ("AMA") House of Delegates on June 17, 2001, the principles define the standards of conduct for doctors and are the basis for the AMA's Code of Medical Ethics opinions.); AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS § 4 (2009), available at <http://www.Psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMedicalEthics.aspx> (identical to AMA Ethics Principle IV).

227. AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT Standard 4 (2002), available at <http://www.apa.org/ethics/code2002.html>.

228. See AM. MED. ASS'N, CODE OF MEDICAL ETHICS, PRINCIPLES OF MEDICAL ETHICS principle IV, available at <http://www.ama-assn.org/ama/pub/category/2512.html>; AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS §§ 4.2, 4.9 (2008), available at <http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/PrinciplesofMed>

confidentiality in the mental health profession in order to be able to speak to a client's concerns on the subject.

### *iii. A Client-Centered Approach*

Although client-centered counseling is generally considered in the context of services leading to resolution of the legal matter, many aspects of this process are relevant and useful to a lawyer in advising her client to seek mental health services. In *Lawyers as Counselors*, the authors advocate taking a client-centered approach to resolving a client's legal problem, in acknowledgment that a client commonly comes to the attorney/client relationship with both legal and non-legal concerns to resolve.<sup>229</sup> A client-centered process respects the client's ability to make informed decisions and acknowledges that clients are in a better position to understand the non-legal consequences of steps toward legal resolution.<sup>230</sup> This approach allows the lawyer to fulfill her ethical obligations to her client and reach beyond the legal concerns in determining the best solution to a legal problem.<sup>231</sup> A lawyer who engages in client-centered counseling will raise the issue of non-legal consequences as part of her legal counseling; she will actively encourage the client to raise non-legal concerns such as his mental health.<sup>232</sup>

#### *a. Discussing Treatment*

A lawyer should be open and honest in her assessment of her client's mental health status. Her discussion should be descriptive, using observations, not conclusions. Descriptions, as opposed to conclusions, are important for at least two reasons. First, as lawyers and not mental health professionals, lawyers are not trained nor licensed to diagnose their clients. Therefore, stringing together what a lawyer perceives as symptoms of a mental illness and coming up with a diagnosis, and then relaying her diagnosis, is not appropriate. That is not to say that the lawyer is prohibited from telling a client that he appears to be "depressed." Depression is a psychiatric

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icalEthics.aspx; AM. PSYCHOL. ASS'N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT Standard 4.05 (2002), available at <http://www.apa.org/ethics/code2002.html>.

229. *LAWYERS AS COUNSELORS*, *supra* note 74, at 5-7.

230. *See id.* at 5-7.

231. *See id.* at 8-11, 277.

232. *See id.* at 9. However, a description of what the lawyer observes as a sign of depression ("You cry whenever you discuss your legal matter with me.") may be more helpful than a statement that a client appears to be depressed (a conclusion).

disorder, listed in the *DSM-IV-TR*.<sup>233</sup> "Depression" is also used non-diagnostically, by laypeople, to refer to sadness.<sup>234</sup> Second, descriptions of behavior may be more easily relatable by a client, as they are observations of a client's behavior. A client could deny such behavior, of course, but a description of what a lawyer observed firsthand has a tangible quality that is missing with a conclusory label of mental illness.

A lawyer must be mindful to respect<sup>235</sup> her client and exercise empathetic understanding<sup>236</sup> of her client's situation. When raising the client's apparent mental problem, a lawyer should be careful in her approach in order to minimize stigmatization of the client. Additionally, she should engage her client in a conversation about mental health treatment without imposing her morals.<sup>237</sup> She should advise her client that she thinks that he or she may benefit from mental health treatment and offer her support. She should normalize treatment as a process that is beneficial to many people.<sup>238</sup> But she should explain that in raising this matter, she is trying to determine her client's values<sup>239</sup> in order to give appropriate and professional advice to seek treatment.

A lawyer should offer to help her client to identify an appropriate treatment provider if the client decides that he would like treatment. She should explain to the client her goal of eliciting relevant information in asking questions,<sup>240</sup> such as her client's values, preferences and needs. Meanwhile, she should be sensitive to the emotional climate of the attorney/client relationship.<sup>241</sup> Lawyers

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233. *DSM-IV-TR*, *supra* note 10, at 369-82 (discussing depressive disorders).

234. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 310 (10th ed. 2001).

235. See BASTRESS & HARBAUGH, *supra* note 182, at 130.

236. See Stephen Ellmann, *The Ethic of Care as an Ethic for Lawyers*, 81 GEO. L.J. 2665, 2698-2702 (1993); Stephen Ellmann, *Empathy and Approval*, 43 HASTINGS L. REV. 991 (1992); BASTRESS & HARBAUGH, *supra* note 182, at 258-65 (communicating advanced empathy); see also LAWYERS AS COUNSELORS, *supra* note 74, at 27-28.

