

PATIENT ONE: AN EXPLORATION OF CRIMINAL JUSTICE AND MENTAL HEALTH

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ABSTRACT

This Article probes issues that arise when an individual suffering from a serious mental health disorder is prosecuted in the criminal justice system. The analysis turns to the pivotal question of Patient One: What becomes of a person suffering from a serious mental health disorder after the criminal justice system is finished with them? Within that framework, there is a discussion of privacy issues, guardianships, and the evaluation and treatment of those who suffer from a serious mental illness, as well as competing interests of those who are charged with the care of those patients.

The purpose of this Article is to examine one representative case in which the criminal justice system intersects with an individual with a serious mental illness and stimulate discussion for reform.

I. INTRODUCTION

In 2017 one-third of the prison population in Iowa was suffering from a serious mental illness.¹ The definition of serious mental illness (SMI) employed by the Iowa Department of Corrections (IDOC) is “chronic and persistent mental illnesses in the following categories: Schizophrenia[;] Recurrent Major Depressive Disorders[;] Bipolar Disorders[;] Other Chronic and Recurrent Psychosis[;] and Dementia and other Organic Disorders.”² In the 2016 report, the IDOC also included a category of inmates suffering from “other Chronic Mental Illness” which totaled twenty-four percent of the prison population.³ The total number of inmates suffering from a serious or chronic mental health disorder

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1. *Iowa Dep’t of Corr. FY2016 Ann. Rep.*, ST. OF IOWA DEP’T OF CORRECTIONS, 2016, at 10, 17, https://doc.iowa.gov/sites/default/files/documents/2017/01/fy16_doc_annual_report_1.pdf [<https://perma.cc/YRA6-EAMC>] (documenting 2,724 out of 8,207 total inmates or 33.2%).

2. *Mental Health Info. Sharing Program*, IOWA DEP’T OF CORR. 2 (Jan. 2017), <http://idph.iowa.gov/Portals/1/Meetings/MeetingFiles/OtherFiles/95/8d8a73aa-da57-475e-b44f-77c91800cbd0.pdf> [<https://perma.cc/2MUQ-WUFU>].

3. *Iowa Dep’t of Corr. FY2016 Ann. Rep.*, ST. OF IOWA DEP’T OF CORRECTIONS, 2016, at 10, 17, https://doc.iowa.gov/sites/default/files/documents/2017/01/fy16_doc_annual_report_1.pdf [<https://perma.cc/YRA6-EAMC>] (documenting 1,974 out of 8,207 total inmates or 24.1%).

constituted fifty-seven percent of the prison population.⁴

Iowa is not alone.⁵ Other jurisdictions have significant numbers of prison populations suffering from mental health disorders.⁶ Inmates in local jails are not included in these percentages. According to the United States Department of Justice (DOJ), jail inmates with mental health problems constitute sixty-four percent of the prison population nationally.⁷ The consequences of these proportions has led to litigation, and ultimately a decision by the United States Supreme Court.⁸

The purpose of this Article is to examine one representative case in which the criminal justice system intersects with an individual with a serious mental illness. Through that lens, the Article will identify problems within the system and suggest changes.

Patient One is one of the 479,900 inmates who was being held in a local jail.⁹ Patient One falls in a group of individuals who have serious mental illness, which renders him incompetent to stand trial.¹⁰ Patient One's illness is serious, chronic, and profound—to such an extent as to place him in the category of those who will

4. *Mental Health Info. Sharing Program*, *supra* note 2 (documenting 2,724 (SMI) + 1,974 (CMI) = 4,698 out of 8,207 inmates or 57.2%).

5. See Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. DEP'T OF JUST. BUREAU OF JUST. STAT. SPECIAL REP. 2-3 (Dec. 14, 2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/L3BC-5WJF>]. “At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 78,800 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.” *Id.* at 1.

6. *Id.* at 11.

7. *Id.* at 1.

8. See *Brown v. Plata*, 563 U.S. 493 (2011). “Prisoners in California with serious mental illness do not receive minimal, adequate care. Because of a shortage of treatment beds, suicidal inmates may be held for prolonged periods in telephone-booth sized cages without toilets. A psychiatric expert reported observing an inmate who had been held in such a cage for nearly 24 hours, standing in a pool of his own urine, unresponsive and nearly catatonic. Prison officials explained they had “no place to put him.” Other inmates awaiting care may be held for months in administrative segregation, where they endure harsh and isolated conditions and receive only limited mental health services. Wait times for mental health care range as high as 12 months. In 2006, the suicide rate in California's prisons was nearly 80% higher than the national average for prison populations; and a court-appointed Special Master found that 72.1% of suicides involved “some measure of inadequate assessment, treatment, or intervention, and were therefore most probably foreseeable and/or preventable.” *Id.* at 503-04 (internal citations omitted).

9. “Patient One” was selected rather than characterizing the individual as the “defendant” to focus on the medical issues faced by individuals in the criminal justice system. James & Glaze, *supra* note 5.

10. *Id.* at 3.

never be competent to stand trial with current therapies and medications.¹¹

In a typical case, an individual is discharged from the criminal justice system, and returns to the streets.¹² The individual's case is typically dismissed, without any aftercare strategy in the mental health system, even though they are incompetent.¹³ Recidivism in these cases is almost guaranteed.¹⁴ Patient One's case history is typical of the category of those who have serious mental health issues, and who have the misfortune of becoming part of the criminal justice system.

However, Patient One's story is different. His criminal case was ultimately dismissed. But Patient One was not unceremoniously dropped onto the streets. There was one important difference in his case: a family member serves as his guardian.¹⁵ Although the worst-case scenario was avoided, there are still

11. *See Drope v. Missouri*, 420 U.S. 162 (1975). "It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." *Id.* at 171.

12. IOWA CODE § 812.9 (2018) ("[T]he defendant shall not remain under placement pursuant to section 812.6 beyond the expiration of the maximum term of confinement for the criminal offense of which the defendant is accused, or eighteen months from the date of the original adjudication of incompetence to stand trial, including time in jail, or the time when the court finds by a preponderance of the evidence that there is no substantial probability that the defendant will be restored to competency in a reasonable amount of time under section 812.8, subsection 8, whichever occurs first. When the defendant's placement in an inpatient facility equals the length of the maximum term of confinement, the complaint for the criminal offense of which the defendant is accused shall be dismissed with prejudice.").

13. IOWA CODE § 812.3(1) (2018). ("If at any stage of a criminal proceeding the defendant or the defendant's attorney, upon application to the court, alleges specific facts showing that the defendant is suffering from a mental disorder which prevents the defendant from appreciating the charge, understanding the proceedings, or assisting effectively in the defense, the court shall suspend further proceedings and determine if probable cause exists to sustain the allegations."); *see also* IOWA CODE § 633.3(23) (defining incompetent as "the condition of any person who has been adjudicated by a court to meet at least one of the following conditions: a. To have a decision-making capacity which is so impaired that the person is unable to care for the person's personal safety or to attend to or provide for necessities for the person such as food, shelter, clothing, or medical care, without which physical injury or illness may occur. b. To have a decision-making capacity which is so impaired that the person is unable to make, communicate, or carry out important decisions concerning the person's financial affairs. c. To have a decision-making capacity which is so impaired that both paragraphs "a" and "b" are applicable to the person.").

14. The Iowa Department of Corrections estimates that individuals with a chronic mental illness diagnosis are at a 40.7 percent risk of returning to prison within three years as opposed to 26 percent of those without mental illness. IOWA DEP'T OF CORR., *supra* note 3.

15. IOWA CODE § 633.3(20) (2018) (noting the court can also appoint a guardian "meaning the person appointed to the custody of the person of the ward under the provisions of the probate code.").

significant deficiencies within the criminal justice system that demand attention. Most importantly, early recognition of the mental health issues.¹⁶

II. THE ARREST

A. “Get the Fuck Out of Here!”

Patient One was arrested for assaulting a peace officer at approximately 10:00 PM on January 2, 2015, while at a group home.¹⁷ In an affidavit attached to the preliminary complaint, an officer described the encounter:

[Patient One] assaulted me while I was on duty. I was called to the facility on [Patient One] causing a problem with the nursing staff. When I arrived [Patient One] started the encounter with, “Get the fuck out of here.” I advised [Patient One] who I was and why I was called down to the residential facility. He again stated for me to leave. I told [Patient One] I could not do that. He began raising his voice and yelling at me. [Patient One] took a stance as if he was going to come at me, I pulled my tazer and ordered [Patient One] to turn around with his hands behind his back. [Patient One] did not comply. I ordered him again. He took a [sic] step toward me, I grabbed [Patient One’s] wrist with my left hand and had tazer in right hand. [Patient One] swung at me I stepped back and then moved forward and we both went to the ground. I was on top of [Patient One] trying to gain control. I took the cartridge out of the tazer and delivered several dry stuns to [Patient One’s] shoulder blade, trap muscle area. The tazer took no affect on [Patient One]. [Patient One] had ahold of my left wrist and was trying to pull it underneath him. After about a minute or two I told the nurse to call 911 and tell them I need assistance. At this time I jumped away from [Patient One] and retrieved the tazer cartridge and placed it back into the tazer. [Patient One] came back to his feet. I radioed to dispatch that I need emergent [sic] assistance. I ordered [Patient One] to turn around and put his hands behind his back, again [Patient One] did not comply. He started walking toward me, I deployed the tazer, striking [Patient One] in the chest and abdominal area. The tazer had very little affect on [Patient One]. He turned away from me, while the tazer was still on its cycle, I struck [Patient One] with my foot to the back of his patella, causing him to

16. “While HIPAA provides important protection of medical privacy, some family members of persons with mental illness argues that HIPAA prevents them from being able to adequately care for their loved ones.” Naomi Weinstein & Michael L. Perlin, “*Who’s Pretending to Care for Him?*” *How the Endless Jail-to-Hospital-to-Street-Repeat Cycle Deprives Persons with Mental Disabilities the Right to Continuity of Care*, 8 WAKE FOREST J. L. & POL’Y 455, 478 (2018) (citing Jorgio Castro, *Piercing the Privacy Veil: Toward a Saner Balancing of Privacy and Health in Cases of Severe Mental Illness*, 66 *Hastings L.J.* 1769, 1772 (2015)).

17. Preliminary Complaint at 1-2 (Jan. 3, 2015), source available from author or IHLR upon request.

fall.¹⁸

Subsequent police reports elaborate on the initial report:

[Patient One] began to fall, and as he did he spun himself around, landing on his back. [Patient One] struck the back of his head with the ground. [Patient One] laid there in a daze. I went to [Patient One] to render aid. I asked [Patient One] what the problem was today, he was unable to answer me. I asked him if he was done fighting me he stated that he was. I assisted [Patient One] up and to his knees where I placed hand cuffs on him. He was assisted to his feet. I radioed that I need medics for the tazer deploy as well as an injury to his head. I assisted [Patient One] to the dining room and had him sit on a dining room chair. At this time officer [Brown]¹⁹ was arriving. I asked officer [Brown] to watch [Patient One] while I got my tazer cartridge and get a voluntary statement for the nurse who witnessed the whole confrontation. Medics arrived on scene along with several other officer, [sic] including Sgt. [Anderson].²⁰ I advised Sgt. [Anderson] what took place. It was decided to have the Pleasant Hill Fire Department transport [Patient One] to [a local hospital] to get his injury checked out. Officer [Brown] followed the ambulance to the hospital. I took the booking sheet to Officer [Brown] and [Patient One] was transported to the Polk County Jail with no further incidences.²¹

III. MISSED OPPORTUNITIES

A. Dispatch

Did dispatch adequately advise the officer of what they were walking into? Situational awareness plays a crucial role. When the officer arrived, he knew or should have known—from the dispatch and from direct observation—that he was dealing with an agitated individual who was in a care facility.²² The complaint came from a nurse on duty.²³ Should the officer have inquired as to the nature of the complaint or required more specificity as to why the nurse “locked herself in the nurse[s] station for her safety”?²⁴ Should the officer have called for back-up prior to arriving on the scene? Did the officer have training in responding to situations involving mentally impaired individuals?

In Patient One’s situation, if the dispatch alerted the officer that the call was

18. Minutes of Testimony - Incident Report at 4 (Jan. 30, 2018), source available from author or IHLR upon request.

19. In order to protect anonymity, a pseudonym is used.

20. In order to protect anonymity, a pseudonym is used.

21. Minutes of Testimony - Incident Report *supra* note 18.

22. *Id.*

23. *Id.*

24. *Id.*

from a nurse in a living facility, and if the officer recognized the mental health issues, perhaps the officer may have avoided tasing Patient One. Importantly, the officer used force first in this situation when he drew his taser.

When I arrived [Patient One] started the encounter with, “Get the fuck out of here.” I advised [Patient One] of who I was and why I was called down to the residential facility. [Patient One] again stated for me to leave. I told [Patient One] I could not do that. [Patient One] began raising his voice and yelling at me. [Patient One] took a stance as if he was going to come at me, I pulled my taser. . . .²⁵

Prior to that, Patient One was agitated and yelling, and arguably no crime had been committed at this point. Could the officer have lowered his voice and dealt with the patient in a quasi-hospital setting? Assuming the responding officer could have deescalated the situation, his actions could have prevented an arrest. The next opportunity for Patient One to be diverted from the criminal justice system was his transport to a local hospital for the treatment of his physical injuries.

Medics arrived on scene along with several other officer, [sic] including Sgt. [Anderson]. I advised Sgt. [Anderson] what took place. It was decided to have the [] Fire Department transport [Patient One] to [the local hospital] to get his injury checked out. Officer [Brown] followed the ambulance to the hospital.²⁶

Notably, Patient One had previously been treated at the local hospital on a number of occasions prior to transport for treatment of injuries. In a latter report by a treating physician it notes:

[Patient One] has an *extensive history of schizophrenia*, and has been hospitalized numerous times in the past, including in Mount Pleasant, Cedar Rapids, Independence, and *three times in the past two years at [the local hospital]*. [Patient One] is frequently non-compliant with oral medications. At his baseline, the patient is psychotic with chronic auditory hallucinations and delusions.²⁷

By the hospital’s failure to recognize Patient One’s history, an opportunity to divert Patient One out of the criminal justice system was missed. At this point in time, Patient One could have been civilly committed,²⁸ avoiding the onus of criminal prosecution.

25. Minutes of Testimony - Incident Report, *supra* note 18.

26. Minutes of Testimony - Incident Report, *supra* note 18.

27. Letter to the Court (May 5, 2015) (emphasis added), source available from author or IHLR upon request.

28. IOWA CODE § 229.6 (2018).

B. Officer Reporting

Although much has been advocated regarding training of police officers to identify mental health concerns when responding to an incident, as a practical matter, little has changed in officer reporting.²⁹ Regarding the initial contact with and interaction between Patient One and the responding police officers, there is no clear portion of the reporting system dedicated to the defendant's mental health status or condition.³⁰ There are three important opportunities to improve this through officer reporting.

First, the case investigation report form should be altered to include a category regarding the mental health of the individual being investigated or arrested.³¹ The initial investigation report is filed by law enforcement. It provides a gateway of information used through the life of a criminal case. This information is used in charging decisions, reviewing those decisions, bond conditions, plea negotiations, and sentencing, or as basis for dismissal of charges. An early recognition of mental health concerns would assist decision-makers in routing the case in a direction that would take into account the mental health of the individual. It would also alert the jail or detention center of possible medical concerns regarding the person after arrest and during booking.

Second, the initial charging document or preliminary complaint forms should be altered.³² There are several categories of information contained in the preliminary complaint, including information regarding: the offender; the offense; status of the offender; a brief narrative of victim information; and an affidavit including a general statement of probable cause.³³ The document is prepared by the prosecutor's office and is based on the initial case investigation report filed

29. See Abigail S. Tucker et al., *Responding to Persons with Mental Illness* (Oct. 1, 2011), <https://leb.fbi.gov/articles/featured-articles/responding-to-persons-with-mental-illness> [<https://perma.cc/Y2ET-SAFC>]; H. Richard Lamb, Linda E. Weinberger, & Walter J. DeCuir, Jr., *The Police and Mental Health*, 53 *PSYCHIATRIC SERVICES* 1226 (Oct. 1, 2002) (pointing out that police have inadequate training in handling encounters with this segment of the community); Gary Cordner, *People with Mental Illness*, *CTR. FOR PROBLEM-ORIENTED POLICING* (2006), http://www.popcenter.org/problems/mental_illness [<https://perma.cc/9CUM-RJ53>]; Linda A. Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons*, *NAT'L INST. JUST. J.* 9 (July 2000), <https://www.ncjrs.gov/pdffiles1/jr000244c.pdf> [<https://perma.cc/7ABS-9RDU>]; Megan Pauly, *How Police Officers Are (or Aren't) Trained in Mental Health*, *ATLANTIC* (Oct. 11, 2013), <https://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/> [<https://perma.cc/R5ET-DW6W>].

30. Minutes of Testimony, *supra* note 18, at 2-4.

31. The Iowa Incident Report form contains a number of categories of information regarding incidents officers are called to investigate. The form includes information regarding the investigation, the victim, and the suspect, but no area for comments regarding mental health of the suspect.

32. IOWA R. CRIM. P. 2.2(1)-(2).

33. Preliminary Complaint, *supra* note 17.

by law enforcement. By incorporating mental health information in this first pleading, courts could make initial competency inquiries that would result in a medical evaluation and subsequent treatment.³⁴

Finally, booking information recorded as an individual enters their term of incarceration should include mental health concerns by arresting officers or the booking agency. This would ensure that others are put on notice of the mental health concerns in order to prevent future escalations.

IV. THE INITIAL APPEARANCE

A. Who Is John E. Baron?

After his arrest, on January 3, 2015, Patient One appeared before a judicial officer for his initial appearance.³⁵ During this appearance, he was asked to waive his preliminary hearing³⁶ as well as fill out an application for court-appointed counsel.³⁷ In both documents, Patient One identified himself by signing “John E. Baron,” a false name. This was documented in the court records and forms.³⁸ In the application for court-appointed counsel, Patient One went further, by indicating his date of birth as “alive and well.”³⁹ In response to the form inquiring into his employment, he wrote “for Sue Ling and myself John E. Baron.”⁴⁰ In the space for property owned, he wrote “bull shit,”⁴¹ and dated the document “spring.”⁴² The rest of the application was left blank.⁴³

After an individual is arrested, they are required to appear before a judicial officer for their initial appearance.⁴⁴ With the defendant physically present, the court has an opportunity to observe the defendant. If the court is alerted by the preliminary complaint and through observing the individual in court that the individual may have mental health issues, the court ought to then make an initial inquiry. This could be accomplished by amending the Iowa Rules of Criminal

34. Law enforcement and prosecutors may be resistant to the inclusion of observations regarding an individual’s mental health status for fear of establishing a possible defense to the crime.

35. *Id.*

36. Waiver of Preliminary Hearing (Jan. 3, 2015), source available from author or *IHLR* upon request.

37. Financial Affidavit and Application for Appointment of Counsel, source available from author or *IHLR* upon request.

38. *Id.*; Waiver of Preliminary Hearing, *supra* note 36, at 2.

39. Financial Affidavit and Application for Appointment of Counsel, *supra* note 37.

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. IOWA R. CRIM. P. 2.2(1)-(2).

Procedure⁴⁵ and the competency statute.⁴⁶ Under the current rules of criminal procedure, there is no requirement for the court to inquire as to the mental health status of individuals at the initial appearance. As for the competency statute, the responsibility is on either the defendant or the defendant's attorney to raise the issue of competency.⁴⁷ The responsibility shifts to the court only if "the defendant or the defendant's attorney has failed or refused to make an application."⁴⁸ These procedures delay early diagnosis and treatment of individuals with mental health concerns. By amending the statute to allow the court to raise the issue initially, the process would be abbreviated, thus allowing an individual with mental health issues to receive an earlier diagnosis and treatment.

As it stands now, the court must wait for counsel to meet with the client and for the application for a competency examination. Even more problematic, if the court declines to appoint counsel because the individual indicates they are going to retain counsel, or if they are going to represent themselves, the delay in treating mental health issues can be considerable and unnecessary.

In Patient One's case, the court accepted the patient's waiver of the preliminary hearing, set bond at \$1000 dollars cash or surety, set an arraignment date for February 20, 2015, and accepted the patient's declination of counsel.⁴⁹ Of course, allowing self-representation presents another set of issues. In Patient One's case, that is exactly what happened: a demand for self-representation.

B. Self-Representation

In *Farretta v. California*, the United States Supreme Court held a defendant in a criminal case has a constitutional right to self-representation.⁵⁰ However, that

45. *Id.*

46. IOWA CODE § 812.3(1) (2018). "If at any stage of a criminal proceeding the defendant or the defendant's attorney, upon application to the court, alleges specific facts showing that the defendant is suffering from a mental disorder which prevents the defendant from appreciating the charge, understanding the proceedings, or assisting effectively in the defense, the court shall suspend further proceedings and determine if probable cause exists to sustain the allegations. The applicant has the burden of establishing probable cause. The court may on its own motion schedule a hearing to determine probable cause if the defendant or defendant's attorney has failed or refused to make an application under this section and the court finds that there are specific facts showing that a hearing should be held on that question." *Id.*

47. *Id.* (stating "the defendant or the defendant's attorney" files an application).