237. See SHAFFER & COCHRAN, *supra* note 28, at 50-52. A lawyer should not impose her moral beliefs and biases upon her client who might not agree with the lawyer's social perspective.

238. One suggestion is to perhaps model by naming other people (not clients) whom the client respects and who have sought treatment. Attorney self-disclosure of having sought mental health treatment may be appropriate. See BASTRESS & HARBAUGH, *supra* note 182, at 265-70.

239. See Linda Smith, *Representing the Elderly Client and Addressing the Question of Competence*, 14 J. CONTEMP. L. 61, 91-92 (1988); LAWYERS AS COUNSELORS, *supra* note 74, at 10-11.

240. "Providing clients with explanations can alleviate that sense of disconnection from the questions of the lawyer and can build (or rebuild) sympathy and connection. Explanation is also a good way to convey your respect for the client's dignity and privacy." Robert Dinerstein et al., *Connection, Capacity and Morality in Lawyer-Client Relationships: Dialogues and Commentary*, 10 CLINICAL L. REV. 755, 763 (2004).

241. An "etiquette barrier" may prevent discussion of uncomfortable subjects. See LAWYERS

have their own biases regarding mental health and mental illness treatment that should be considered. A lawyer who proposes mental health treatment to her client must be cognizant that her own beliefs about mental illness and treatment may not be accepted by her client. Even if the lawyer and the client agree that mental illness exists, each may have a different idea of the cause and the appropriate treatment.<sup>242</sup>

Advising a client to seek mental health treatment should be done with a goal of empowering a client. Lawyers must be aware of the danger of appearing paternalistic and manipulative.<sup>243</sup> Caution must be taken to ensure that the advice is not coercive,<sup>244</sup> and does not promote a mental health philosophy in which the client does not believe. The counseling should not be done in a directive manner, but rather, in a manner that is cognizant of the differential power between the lawyer and the client, which may be increased if they are of different races or cultures.<sup>245</sup>

Moreover, a lawyer must be attuned to any expression of anxiety from the client during the conversation and confirm that the client understands the lawyer's suggestions and reasoning.<sup>246</sup> It is important for the lawyer to actively listen to the client and provide feedback to the client's comments.<sup>247</sup> A client whose self-esteem is threatened by the topic may be unwilling to speak about mental illness.<sup>248</sup> A client might not divulge concerns that negatively affect his self-esteem.<sup>249</sup> The lawyer should be aware of a client's possible hesitancy, and should provide support to a client who does share his concerns with the lawyer.

Furthermore, a lawyer should be aware of issues of transference and counter-transference in the attorney/client relationship, so that

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AS COUNSELORS, *supra* note 74, at 23-24.

242. Regarding teaching law students cultural self-awareness in a clinical law program, see Carwina Weng, *Multicultural Lawyering: Teaching Psychology to Develop Cultural Self-Awareness*, 11 CLINICAL L. REV. 369 (2005).

243. See Ellmann, *supra* note 236, at 2702-12; Stephen Ellmann, *Lawyers and Clients*, 34 UCLA L. REV. 717 (1987).

244. See MODEL RULES OF PROF'L CONDUCT R. 1.2 (2002).

245. See Michelle S. Jacobs, *People from the Footnotes: The Missing Element in Client-Centered Counseling*, 27 GOLDEN GATE U. L. REV. 345, 377-91 (1997); Ellmann, *supra* note 236, at 2698 (asserting that lawyers can care for the client in the paradigm of an unequal attorney/client relationship).

246. See Bryant, *supra* note 202, at 72-76 (teaching students to be prepared for and to deal with difficulties in cross-cultural conversations).

247. See *id.*; LAWYERS AS COUNSELORS, *supra* note 74, at 41-63 (discussing active listening).

248. See BASTRESS & HARBAUGH, *supra* note 182, at 177.

249. See LAWYERS AS COUNSELORS, *supra* note 74, at 19-20 (discussing ego threat).

she can respond appropriately. Transference is the client's projection onto the attorney of thoughts and attitudes about someone in the client's past who has some emotional significance to the client.<sup>250</sup> Counter-transference is the attorney's projection onto the client of thoughts and attitudes about someone in the attorney's past.<sup>251</sup> It is also important for an attorney to understand the reasons for her emotional reactions to her clients.<sup>252</sup> These phenomena can affect an otherwise appropriate attorney/client relationship, and a lawyer must be vigilant and work to regulate her behavior.<sup>253</sup>