48. *Id.* (noting "the court may on its own motion schedule a hearing to determine probable cause if the defendant or defendant's attorney has failed or refused to make an application...").

49. Order of Initial Appearance (Jan. 3, 2015), source available from author or *IHLR* upon request.

50. *Faretta v. California*, 422 U.S. 806 (1975). "In the federal courts, the right of self-representation has been protected by statute since the beginnings of our Nation. Section 35 of the Judiciary Act of 1789, 1 Stat. 73, 92, enacted by the First Congress and signed by President Washington one day before the Sixth Amendment was proposed, provided that 'in all the courts of

right is not absolute. In *Indiana v. Edwards*, the Supreme Court held counsel may be appointed where the defendant is competent to stand trial, but may not be able to represent themselves.⁵¹ The Court asked “whether the Constitution permits a State to limit that defendant’s self-representation right by insisting upon representation by counsel at trial—on the ground that the defendant lacks the mental capacity to conduct his trial defense unless represented.”⁵² In answering the question, the Court reasoned:

The nature of the problem before us cautions against the use of a single mental competency standard for deciding both (1) whether a defendant who is represented by counsel can proceed to trial and (2) whether a defendant who goes to trial must be permitted to represent himself. Mental illness itself is not a unitary concept. It varies in degree. It can vary over time. It interferes with an individual’s functioning at different times in different ways.⁵³

As other legal scholars have noted, there are no set standards for a trial court to determine competency for self-representation.⁵⁴ The tension between the right

the United States, the parties may plead and manage their own causes personally or by the assistance of such counsel’ The right is currently codified in 28 U.S.C. s 1654. With few exceptions, each of the several States also accords a defendant the right to represent himself in any criminal case. The constitutions of 36 States explicitly confer that right. Moreover, many state courts have expressed the view that the right is also supported by the Constitution of the United States. This Court has more than once indicated the same view. In *Adams v. United States ex rel. McCann*, . . . the Court recognized that the Sixth Amendment right to the assistance of counsel implicitly embodies a ‘correlative right to dispense with a lawyer’s help.’ The defendant in that case, indicted for federal mail fraud violations, insisted on conducting his own defense without benefit of counsel. He also requested a bench trial and signed a waiver of his right to trial by jury. The prosecution consented to the waiver of a jury, and the waiver was accepted by the court. The defendant was convicted, but the Court of Appeals reversed the conviction on the ground that a person accused of a felony could not competently waive his right to trial by jury except upon the advice of a lawyer. This Court reversed and reinstated the conviction, holding that ‘an accused, in the exercise of a free and intelligent choice, and with the considered approval of the court, may waive trial by jury, and so likewise may he competently and intelligently waive his Constitutional right to assistance of counsel.’ . . . The *Adams* case does not, of course, necessarily resolve the issue before us. It held only that ‘the Constitution does not force a lawyer upon a defendant.’ . . . Whether the Constitution forbids a State from forcing a lawyer upon a defendant is a different question. But the Court in *Adams* did recognize, albeit in dictum, an affirmative right of self-representation.” *Id.* at 814-15.

51. *Indiana v. Edwards*, 554 U.S. 164 (2008).

52. *Id.* at 174.

53. *Id.* at 175.

54. E. Lea Johnston, *Communication and Competence for Self-Representation*, 84 *FORDHAM L. REV.* 2121 (2016); E. Lea Johnston, *Representational Competence: Defining the Limits of the Right to Self-Representation at Trial*, 86 *NOTRE DAME L. REV.* 523 (2011); Jason R. Marks, *State Competence Standards for Self-Representation in a Criminal Trial: Opportunity and Danger for*

to self-representation in *Farretta* and the limitation imposed by *Edwards* have yet to be reconciled by either the psychiatric or legal communities. The competency standards currently utilized to evaluate the competency to stand trial,⁵⁵ competency to plead guilty,⁵⁶ and competency to self-represent,⁵⁷ are standards developed by the legal community with little input from the psychiatric community. The Supreme Court attempted to differentiate competency to stand trial,⁵⁸ competency to plead guilty,⁵⁹ and competency for self-representation.⁶⁰

State Courts after Indiana v. Edwards, 44 U.S.F. L. REV. 825 (2010); Christopher Slobogin, *Mental Illness and Self-Representation*, 7 OHIO ST. J. CRIM. L. 391 (2009).

55. See *Faretta*, 422 U.S. 806.

56. See *Moran*, 509 U.S. 389.

57. See *Edwards*, 554 U.S. 164.

58. *Id.* at 169-70. The two cases that set forth the Constitution's "mental competence" standard, *Dusky v. United States*, 362 U.S. 402 (1960), and *Drope v. Missouri*, 420 U.S. 162 (1975), specify that the Constitution does not permit trial of an individual who lacks "mental competency." *Dusky* defines the competency standard as including both (1) "whether" the defendant has "a rational as well as factual understanding of the proceedings against him" and (2) whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding." *Dusky*, 362 U.S. at 402 (emphasis added) (internal quotation marks omitted). *Drope* repeats that standard, stating that it "has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial." *Drope*, 420 U.S. at 171. (emphasis added).

59. *Edwards*, 554 U.S. at 175. The court noted the competency required to plead guilty stating: "This Court, reversing the Court of Appeals, 'reject[ed] the notion that competence to plead guilty or to waive the right to counsel must be measured by a standard that is higher than (or even different from) the *Dusky* standard.' . . . The decision to plead guilty, we said, 'is no more complicated than the sum total of decisions that a [represented] defendant may be called upon to make during the course of a trial.' . . . Hence 'there is no reason to believe that the decision to waive counsel requires an appreciably higher level of mental functioning than the decision to waive other constitutional rights.' . . . And even assuming that self-representation might pose special trial-related difficulties, 'the competence that is required of a defendant seeking to waive his right to counsel is the competence to waive the right, not the competence to represent himself.' For this reason, we concluded, 'the defendant's "technical legal knowledge" is "not relevant" to the determination.'" *Id.* at 172 (quoting *Faretta*, 422 U.S. at 836). See also *Moran*, 509 U.S. 389 (1993).

60. *Edwards*, 554 U.S. 164 (citing *Faretta*, 422 U.S. 806). The court stated the underlying rationale for self-representation, "The Court's foundational 'self-representation' case, *Faretta*, held that the Sixth and Fourteenth Amendments include a 'constitutional right to proceed without counsel when' a criminal defendant 'voluntarily and intelligently elects to do so.' . . . The Court implied that right from: (1) a 'nearly universal conviction,' made manifest in state law, that 'forcing a lawyer upon an unwilling defendant is contrary to his basic right to defend himself if he truly wants to do so,'; . . . (2) Sixth Amendment language granting rights to the 'accused'; (3) Sixth Amendment structure indicating that the rights it sets forth, related to the 'fair administration of

The Court—in an effort to answer a medical question with a legal solution—cited to the Amicus brief by the American Psychiatric Association (“APA”):

The American Psychiatric Association (APA) tells us (without dispute) in its *amicus* brief filed in support of neither party that “[d]isorganized thinking, deficits in sustaining attention and concentration, impaired expressive abilities, anxiety, and other common symptoms of severe mental illnesses can impair the defendant’s ability to play the significantly expanded role required for self-representation even if he can play the lesser role of represented defendant.” . . . Motions and other documents that the defendant prepared in this case (one of which we include in the Appendix, *infra*) suggest to a layperson the common sense of this general conclusion.⁶¹

The APA’s amici brief further states:

Serious mental illnesses present a genuine threat to the vital public interest in reliable adjudication of contested criminal charges. Such illnesses are often associated with delusional misperceptions of reality, inability to think coherently, and hallucinations. . . . The defendant may not be able to recount relevant facts (*e.g.*, where was Edwards aiming when he fired his gun?), may misunderstand courtroom developments, may fail to maintain focus during trial proceedings, and may respond irrationally. Cognitive deficiencies are commonly linked with impaired ability to formulate and to express thoughts in an understandable, coherent manner. . . . Severe anxiety, which is often present in psychotic disorders . . . can impair attentiveness and the ability to function in tense settings. Depression can make decision-making difficult or so diminish motivation as to produce self-destructive decisions. . . . Long tradition specifically recognizes these risks and the importance of addressing them, for the protection of the defendant himself and of the public interest in reliable adjudication. The law governing competence to stand trial rests centrally, if not exclusively, on this basis.⁶²

As previously noted, the pre-trial process governed by the Iowa Rules of

American justice,’ are ‘persona[.]’ to the accused . . . ; (4) the absence of historical examples of *forced* representation; and (5) “‘respect for the individual,’” . . . *Faretta* does not answer the question before us both because it did not consider the problem of mental competency (cf. 422 U.S., at 835, 95 S.Ct. 2525 (Faretta was ‘literate, competent, and understanding’)), and because *Faretta* itself and later cases have made clear that the right of self-representation is not absolute.” *Id.* at 170-71.

61. *Edwards*, 554 U.S. 164 at 176 (quoting Brief for the American Psychiatric Association and American Academy of Psychiatry and the Law as Amici Curiae in Support of Neither Party, *Indiana v. Edwards*, 554 U.S. 164 (2008), 2008 U.S. S. Ct. Briefs LEXIS 176, *17 (2008)).

62. Brief for American Psychiatric Association and American Academy of Psychiatry and Law as Amici Curiae Supporting Neither Party, *Indiana v. Edwards*, 554 U.S. 164 (2008), 2008 U.S. S. Ct. Briefs LEXIS 176, *17 (2008).

Criminal Procedure would put Patient One at a horrible disadvantage should the court allow self-representation. First, Patient One would be required to identify his own mental health issues and the possible defenses that could be raised as a result, including: insanity⁶³ and diminished responsibility.⁶⁴ He would be required to file pre-trial motions for expert witnesses;⁶⁵ file a notice of defense;⁶⁶ and conduct discovery depositions of the state's witnesses.⁶⁷ Needless to say, it is absurd for a court to allow Patient One—who suffers from schizophrenia and is delusional—to proceed on a pre-trial basis, much less self-represent at trial.⁶⁸

63. IOWA CODE § 701.4 (2017). Iowa adopted the 1843 M'Naghten standard defining insanity. See ROBERT R. RIGG, VOL. 4, IOWA PRACTICE SERIES, CRIMINAL LAW §§ 2.5-2.13 (2018-2019 ed.)

64. See RIGG, *supra* note 63, at §§ 2.14-2.20.

65. See *Ake v. Oklahoma*, 470 U.S. 68 (1985); see also IOWA R. CRIM. P. 2.20(4).

66. IOWA R. CRIM. P. 2.11(11)(4).

67. IOWA R. CRIM. P. 2.13. Rule 2.13 provides that Iowa allows pre-trial depositions of the state's witnesses.

68. See E. Lea Johnston, *Communication and Competence for Self-Representation*, 84 *FORDHAM L. REV.* 2121 (2016). Professor Johnston makes a case for a model standard for self-representation: "A communication deficiency should support a finding of representational incompetence only to the extent that the deficiency either reveals an absence of meaningful autonomy or poses a grave threat to the reliability or the actual or apparent fairness of the adjudication. The four categories of communication deficiencies—involving disordered speech, an inability to be understood by courtroom actors, an inability to communicate in a timely fashion within the particular context of trial, and suboptimal advocacy—hold varying relationships to mental illness and cognitive impairment and thus offer differing implications for a defendant's autonomous potential. They also differ in the extent to which they may be ameliorated by standby or hybrid counsel and so vary in their necessary relationship to the fairness or accuracy of an adjudication. After evaluating the constitutional significance of each subset of communication impairment, this part concludes by exploring the implications for existing state representational competence standards. It also proposes a two-part representational competence standard that coheres with Supreme Court precedent and the values animating representational competence." *Id.* at 2157. As noted by Professor Johnston, Iowa addressed competence for self-representation in *State v. Jason*, 779 N.W.2d 66 (Iowa Ct. App. 2009). "We emphasize that the issue to be decided on remand is not whether the defendant lacked the technical legal skill or knowledge to conduct the trial proceedings effectively without counsel.... That fact, however, has no bearing on whether he was competent to represent himself for purposes of *Edwards*. Rather, the determination of his competence or lack thereof must be predicated solely on his ability to 'carry out the basic tasks needed to present his own defense without the help of counsel'; [*Edwards*, 554 U.S. at —, 128 S. Ct. at 2386, 171 L.Ed.2d at 356]; notwithstanding any mental incapacity or impairment serious enough to call that ability into question. Of course, in making this determination, the trial court should consider the manner in which the defendant conducted the trial proceedings and whether he grasped the issues pertinent to those proceedings, along with his ability to communicate coherently with the court and the jury." *State v. Connor*, 973 A.2d 627, 657 (Conn. 2009).

Although Patient One never reached the issue of self-representation due to the civil commitment proceedings, it is worthy to note because of the court's missed opportunity: rendering a serious inquiry into Patient One's mental health status. A protocol should be developed for trial courts to implement when an individual appearing before it requests self-representation. It should include an inquiry into the defendant's current mental health history as well as the appointment of an expert to evaluate the defendant's capacity for self-representation.

C. Hope (Maybe?) John E. Baron

On January 6, 2015, the medical staff at the jail where Patient One was detained filed an application for civil commitment.⁶⁹ In a letter attached to an affidavit requesting the civil commitment, a doctor noted the patient has:

[A] history of Schizophrenia, Hypertension, Hypothyroidism, Gerd, Hyperlipidemia and Diabetes (II). [Patient One is] currently not oriented to place, person or time, delusional and at times irritable & unpredictable. It is difficult to engage [Patient One] in services provided at the jail due to his current symptoms and non-compliance with medication.⁷⁰

The patient was appointed an attorney,⁷¹ and committed to a medical facility from the jail.⁷² An additional hearing was set for January 12, 2015.⁷³

69. Application Alleging Serious Mental Impairment Pursuant to Iowa Code Section 229.6 (Jan. 6, 2015), source available from author or *IHLR* upon request; see IOWA CODE § 229.6 1 for proceedings for the involuntary hospitalization of an individual. The application included:

“2. The application shall:

a. State the applicant's belief that the respondent is a person who presents a danger to self or others and lacks judgmental capacity due to either of the following:

(1) A substance-related disorder as defined in section 125.2.

(2) A serious mental impairment as defined in section 229.1.

b. State facts in support of each belief described in paragraph 'a'.

c. Be accompanied by any of the following:

(1) A written statement of a licensed physician in support of the application.

(2) One or more supporting affidavits otherwise corroborating the application.

(3) Corroborative information obtained and reduced to writing by the clerk or the clerk's designee, but only when circumstances make it infeasible to comply with, or when the clerk considers it appropriate to supplement the information supplied pursuant to, either subparagraph (1) or (2). See Iowa Code §229.6 (2).”

70. Affidavit in Support of Application Alleging Serious Mental Impairment Pursuant To Iowa Code Section 229.6 at 2, (Jan. 6, 2015), source available from author or *IHLR* upon request.

71. Order Appointing Counsel (Jan. 7, 2015), source available from author or *IHLR* upon request.

72. Order for Immediate Custody (Jan. 7, 2015), source available from author or *IHLR* upon request.

73. Notice to Respondent, Order Setting Hearing (Jan. 7, 2015), source available from author or *IHLR* upon request.

D. Taking a Breath

At this point, there are two cases pending: (1) the criminal case⁷⁴ and (2) the civil commitment.⁷⁵ The bad news is the patient was arrested at his residential facility under circumstances that would indicate he was suffering from mental disease. Patient One was not appointed an attorney, and the case proceeded to an arraignment on the criminal case.⁷⁶ The good news is that within two weeks, medical personal at the jail facility instituted civil commitment proceedings, appointed Patient One counsel, and had a preliminary diagnosis of schizophrenia with a treatment plan in place, subject to additional judicial review.⁷⁷ It would appear any deficiencies in one case would correct the other. In other words—ideally—the court systems would communicate with each other. In the criminal case, the fact that the patient had a serious psychiatric condition, which is relevant in the civil commitment proceeding, could impact the criminal case. Certainly, competency is an issue in the criminal case, not to mention defenses of insanity or diminished responsibility. That did not happen. The two court systems failed to communicate with one another.

V. THE MENTAL HEALTH CIVIL COMMITMENT PROCEEDING

In the history provided to the court in the physician's report, the "presenting problem" section of the report states:

[Patient] cooperative and pleasant during assessment. [Patient] does not know the date but is aware [he is] at [a local hospital]. [Patient] signed [his] consent as "John Barron." [Patient] says [Patient One] is someone "I was hooked into. [Patient] says [Patient One] disappeared. [Patient] also states "I am the Lord and in the year of the angels created earth." [Patient] says [he] has a home in heaven and tomorrow [he] will be president. [Patient] reports [he is] married and has 5,000,000,000 children. [Patient] says [he has] been in jail because [he] got into a fight with a police officer. . . . [Patient] is not compliant with [his] medications and has not been for at least 2-3 weeks.⁷⁸

When asked if he has a religious preference, Patient One said "Let the people cry out."⁷⁹ From the attending psychiatrist section of the report it is indicated the patient was "well known" to the psychiatrist due to at least one prior

74. (No. SRCR282457) (filed Jan. 6, 2015).

75. (No. MHMH017634) (filed Jan. 6, 2015).

76. Order of Initial Appearance (In-Custody) (Jan. 3, 2015), source available from author or *IHLR* upon request.

77. (No. MHMH017634) (filed Jan. 6, 2015).

78. Physician's Report of Examination Pursuant to Section 229.10(2) of the Code at 6 (Jan. 12, 2015), source available from author or *IHLR* upon request.

79. *Id.* at 3.

hospitalization.⁸⁰ As a result, Patient One was civilly committed for treatment based on a finding by the court that he was “[s]eriously mentally impaired.”⁸¹ The civil commitment proceeded, along a parallel track with the criminal case, but with a very different objective: Patient One’s treatment.

After the initial commitment proceeding, the case was set for periodic review.⁸² The first report came within fifteen days of the court’s initial finding.⁸³ The report indicated the diagnosis as “schizophrenia with hallucination, delusions, occasional agitation, disorganized thoughts and behavior.”⁸⁴ In concluding the patient was incapable of “satisfying their needs for nourishment, clothing, essential medical care or shelter” for the reasonably foreseeable future.⁸⁵ The report cited to the patient’s arrest, indicating he was, “aggressive towards police prior to admission and required tazing to contain his behavior.”⁸⁶

80. *Id.* at 7.

81. Findings of Fact and Order Pursuant to Iowa Code Section 229.13 (Jan. 12, 2015), source available from author or *IHLR* upon request. *See* IOWA CODE § 229.1(20) (2017) (providing “Seriously mentally impaired.” or “serious mental impairment” describes the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment, and who because of that illness meets any of the following criteria:

a. Is likely to physically injure the person’s self or others if allowed to remain at liberty without treatment.

b. Is likely to inflict serious emotional injury on members of the person’s family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment.

c. Is unable to satisfy the person’s needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.”).

82. IOWA CODE § 229.15(1) (2017). “Not more than thirty days after entry of an order for continued hospitalization of a patient under section 229.14, subsection 1, paragraph “b”, and thereafter at successive intervals of not more than sixty days continuing so long as involuntary hospitalization of the patient continues, the chief medical officer of the hospital shall report to the court which entered the order. The report shall be submitted in the manner required by section 229.14, shall state whether the patient’s condition has improved, remains unchanged, or has deteriorated, and shall indicate if possible the further length of time the patient will be required to remain at the hospital. The chief medical officer may at any time report to the court a finding as stated in section 229.14, subsection 1, and the court shall act upon the finding as required by section 229.14, subsection 2.” *Id.*

83. Chief Medical Officer’s Report of Psychiatric Evaluation Pursuant to Section 229.14 The Code. 15 Day Report at 1 (filed Jan. 27, 2015) (No. MHMH017634).

84. Chief Medical Officer’s Report of Psychiatric Evaluation Pursuant to Section 229.14 The Code. 15 Day Report at 1 para 8 (Jan. 27, 2015), source available from author or *IHLR* upon request.