The lawyer must respect the client's voice and refusal or denial of a problem or rejection of advice.<sup>254</sup> However, a client's denial may be subject to interpretation. A client's statement may indicate he does not accept that there is something wrong with his mental health, or that he is not open to suggestions to seek treatment.<sup>255</sup> Additionally, "I don't have a problem"<sup>256</sup> is a comment that is appropriate for a number of people who have self-limited mental disorders that do not need to be treated, since with their mild or transient disorders the time and effort would outweigh any benefit. It is possible that the client's behavior is affected by a stressful life event, such as the legal matter that brought the client to see the attorney in the first place. Some problems are self-limited and will dissipate with no treatment. Nevertheless, in one study in the U.S., the statement "I don't have a problem" also came from over fifty percent of the subjects with serious mental illness, and was determined to be a substitute for "I don't want to talk about it."<sup>257</sup> A lawyer should listen to her client and not manipulate her client into getting treatment. But, she should advise her client that she is open to discussion of mental health services if her client raises the matter at a later time. A lawyer could help to reduce the stigma of mental illness through respect for and sensitivity toward the client and the

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250. See BASTRESS & HARBAUGH, *supra* note 182, at 191-93.

251. See *id.* at 296-97; see also Silver, *supra* note 27 (discussing the effect of emotions on client representation).

252. See Silver, *supra* note 27, at 299.

253. See *id.* at 312-13.

254. See Margulies, *supra* note 19, at 1079-80 (discussing the need to avoid paternalism while representing elderly clients of unknown mental capacity).

255. See SHAFFER & COCHRAN, *supra* note 28, at 16-17 (the lawyer as "hired gun" model of legal representation may promote client autonomy).

256. Ronald C. Kessler et al., *The Epidemiology of Adult Mental Disorders, in A PUBLIC HEALTH PERSPECTIVE*, *supra* note 9, at 157, 168 (54.6 percent of respondents with serious mental illness and 83.4 percent of respondents with less serious mental illness gave this response).

257. *Id.* (asserting that some people do not seek treatment because they want to solve the problem themselves or feel that the problem will solve itself.)

attorney/client relationship. She should work to develop her client's belief that she has her client's best interests in mind in discussing the topic.

A client may decline to seek mental health treatment after it is recommended by the lawyer. The lawyer should respect her client's autonomy to make decisions about receiving or declining mental health services. The lawyer's work may become more challenging where the lack of mental health treatment may have a negative effect on the legal matter. However, a lawyer retained to assist her client in a legal matter will need to continue with her representation, while disclosing the risks of no treatment to her client.

#### *b. Disclosing Risks*

A lawyer should counsel her client about the risks of seeking mental health treatment, so that the client can weigh the risks and benefits of proceeding. Model Rule of Professional Conduct 1.4 sets forth that "[a] lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."<sup>258</sup> The lawyer should disclose how treatment might affect the legal matter and should consider the effect of treatment, if any, on the attorney/client relationship. Treatment could have repercussions beyond improvements to the client's mental health and an effect on the legal matter for which the attorney/client relationship exists. As a matter of professionalism, a lawyer should discuss those risks with her client. Risks that may reach beyond the legal matter include difficulty in obtaining health and life insurance, higher insurance premiums, and difficulty in obtaining jobs in high security sectors.<sup>259</sup>

#### *iv. Billing for Research*<sup>260</sup>

A lawyer who does not already have appropriate referrals for her client may need to spend time researching mental health services providers. A lawyer in private practice may be concerned about whether she can bill her client for her time in obtaining appropriate referrals.<sup>261</sup> In a legal services setting, a client may not pay legal

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258. See MODEL RULES OF PROF'L CONDUCT R. 1.4(b) (2002).

259. Risks may include the client's decision to decline to address what the attorney sees as a mental or behavioral problem.

260. See Stolle et al., *supra* note 25, at 5, 33 n.91.

261. See Scott E. Isaacson, *Preventive Law: A Personal Essay*, UTAH BAR J., Oct. 1996, at 14 (advocating for preventive law while acknowledging the difficulties of practicing it under the



fees. However, the lawyer will experience lost opportunity costs of an inability to complete other tasks when there are competing time demands.<sup>262</sup>

Outside of free legal services, the lawyer has an obligation to discuss billing if the client is paying for the services rendered.<sup>263</sup> With a billable client, the lawyer should consider whether the treatment is sought in support of successful resolution of the legal matter. If the treatment has potential positive impact on the legal case and is part of the legal strategy, then the work is more likely to be billable. For example, in a case of arguing for a downward departure for sentencing in a criminal matter based on mental health treatment obtained pre-sentence, the research may be covered by the scope of legal representation. However, in a situation where treatment is not case related or has no impact on the case outcome,<sup>264</sup> the work may not be billable without consent of the client.<sup>265</sup> A lawyer should consider billing this research at a lower rate or under a different billing structure. She could ask her client what research he is comfortable with the lawyer conducting in regard to providers, including inquiry into providers, costs and fees, cultural preferences, language appropriateness, and appointment availability.