85. IOWA CODE § 229.1(20.c) (2018).

86. Medical Officer’s Report at para. 11 (Jan. 27, 2015), source available from author or *IHLR* upon request.

The next report was filed on February 5, 2015. The report indicated Patient One was receiving “structure, supportive therapy, medications, behavioral redirection, and social work intervention.”⁸⁷ It again references a history of Patient One’s “treatment for Schizophrenia”⁸⁸ The report concludes, “Patient remains paranoid and delusional. Not cooperative with attempts towards discharge planning. Continues with extremely poor insight into illness and need for treatment.”⁸⁹ As before, the court entered an order for continued hospitalization.⁹⁰

A thirty-day report was filed on March 27, 2015, with the same effect.⁹¹ The court entered an order for continued hospitalization.⁹² In the order, the court authorized a sixty-day evaluation.⁹³

On May 26, 2015, as required by the treating physician, a report was filed to the court indicating, despite treatment with “supportive therapy” and being medicated with “Haldol⁹⁴ [and] Seroquel,⁹⁵” the patient should remain

87. Medical Officer’s Report at para 1 (Feb. 5, 2015), source available from author or *IHLR* upon request.

88. Medical Officer’s Report at para. 3 (Feb. 5, 2015), source available from author or *IHLR* upon request.

89. Medical Officer’s Report at para. 15 (Feb 5, 2015), source available from author or *IHLR* upon request.

90. Order for Continued Hospitalization (Mar. 27, 2015), source available from author or *IHLR* upon request.

91. Medical Officer’s Report (Mar. 27, 2015), source available from author or *IHLR* upon request.

92. Order for Continued Hospitalization (Mar. 27, 2015), source available from author or *IHLR* upon request.

93. Order for Continued Hospitalization (Mar. 27, 2015), source available from author or *IHLR* upon request.

94. U.S. NAT’L LIBRARY OF MEDICINE, MEDLINE PLUS: HALOPERIDOL (2018), <https://medlineplus.gov/druginfo/meds/a682180.html>, <https://perma.cc/M6EBPKZ3>. “Haloperidol is used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real). Haloperidol is also used to control motor tics (uncontrollable need to repeat certain body movements) and verbal tics (uncontrollable need to repeat sounds or words) in adults and children who have Tourette’s disorder (condition characterized by motor or verbal tics). Haloperidol is also used to treat severe behavioral problems such as explosive, aggressive behavior or hyperactivity in children who cannot be treated with psychotherapy or with other medications. Haloperidol is in a group of medications called conventional antipsychotics. It works by decreasing abnormal excitement in the brain.” *Id.*

95. U.S. FOOD & DRUG ADMIN., MEDICATION GUIDE: SEROQUEL (2013), <https://www.fda.gov/downloads/Drugs/DrugSafety/ucm089126.pdf>, <https://perma.cc/TQ62-4XK5>. “Seroquel is a prescription medicine used to treat: schizophrenia in people 13 years of age or older; bipolar disorder in adults, including: depressive episodes associated with bipolar disorder, manic episodes associated with bipolar I disorder alone or with lithium or divalproex, [and] long-term treatment of bipolar I disorder with lithium or divalproex; manic episodes associated with bipolar I disorder

hospitalized.⁹⁶ The report concludes, “Patient remains delusional, but improved over admission. However, [patient] required support and structure to maintain this improvement and this is not currently available in the community.”⁹⁷ The court entered an order requiring an additional report be filed with the court in 30 days.⁹⁸

The next day on May 27, 2015. The patient was discharged from one hospital and transferred to a long-term care facility.⁹⁹ In the discharge report, the treating physician notes “Patient is improved over admission. [He] has been accepted at the . . . Center for long term placement and is appropriate for that level of support and supervision at this time.”¹⁰⁰ On May 27, 2017, Patient One was transferred to long-term care facility with an additional thirty-day report to be filed by his new treating physician.¹⁰¹ After being prompted by the court,¹⁰² an additional report was filed by the long-term care facility. The report notes the patient condition “remains unchanged.”¹⁰³ The court entered another order continuing the outside placement, this time requiring a ninety-day report to the court.¹⁰⁴

In September 2015, at the mental health advocate’s request, the court entered an order appointing an advocate in [] County, Iowa.¹⁰⁵ On the same date, the court entered a notification of the court’s intent to transfer venue to [a different] County.¹⁰⁶ The court also continued the patient’s hospitalization.¹⁰⁷ On October

in children ages 10 to 17 years old.” *Id.*

96. Medical Officer’s Report at para.14(c) (May 26, 2015), source available from author or *IHLR* upon request.

97. Medical Officer’s Report at para. 15 (May 26, 2015), source available from author or *IHLR* upon request.

98. Order for Continued Hospitalization (May 26, 2015), source available from author or *IHLR* upon request.

99. Order for Transport, MHMH017634 (May 27, 2015), source available from author or *IHLR* upon request.

100. Medical Officer’s Report at para. 15 (May 26, 2015), source available from author or *IHLR* upon request.

101. Order Transferring Respondent Inpatient to a Facility Outside the Hospital (May 27, 2015), source available from author or *IHLR* upon request. As will be noted, his bond was posted in the criminal case on May 20, 2015. If his bond had not been posted, Patient One would have discharged to the custody of the jail.

102. Notice to Comply with Periodic Reports (June 29, 2015), source available from author or *IHLR* upon request.

103. Periodic Report (June 29, 2015), source available from author or *IHLR* upon request.

104. Order Continuing Inpatient to a Facility Outside the Hospital (July 1, 2015), source available from author or *IHLR* upon request.

105. Memorandum Requesting New Advocate be Appointed; Memorandum Requesting the Case be Transferred (Sept. 22, 2015); Order Appointing Advocate (Sept. 22, 2015), source available from author or *IHLR* upon request.

106. Notification of Intent to Transfer Venue (Sept. 22, 2015), source available from author or *IHLR* upon request.

107. Order Continuing Inpatient to Facility Outside the Hospital (Sept. 22, 2015), source available from author or *IHLR* upon request.

7, 2015, venue in Patient One's case was transferred to [the different] County.¹⁰⁸

VI. TWO PARALLEL UNIVERSES

While there is a sizeable debate about parallel universes in physics, there is no doubt they exist in the form of two separate tracks: the criminal case and the civil commitment case for Patient One.

A. *The Criminal Case*

The time limits for discovery and speedy trial continued to run for the second month of Patient One's incarceration. No order suspending the proceedings, which could take place under the competency statute, was issued, even though the civil commitment proceedings were running concurrently with the criminal case.¹⁰⁹

The significance of not suspending the criminal proceeding puts pressure on the state in order to resolve the criminal case. Ordinarily, the state is obligated to take the case to trial within 135 days of the arrest and initial appearance of the defendant.¹¹⁰ Most criminal cases where the defendant is incarcerated and is charged with a serious misdemeanor are disposed of within approximately ninety days.

If an order suspending the criminal proceeding was issued, and Patient One was evaluated for competency, the initial hearing would take place within fourteen days.¹¹¹ If the patient is found incompetent by a preponderance of evidence, the defendant could be committed for treatment to restore competency.¹¹² A follow-up report is required initially within thirty days¹¹³ and

108. Change of Venue (Oct. 7, 2015), source available from author or *IHLR* upon request.

109. IOWA CODE § 812.3(1) (2017) "If at any stage of a criminal proceeding the defendant or the defendant's attorney, upon application to the court, alleges specific facts showing that the defendant is suffering from a mental disorder which prevents the defendant from appreciating the charge, understanding the proceedings, or assisting effectively in the defense, the court shall suspend further proceedings and determine if probable cause exists to sustain the allegations." *Id.*

110. The 135-day window is the result of the combinations of two rules of Iowa Criminal Procedure. The first rule, IOWA R. CRIM. P. 2.33(2)(a), provides that "[w]hen an adult is arrested for the commission of a public offense . . . and an indictment is not found against the defendant within forty-five days, the court must order the prosecution to be dismissed, unless good cause to the contrary is shown or the defendant waives the defendant's right thereto." The second rule, Iowa R. Crim. P. 2.33(2)(b), provides that "[i]f a defendant indicted for a public offense has not waived the defendant's right to a speedy trial the defendant must be brought to trial within ninety days after indictment is found or the court must order the indictment to be dismissed unless good cause to the contrary be shown." Ninety days plus forty-five days is 135 days.

111. IOWA CODE § 812.4(1) (2018).

112. IOWA CODE § 812.4 (2018).

113. IOWA CODE § 812.7 (2018).

every sixty days thereafter¹¹⁴ until there is finding of restoration of competency,¹¹⁵ or if there is a finding that there is no substantial probability of restoration of competency, the court shall dismiss the criminal case.¹¹⁶ A person could be held for a total of eighteen months from the day of finding the person incompetent, but no more than the maximum time of incarceration for the offense the patient is charged.¹¹⁷ In Patient One's case, a period of not more than one year.¹¹⁸ Patient One was held to answer for the criminal charges for 327 days.¹¹⁹

Patient One's family posted bond on May 21, 2015, or 140 days after his arrest. As previously noted, this allowed him to be transferred into a long-term care facility, rather than returning to the jail.¹²⁰ Patient One had forty days to file pre-trial motions from his arraignment,¹²¹ which occurred on February 18, 2015. The public defender's office was appointed to represent the patient at the arraignment.¹²² The patient acknowledged the receipt of the trial information by again signing, "John Barron."¹²³ A pre-trial conference was set for February 27, 2015, and a trial date was set for March 30, 2015. The next day, the state public defender withdrew from the case, and new counsel was appointed.¹²⁴ A request to dismiss the criminal case was sent to the prosecuting attorney on March 12, 2015.¹²⁵ On March 20, 2015, defense counsel in the criminal case moved to continue the pre-trial conference on the grounds that the defendant was civilly committed and was receiving treatment in a local hospital.¹²⁶ The defendant did not waive speedy trial or ask for a competency examination, holding the state to

114. IOWA CODE § 812.7 (2018).

115. IOWA CODE § 812.8 (2018).

116. IOWA CODE § 812.7 (2018).

117. IOWA CODE § 812.9 (2018).

118. IOWA CODE § 903.1(1)(b) (2018).

119. January 3, 2015, through November 23, 2015. Criminal Complaint (Jan. 3, 2015), source available from author or *IHLR* upon request; Order of Dismissal (Nov. 24, 2015), source available from author or *IHLR* upon request.

120. Surety Bond (May 21, 2015), source available from author or *IHLR* upon request (noting that his bond was posted in the criminal case on May 20, 2015. Had it not been he would have been discharged to the custody of the jail.); Order for Transport (No. 05771-MHMH017634).

121. IOWA R. CRIM. P. 2.11(4) (providing that "*Time of filing.* Motions hereunder, except motions in limine, shall be filed when the grounds therefor reasonably appear but no later than 40 days after arraignment....").

122. Order for Appointment of Counsel at 1 (Feb. 18, 2015), source available from author or *IHLR* upon request.

123. Receipt of Copy of Trial Information & Minutes of Testimony by Defendant at 2 (Feb. 18, 2015), source available from author or *IHLR* upon request.

124. Order Granting Public Defender's Motion to Withdraw Due to a Lack of Staff (Feb. 19, 2015), source available from author or *IHLR* upon request.

125. Email to the Prosecutor (Mar. 12, 2015), source available from author or *IHLR* upon request.

126. Motion to Continue Trial Dates (Mar. 20, 2015), source available from author or *IHLR* upon request.

the obligation to bring the defendant to trial within the 135-day period, or 90 days from the date the state filed the trial information.¹²⁷ That would require the state to try the defendant by April 30, 2015. Patient One's total time of incarceration would have been 118 days.¹²⁸

Finally, on April 9, 2015, defense counsel in the criminal case filed an application for a competency examination, and the court suspended the proceedings on April 10, 2015. A letter from the treating physician was filed on May 21, 2015, which stated the following:

[The patient] has an extensive history of schizophrenia and has been hospitalized numerous times in the past, including in [three other cities], and three times in the past two years at [a local hospital]. [The patient] is frequently non-compliant with oral medications. At his baseline, [the patient] is psychotic with chronic auditory hallucinations and delusions. Currently, he believes that he is to become the first self-appointed President of the United States, and says he must get to Washington D.C. as soon as he is discharged.

Prior to this hospitalization, [the patient] was involved in an altercation with police which resulted in misdemeanor charges being brought against him. [The patient] has remained delusional about this event from the time of his admission to today. [The patient] states that . . . he was only defending himself. [Patient One] has not wavered from that position. I believe [the patient] is not able to understand the charges against him or participate in his own defense due to his mental illness.

[The patient] is [sic] significantly improved over the time of admission, and has demonstrated no aggression towards anyone since his admission. [The patient] is currently calm, pleasant, and friendly. However, he remains very delusional, and continues with chronic auditory hallucinations. Given [the patient's] history and experience working with [the patient] over the last two years, I am confident that [the patient] is extremely unlikely to improve to a point where he would be competent to participate appropriately in this criminal process.

127. This occurred on January 30, 2015 (Iowa R. Crim. Proc. R 2.33(2)(a)-(b) allows the state 45 days from the date of arrest to file Trial Information, and then 90 days from the date Trial Information is filed to bring him to trial. If trial Information is filed before 45 days, the 90-day rule is triggered. A waiver is an affirmative duty. Since Patient One did not waive, the speedy trial rule was triggered. Patient One did not ask for a competency examination because he was pro se at that time. Eventually, when counsel was appointed, counsel filed for a competency exam under chapter 812.3(2) under the Iowa Code, which suspends all the time provisions provided in the Iowa Rules of Criminal Procedure. (45+90=135 days). Iowa R. Crim. P. 2.33(2)(a)-(b)).

128. January 3, 2015 through April 30, 2015.

[Local hospital] staff has worked to find an appropriate alternative to [the patient's] previous placement. [The patient] has now been accepted by the . . . Center for admission to their facility pending the outcome of the criminal process, and finalizing of the financial arrangements. [Patient One's] guardian has approved this plan. I request that the court consider dropping the misdemeanor charges against [the patient]. In my clinical opinion, [the patient] is not restorable to competency. He has been hospitalized behind locked doors since early January of 2015. There is little to suggest that the public good would be further served from a longer period of containment for [the patient]. At this time, there is no evidence that [the patient] is acutely dangerous, and [the patient] has been stabilized on long acting injectable medication to help ensure his adherence with treatment.¹²⁹

Although the May 5, 2015 letter answers all the pertinent legal questions posed by a competency examination, the case was continued until November of that year:

1. Did the defendant suffer from a “mental disorder”?¹³⁰ Yes. The patient “has an extensive history of schizophrenia and has been hospitalized numerous times in the past . . .”¹³¹
2. Does the mental disorder prevent the defendant from “appreciating the charge, understanding the proceedings, or assisting effectively in the defense”?¹³² Yes. Patient One’s treating physician stated, “I believe [the patient] is not able to understand the charges against him or participate in his own defense due to his mental illness.”¹³³
3. Is there “no substantial probability that the defendant will be restored to competency in a reasonable amount of time”?¹³⁴ Yes. It is the physician’s opinion that “the patient is not restorable to competency.”¹³⁵

In three subsequent reports, the treating physician found no change in the patient’s mental health status. The first report indicated the patient’s “mental stability as having auditory hallucinations and delusions as part of [his] daily life with little improvement in the future.”¹³⁶

The second report indicated the patient “...is diagnosed with schizophrenia...has frequent auditory hallucinations, delusions, disorganized

129. Letter to the District Judge (May 5, 2015), source available from author or *IHLR* upon request.

130. IOWA CODE § 812.3(2) (2018).

131. Letter to the District Judge, *supra* note 129.

132. IOWA CODE § 812.3(2) (2018).

133. Letter to the District Judge, *supra* note 129.

134. IOWA CODE § 812.8(8) (2018).

135. Letter from Janice Landy, MD, Section Chief for Behavioral Health, Broadlawns Med. Ctr., to Judge (May 21, 2015), source available from author or *IHLR* upon request.

136. Letter from James Brooks, MD, Psychiatrist, Davis Ctr. and Life Sols. Behavioral Health, to Judge (June 22, 2015), source available from author or *IHLR* upon request.

thought patterns.”¹³⁷ The final report states the patient, “is diagnosed with schizophrenia...[the patient] would not effectively assist in his defense due to his frequent auditory hallucinations, delusions and disorganized thought pattern[]...[The patient believes] that he is the President of the United States and [the patient’s] name is Jon Barron.”¹³⁸ The criminal case was dismissed on November 23, 2015. What happened between counsel’s appearance on February 20, 2015, and dismissal entered on November 23, 2015, is typical of the delays that occur when a criminal case intersects with a civil commitment order.

B. Disincentive to Resolve Mental Health Issues

A defendant charged in a criminal case has a significantly shorter incarceration than a defendant who has proceedings suspended due to incapacity to stand trial. As noted above, the maximum window for a prosecution in a criminal case is 135 days.¹³⁹ In Patient’s One’s criminal case, his incarceration would have been a maximum of 118 days.¹⁴⁰ If Patient One would have taken the plea offer at the arraignment, which was a one-year suspended sentence with probation,¹⁴¹ Patient One would have been released on February 18, 2015, forty-six days after his arrest. By raising the issue of Patient One’s competency, defense counsel has increased Patient One’s incarceration in either the jail for the criminal proceedings or inpatient treatment for the civil commitment proceeding.

C. Lack of Communication Between Civil Commitment and Criminal Courts

After the civil commitment proceeding had been initiated, and the defendant was transported to a local hospital’s psychiatric unit, there was no communication between the mental health court and the criminal court. This is especially concerning since two judges, two assistant county attorneys, and an attorney appointed to represent Patient One in the civil commitment proceeding were involved.

A simple solution would be to link the two systems. Practically speaking, this would make available all filings in the mental health court system to the actors in the criminal court system. Requiring that counsel be appointed in the criminal case, at least on a stand-by basis, would help assure expediting competency questions. It would be fair to assume that an individual’s inability to manage

137. Letter from James Brooks, *supra* note 136.

138. *Id.*

139. IOWA R. CRIM. P. 2. 33. This number comes from forty-five days from the date of arrest and appearance to file the trial information plus ninety days from the filing of the trial information to trial.

140. Patient One Case *supra* note 126 (The trial information was filed January 30, 2015, for twenty-eight days plus the ninety days for a period ending April 30, 2015).

141. Trial Information (Jan. 30, 2015), source available from author or *IHLR* upon request (discusses the plea offer).

basic health care¹⁴² would make it implausible that the individual could appreciate charges, understand the proceedings, or effectively assist counsel in the criminal justice system.¹⁴³ Any privacy concerns could be addressed by limiting access to sensitive information. In Iowa, amending the civil commitment statute and the competency statutes would provide the best vehicle to accomplish sharing information regarding mental health status.¹⁴⁴

D. Aftercare & Guardianship

One of the greatest challenges at the intersection of mental health and the criminal justice system is the constant nature of the former and the terminal nature of the latter. In the criminal justice system, there is a final event: a term of probation is discharged, a term of incarceration is completed, or a case is dismissed. Each time a terminal event occurs and coincides with an individual who has an underlying mental health issue, the individual is typically released without a plan for aftercare. The system is out of the picture, yet the underlying medical condition persists. This significantly increases the rate of recidivism.

Patient One is fortunate. He had a guardian involved in his case, so aftercare was eventually provided. This was a matter of good fortune rather than by design of the criminal justice system. In most situations, aftercare is not anticipated let alone provided. In fact, it seems to be discouraged.

As demonstrated in Patient One's case, the importance of having a guardian cannot be minimized. The guardian interceded in posting the bond and making arrangements for aftercare upon the dismissal of the criminal case. If no guardian was appointed, Patient One would have returned to the custody of the local jail

142. IOWA CODE ANN. § 229.6(2)(a)(2) (West 2018) (effective July 1, 2017). In Iowa, an application for order of involuntary hospitalization requires an allegation of a serious mental impairment. *Id.* See IOWA CODE ANN. § 229.1(20) (West 2018) (effective July 1, 2018):

“Seriously mentally impaired” or “serious mental impairment” describes the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment, and who because of that illness meets any of the following criteria:

- a. Is likely to physically injure the person’s self or others if allowed to remain at liberty without treatment.
- b. Is likely to inflict serious emotional injury on members of the person’s family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment.
- c. Is unable to satisfy the person’s needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.

143. IOWA CODE ANN. § 812.3 (West 2018) (proposed Feb. 23, 2017).

144. In Patient One’s case, this would require sharing information between the local jail, the private contactor providing health care for inmates in the jail, the local hospital treating for mental health disorders, the mental health courts, and the criminal courts.

from a hospital setting for disposition of the criminal charges.

A series of interviews took place between July and August of 2018 with Patient One's guardian; as a result, some important observations were made by the guardian.¹⁴⁵

The onset of Patient One's symptoms began in his late teens or early twenties, where he was incapable of holding jobs and labored under the belief that he could make a living as a fur trapper.¹⁴⁶ Patient One's symptoms included several delusions increasing in severity and length over time. In his late twenties, Patient One required a number of psychiatric commitments. The guardian noted that one suggested change is the length of the emergency psychiatric commitment. Increasing the term of the psychiatric commitment to a week or more would help to properly diagnose and adequately assess the needs of a patient.

The guardian also suggested hiring more medical personnel who have sufficient training and experience to evaluate individuals with psychiatric disorders. It goes without saying that medical personnel should receive additional training in diagnosis and treatment in order to keep up to date.

The guardian noted her frustration with the criminal justice system in dealing with her ward. She noted the indifference of local law enforcement in releasing her ward onto the street without any follow-up mental health treatment. As was previously mentioned in this Article, training for law enforcement in recognizing mental health issues is imperative to the effective treatment of those who come into contact with law enforcement.