The lawyer should consider whether the work may be considered work that counts toward the lawyer's ethical obligation to the profession to provide pro bono services.<sup>266</sup> Pro bono work includes work that is part of a lawyer's moral duty to society.<sup>267</sup> Whether or not a lawyer gets paid for the time, efforts, and resources spent to determine an appropriate mental health services provider for a client, the task is a facet of humanitarian work. In either the billable or the non-billable setting, the research on mental health service providers can be compiled for future referrals. The research into finding an appropriate mental health services referral may be conducted by the lawyer, or by someone who is more familiar with the various types of providers. For example, some law firms, such as law school clinics,

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billable hour system).

262. Also, the flow of information may be stifled if the client senses that the attorney is in a rush. See BASTRESS & HARBAUGH, *supra* note 182, at 180.

263. See MODEL RULES OF PROF'L CONDUCT R. 2.1 cmt. ¶ 2 (2002) (asserting that cost is a client consideration).

264. See Stolle et al., *supra* note 25, at 5, 7 ("Furthermore, some lawyers worry that their clients will complain if they seek legal advice for one subject, and wind up paying a preventive lawyer more than was anticipated to deal with problems that they didn't know they had.").

265. See RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 94 cmt. h (2000).

266. See MODEL RULES OF PROF'L CONDUCT R. 6.1 (2002).

267. See CARNEGIE REPORT, *supra* note 6, at 138-39.

legal services organizations, and public defender offices employ social workers to assist lawyers in the legal matter.<sup>268</sup>

## Conclusion

Any lawyer who represents clients in legal matters will encounter clients living with mental illness. A client's psychological problems may be the trigger for the client's search for legal services.<sup>269</sup> Or, a lawyer might determine that the problem which led a client to seek legal services is not purely a legal problem<sup>270</sup> and instead includes a component of problems relating to mental illness. A lawyer's concern that her client may suffer from a mental problem should commence the lawyer's inquiry into how to respond, as a professional and as a moral being.

The *Carnegie Report* promotes the importance of training lawyers to develop an identity and purpose "guided by the values for which the professional community is responsible."<sup>271</sup> A vital aspect of professional identity is recognizing an obligation to adhere to the ethical-social values of the legal profession.<sup>272</sup> A lawyer should lean toward assisting her client and making a mental health referral if there is one that is appropriate. Of course, a lawyer must practice good judgment in deciding whether to recommend mental health treatment to a client.<sup>273</sup> A lawyer should consider whether and how the mental problem or evaluation and treatment of a mental illness might affect the legal case. Sensitivity and respect must be accorded to the client and the legal relationship because discussions of mental problems will raise issues of stigma, mistrust, cultural values, and confidentiality, and may affect the relationship. If a lawyer believes that advising her client to seek treatment is appropriate, she should be willing to provide substantive advice to her client. General advice to

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268. There may be a danger in having a law firm's social worker research where there are mandatory reporter laws. See Alexis Anderson et al., *Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659 (2007).

269. See Serena Stier, *Reframing Legal Skills: Relational Lawyering*, 42 J. LEGAL EDUC. 303, 309 (1982) (quoting CHARLES W. WOLFRAM, MODERN LEGAL ETHICS 691 (1986)).

270. See *id.* at 306 (1982) (addressing inclusion of collaborative client engagement as part of an ethical, respectful attorney/client relationship).

271. CARNEGIE REPORT, *supra* note 6, at 28.

272. See *id.* at 129-31.

273. "Judgment is not something one inherently possesses, but something one learns." Mark Neal Aaronson, *We Ask You to Consider: Learning About Practical Judgment in Lawyering*, 4 CLINICAL L. REV. 247, 284 (1998). Regarding a framework for helping clinical law students to develop sound independent professional judgment, see Angela Olivia Burton, *Cultivating Ethical, Socially Responsible Lawyer Judgment: Introducing the Multiple Lawyering Intelligences Paradigm into the Clinical Setting*, 11 CLINICAL L. REV. 15 (2004).

seek counseling without providing specific referrals may be inadequate to assist a client in seeking treatment.

A lawyer should be mindful of her client's values in determining what service provider might be appropriate and should consider that treatment may be found outside of traditional western or formal schemes. Difficulties may arise when a lawyer attempts to be sensitive to a client's perceived culture or ethnicity while trying to avoid stereotyping and overgeneralization. Appropriate treatment accounts for a client's age, gender, cultural, racial and ethnic preferences. It would also fit within a client's financial means and work and life obligations.

A lawyer should support her client's goals and interests, mindful of her ethical obligations of zealous advocacy and client confidentiality. Certainly, there are situations in which a lawyer would determine that it is in the client's interests to remain silent about the client's mental problems. But in the context of a trusting attorney/client relationship, an attorney has an opportunity to support a client in accessing appropriate and valuable mental health services and treatment.