The guardian also indicated what a relief it was for her when Patient One was hospitalized until he turned sixty-five. This allowed the guardian to make arrangements for long-term care for her ward. The question is: What will happen when the guardian is no longer able to care for her ward? Who will succeed her as his guardian?

In this regard, Patient One's disease is one that will last decades. In his case—from his late teens to currently sixty-eight—a half century of care. This point is often lost on individuals who do not regularly interact with individuals who have serious mental health issues. What will become of Patient One when his guardian is gone? He is currently sixty-eight and she is seventy-four.

VII. HIPAA AND STATE PRIVACY STATUTES: MYTHS AND MAGICAL THINKING

One impediment to sharing health care information is HIPAA and state health care privacy statutes. The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996 with the goal of "ensur[ing] that individuals' health information is properly protected while allowing the flow of

145. It should be noted that the guardian is a family member and is also a registered nurse. The guardianship was established in 1996.

146. The guardian estimated that Patient One's psychiatric issues were exacerbated by the death of his mother. He was the youngest of five children and the death occurred when he was fifteen years old. The family was also extremely poor.

information needed to promote high-quality health care.”¹⁴⁷ In spite of the claim that one of HIPAA’s objectives is to simplify the exchange of patient information,¹⁴⁸ it has turned into a tool that allows health care providers and their agents to bully individuals, conceal medical errors, and delay investigations into patients’ cases. There is nothing simple about HIPAA.

The potential penalties for wrongful disclosure of HIPAA protected information are indeed onerous.¹⁴⁹ Section 1320d-6 creates an offense and penalties for “wrongful disclosure of individually identifiable health information.”¹⁵⁰ Under subsection (a) of the statute, a person commits the offense when, knowingly, *one* of the following elements is satisfied: “(1) [U]ses or causes to be used a unique health identifier; (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person.”¹⁵¹ Subsection (b) provides for the penalties, stating a person found in violation of the above statute shall:

- (1) be fined not more than \$50,000, imprisoned not more than 1 year, or both;
- (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and
- (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both.¹⁵²

In order for the penalties statute to apply, one must be a “covered entity” described in another provision of the statute.¹⁵³ “The term ‘HIPAA privacy regulation’ means the regulations promulgated by the Secretary under this part and section 264 of the Health Insurance Portability and Accountability Act of

147. SHARYL J. NASS ET AL., BEYOND THE HIPAA PRIVACY RULE: ENHANCING PRIVACY, IMPROVING HEALTH THROUGH RESEARCH 2 (2009), https://www.ncbi.nlm.nih.gov/books/NBK9578/pdf/Bookshelf_NBK9578.pdf [<https://perma.cc/7VPD-ZSJS>].

148. “The Institute of Medicine Committee on Health Research and the Privacy of Health Information . . . was charged with . . . assess[ing] whether the HIPAA Privacy Rule is having an impact on the conduct of health research, defined broadly as ‘a systematic investigation, including research development, testing and evaluation, design to develop or contribute to generalizable knowledge.’ . . . The committee’s conclusion is that the HIPAA Privacy Rule does not protect privacy as well as it should, and that, as currently implemented, the HIPAA Privacy Rule impedes important health research.” *Id.*

149. “Criminal violations of HIPAA are handled by the DOJ. As with the HIPAA civil penalties, there are different levels of severity for criminal violations.” *HIPAA Violations & Enforcement*, AM. MED. ASS’N, <https://www.ama-assn.org/practice-management/hipaa-violations-enforcement> [<https://perma.cc/QJ8X-ZEZR>].

150. 42 U.S.C. § 1320d-6 (2018).

151. 42 U.S.C. § 1320d-6(a) (2018).

152. 42 U.S.C. § 1320d-6(b) (2018).

153. 42 U.S.C. § 1320d-6(a) (2018); 42 U.S.C. § 1320d-9(d) (2018).

1996 (42 U.S.C. 1320d-2 note).¹⁵⁴ That, in term, refers to an executive order, which provides, in part: HIPAA applies only to “covered entities,” such as health care plans, providers, and clearinghouses. HIPAA regulations therefore do not apply to other organizations and individuals that gain access to protected health information, including Federal officials who gain access to health records during health oversight activities.¹⁵⁵ Which, in turn, leads to the Code of Federal Regulation that states a covered entity refers to “(1) A health plan[,] (2) [a] health care clearinghouse[,] [or] (3) [a] health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.¹⁵⁶ It may also include:

- (2) A covered entity may be a business associate of another covered entity.
- (3) Business associate includes:
 - (i) A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information.
 - (ii) A person that offers a personal health record to one or more individuals on behalf of a covered entity.
 - (iii) A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.¹⁵⁷

The Code defines disclosure as, “the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.”¹⁵⁸ Answering a fairly straightforward question: “What is a covered entity under HIPAA?” requires navigating the enabling statutes, executive orders, and the Code of Federal Regulations. This is not a simple task. Likely, those unfamiliar with the law’s complexities and consequences would find it a daunting task to unearth.

In 2014, ProPublica published an article entitled “Are Patient Privacy Laws Being Misused to Protect Medical Centers.”¹⁵⁹ In it, the author, Charles Ornstein, documents several situations where HIPAA was used to shield medical institution *rather than* the patients HIPAA was designed to protect. For example, threatening a mother with jail for photographing her son who was a patient at a medical

154. 42 U.S.C. § 1320d-9(b)(3).

155. To Protect the Privacy of Protected Health Information in Oversight Investigations, 65 Fed. Reg. 81,321 (Dec. 20, 2000).

156. 45 C.F.R. § 160.103 (2014).

157. *Id.*

158. *Id.*

159. Charles Ornstein, *Are Patient Privacy Laws Being Misused to Protect Medical Centers?*, PROPUBLICA (July 24, 2014, 11:30 AM), <https://www.propublica.org/article/who-do-federal-privacy-laws-protect-patients-or-medical-centers> [<https://perma.cc/V39S-REKM>].

facility¹⁶⁰; a nursing home refusing to cooperate with the investigation of a rape against a resident¹⁶¹; and threatening whistle blowers at the Department of Veterans Affairs.¹⁶² In some instances, medical providers even deny patients access to *their own* medical records. Quoting Devin McGraw, former director of the Health Privacy Project at the Center for Democracy and Technology, as stating: “Sometimes it’s really hard to tell whether people are just genuinely confused or misinformed, or whether they’re intentionally obfuscating.”¹⁶³ Probably the most egregious examples are when health care providers cite HIPAA’s privacy provisions as prohibitions for disclosure to the patient—the opposite is true.¹⁶⁴

*A. Bubble, Bubble, Toil and Trouble*¹⁶⁵

Adding state privacy provisions into the mix:

HIPAA Compliance. HIPAA provides that it supersedes any contrary provisions of state law. 42 U.S.C. § 1320d-7(a)(1) (2012). HIPAA regulations have been described as “dense, complex, confusing and lengthy.” *Cohan v. Ayabe*, 132 Haw. 408, 322 P.3d 948, 956 (2014). But, the parties in this case agree Iowa law controls if it is “more stringent” in protecting mental health information than the privacy restrictions imposed under HIPAA. See 45 C.F.R. § 160.203(b); *Holman v. Rasak*, 486 Mich. 429, 785 N.W.2d 98, 111 (2010) (“[A]ny HIPAA standard or requirement that is contrary to state law preempts state law, unless the state law is more stringent than HIPAA. 45 C.F.R. 160.203.... More stringent means that the state law provides greater privacy protection than HIPAA. 45 C.F.R. 160.202.”).¹⁶⁶

160. *Id.* (citing Sarah Okeson, *Secret Video: Mercy Guard Threatened Photo-Taking Mom*, SPRINGFIELD NEWS-LEADER (July 18, 2014, 11:25 AM) <https://www.news-leader.com/story/news/local/ozarks/2014/07/18/caught-camera-mercy-guard-chided-photo-taking-mom/12835341/> [<https://perma.cc/SQ6S-HNWL>]).

161. *Id.* (citing Katie Kustura & Skyler Swisher, *Daytona Police, Attorneys Butt Heads in Investigation of Possible Sex Crime at Healthcare Facility*, DAYTONA BEACH NEWS J. (July 18, 2014, 10:36 PM), <http://www.news-journalonline.com/news/20140718/daytona-police-attorneys-butt-heads-in-investigation-of-possible-sex-crime-at-healthcare-facility> [<https://perma.cc/XK7U-ZK8Z>]).

162. *Id.* (citing Joe Davidson, *VA Uses Patient Privacy to go After Whistleblowers, Critics Say*, WASHINGTON POST (July 17, 2017), https://www.washingtonpost.com/politics/federal-government/va-uses-patient-privacy-to-go-after-whistleblowers-critics-say/2014/07/17/bafa7a02-0dcb-11e4-b8e5-d0de80767fc2_story.html?utm_term=.dc70e143c6c4 [<https://perma.cc/JKB7-GWKZ>]).

163. *Id.*

164. *Id.*

165. WILLIAM SHAKESPEARE, *MACBETH* act 4, sc. 1.

166. *In re A.M.*, 856 N.W.2d 365, 379 (Iowa 2014).

Therefore, HIPAA must also be read in conjunction with state privacy laws, and that if the state laws are more stringent, the state privacy law will prevail.¹⁶⁷

For example, in Iowa, that means analyzing two privacy statutes. The first statute deals with the general physician-patient or medical privilege.¹⁶⁸ The second statute deals with mental health providers.¹⁶⁹ The general physician-patient privilege allows for disclosure of information in situations where the patient waives the privilege,¹⁷⁰ or where the party to an action puts the underlying medical condition at issue in a civil action.¹⁷¹ Pleading insanity or diminished responsibility in a criminal prosecution also waives the physician patient privilege.¹⁷²

167. *Id.* at 370 (“The parties agree that Iowa law controls if it is more stringent than HIPAA in protecting mental health information. We therefore examine the Iowa enactments before turning to HIPAA. We conclude the Iowa protections are more stringent than HIPAA and are dispositive.”).

168. IOWA CODE § 622.10(1) (2018) (“A practicing attorney, counselor, physician, surgeon, physician assistant, advanced registered nurse practitioner, mental health professional, or the stenographer or confidential clerk of any such person, who obtains information by reason of the person’s employment, or a member of the clergy shall not be allowed, in giving testimony, to disclose any confidential communication properly entrusted to the person in the person’s professional capacity, and necessary and proper to enable the person to discharge the functions of the person’s office according to the usual course of practice or discipline.”).

169. IOWA CODE § 228.2 (1) (2018) (“Except as specifically authorized . . . or for the purposes of care coordination as defined . . . if not otherwise restricted by federal law or regulation, a mental health professional, data collector, or employee or agent of a mental health professional, of a data collector, or of or for a mental health facility shall not disclose or permit the disclosure of mental health information.”).

170. IOWA CODE § 622.10(2) (2018). “The prohibition does not apply to cases where the person in whose favor the prohibition is made waives the rights conferred; nor does the prohibition apply to physicians or surgeons, physician assistants, advanced registered nurse practitioners, mental health professionals, or to the stenographer or confidential clerk of any physicians or surgeons, physician assistants, advanced registered nurse practitioners, or mental health professionals, in a civil action in which the condition of the person in whose favor the prohibition is made is an element or factor of the claim or defense of the person or of any party claiming through or under the person. The evidence is admissible upon trial of the action only as it relates to the condition alleged.”).

171. IOWA CODE § 622.10(3) (2018).

172. *State v. Cole*, 295 N.W.2d 29, 35-36 (Iowa 1980). (“Several courts have held that a plea of insanity or diminished capacity waives the privilege by putting the matter in issue . . . We believe the defense of diminished capacity waived the privilege here, even if it had existed, for the simple reason it would be incongruous to allow a party to put a matter in issue and then deny access of an opposing party to relevant information concerning it. *Id.* Our modern concept of criminal trials favors full disclosure of facts, within constitutional limitations, on both sides of the table. The ‘sporting’ theory of justice resulting from concealment and surprise is no longer the rule . . . Even the most restrictive authorities would say *Cole* would have waived the privilege by introducing

Although not specifically addressed within the statute, presumably by raising the issue of competency would also constitute a waiver.¹⁷³ In fact, the competency statute requires the court to order a psychiatric examination with a subsequent report to be filed with the court¹⁷⁴ with status reports to follow in the event the court finds the individual incompetent to stand trial.¹⁷⁵

The second statute provides for the disclosure of mental health and psychological information acquired pursuant to a “court-ordered examination.”¹⁷⁶ Also, disclosure is permitted specifically in civil commitment proceedings.¹⁷⁷ These are straightforward authorization to disclose information under the general title of the subsection on “Compulsory disclosures.”¹⁷⁸ Arguably, the state privacy statutes in effect in Iowa are easier to decipher than federal statutes and rules, but they could be improved significantly.

evidence on it; our view that a waiver is effected by a plea of insanity or diminished capacity merely advances the timetable to permit adequate preparation and avoids the delay which might otherwise be required to meet the defense . . . ([R]equiring disclosure [by defendant] in advance merely regulates the procedure by which he presents his case.’); see also LAURIE K. DORE, IOWA PRACTICE EVIDENCE § 5.502:13 (7 vol.) (2016).

173. IOWA CODE § 622.10(2) (2018).

174. IOWA CODE § 812.3(2) (2018). (“Upon a finding of probable cause sustaining the allegations, the court shall suspend further criminal proceedings and order the defendant to undergo a psychiatric evaluation to determine whether the defendant is suffering a mental disorder which prevents the defendant from appreciating the charge, understanding the proceedings, or assisting effectively in the defense. The order shall also authorize the evaluator to provide treatment necessary and appropriate to facilitate the evaluation. If an evaluation has been conducted within thirty days of the probable cause finding, the court is not required to order a new evaluation and may use the recent evaluation during a hearing under this chapter. Any party is entitled to a separate psychiatric evaluation by a psychiatrist or licensed, doctorate-level psychologist of their own choosing.”)

175. IOWA CODE § 812.7 (2018). (“The psychiatrist or licensed doctorate-level psychologist providing outpatient treatment to the defendant, or the director of the facility where the defendant is being held and treated pursuant to a court order, shall provide a written status report to the court regarding the defendant’s mental disorder within thirty days of the defendant’s placement pursuant to section 812.6. The report shall also state whether it appears that the defendant can be restored to competency in a reasonable amount of time. Progress reports shall be provided to the court every sixty days or less thereafter until the defendant’s competency is restored or the placement of the defendant is terminated.”).

176. IOWA CODE § 228.6 (2) (2018). (“Mental health information acquired by a mental health professional pursuant to a court-ordered examination may be disclosed pursuant to court rules.”). *Id.*

177. IOWA CODE § 228.6(3) (2018). (“Mental health information may be disclosed by a mental health professional if and to the extent necessary, to initiate or complete civil commitment proceedings under chapter 229.”). *Id.*

178. IOWA CODE § 228.6 (2018).

B. HIPAA Has Been Characterized as, “Dense, Complex, Confusing and Lengthy”¹⁷⁹ so “The First Thing We Do, Let’s Kill all the Lawyers”¹⁸⁰

Unfortunately for non-lawyer colleagues in the health profession, that is not a practical proposition. Competing interests exist within the health care industry. If we take Patient One and put him through the various represented interests illustrates the point. The health care facility would be the first entity that would have an interest. The second entity would be the local hospital where Patient One was taken for treatment. The third would be the local jail where Patient One was booked. The fourth would be the health care provider employed by the jail that instituted civil commitment proceedings. The fifth would be the local hospital where Patient One was committed. The sixth and seventh would be the institution where Patient One received treatment whose medical information was given to the local hospital. The final entity would be the health care provider he was transferred to as a result of the civil commitment.

Each one of the above institutions would be governed by HIPAA and state privacy statutes. Each would presumably be represented by counsel whose primary interest is protecting its legal interests, not necessarily the interests of the patients that HIPAA was designed to protect. This creates divided loyalty with counsel. Thus, lending HIPAA to the critique that the providers are using it to guard themselves. This leads to inevitable threat first heard by Sherlock Holmes in *The Hound of Baskervilles* when someone outside the entity asks for patient information:

Sherlock: I never did ask, Dr. Franklyn. What is it exactly that you do here?

Doctor: Oh, Mr. Holmes, I would love to tell you, but then, of course, I’d have to kill you.

Sherlock: That would be tremendously ambitious of you.¹⁸¹

Whether the motive behind an individual’s denial of information is “genuinely confused or misinformed, or whether they’re intentionally obfuscating,” is irrelevant.¹⁸² The denial upon request of information is wrong. Unfortunately, this is the default position for all entities covered by HIPAA or state privacy laws when faced with such requests.

VIII. PROGNOSIS AND CONCLUSION

A. Short-Term Recommendations

As previously noted, the current prison and jail populations across the United

179. *In re A.M.*, 856 N.W.2d 365, 379 (Iowa 2014) (citing *Cohan v. Ayabe*, 322 P.3d 948, 956 (2014)).

180. WILLIAM SHAKESPEARE, *HENRY VI* act 4, sc. 2.

181. ARTHUR CONAN DOYLE, *THE HOUND OF BASKERVILLES* (1902).

182. Charles Ornstein, *supra* note 159.

States are inundated with individuals who have serious mental illness.¹⁸³ Unless action is taken, the prognosis is dismissal. The first step is to identify those who have serious mental impairment. To that end, adequate training for dispatch and first responders is essential. Not only is it necessary for those responders to be trained, it is critical they report those individuals who have identifiable mental health issues. Forms for the report should be uniform and redundant. In other words—not only should the initial case report have an area designated for mental health, but all follow-up reports in the criminal and civil courts should be adapted to allow for the identification of persons with serious mental illness. This redundancy should encourage a system that double checks itself with each report or pleading.

In all cases where an individual is taken to a hospital for treatment prior to incarceration, the hospital should be required to perform a records-check to establish a patient's history prior to any discharge to police custody. The records-check should be incorporated into the transporting agency records, and then forwarded to court.

Court rules should be adopted to allow judges in the criminal court to trigger mental health evaluations for competency as early as the initial appearance. Those rules should also allow criminal courts to initiate civil commitment proceedings. Once triggered, the civil commitment proceeding should be attached to the criminal proceedings, running concurrently. Privacy statutes should be amended to allow the flow of information between the civil commitment courts and criminal courts. This amendment would allow all actors in both systems access to the information.

In the event of a civil commitment proceeding along with a criminal filing, there should be a joint hearing or joint hearings involving all parties on both proceedings so parties are able to coordinate with health care professionals as to the proposed plan of treatment.

One goal in these recommendations is to shorten the time individuals with serious mental health issues spend incarcerated. Additionally, this would incentivize defense attorneys to raise their client's mental issues upfront, rather than feel reluctant because their client would spend more time if the issues went undisclosed.

In cases like Patient One's—where competency will not be restored in the foreseeable future—the competency statutes should require the appointment of

183. *Incarceration Nation*, 45 AM. PSYCHOLOGICAL ASSN. 9, 56 (Oct. 2014), <http://www.apa.org/monitor/2014/10/incarceration.aspx> [<https://perma.cc/9HWK-565G>]. “[T]he United States has only 5 percent of the world’s population, [yet] it has nearly 25 percent of its prisoners. While at least half of prisoners have some mental health concerns, about 10 percent to 25 percent of U.S. prisoners suffer from serious mental illnesses, such as major affective disorders or schizophrenia, the report finds.” See also Sarah Varney, *By the Numbers: Mental Illness Behind Bars*, PUB. BROAD. SYS. (May 15, 2014, 6:39 PM), <https://www.pbs.org/newshour/health/numbers-mental-illness-behind-bars/> [<https://perma.cc/VP2P-HMHF>]. “In state prisons, 73 percent of women and 55 of men have at least one mental health problem. In federal prisons, 61 percent of women and 44 percent of men. In local jails, 75 percent of women and 63 percent of men.”

a guardian or conservator prior to the discharge of the person and dismissal of the criminal proceeding. The guardianship and conservator provisions should be reconciled with the competency statute. Currently in Iowa, the burden to establish a guardian is clear and convincing evidence to establish “a person whose decision-making capacity is so impaired that the person is unable to care for the person’s personal safety or to attend to or provide for necessities for the person.”¹⁸⁴ If a guardian has been appointed prior to the commencement of the criminal proceeding, the competency statute should be amended to create a presumption of *incompetency* rather than competency.¹⁸⁵ It is inconceivable that a person who requires a guardian “to attend to or provide for [their] necessities” and still be competent to stand trial.¹⁸⁶ Currently, it is possible for a court to make a finding that an individual cannot make decisions regarding their basic life functions but they can effectively assist in their own defense. This reality defies logic.

These adjustments could be made fairly quickly and with little legislative or judicial effort. Furthermore, such changes would cause a reduction—albeit small—in the number of individuals with chronic mental illness in the criminal justice system.

B. Long-Term Recommendations

Three important steps must be taken to change HIPPA and its

184. *In re Guardianship of R.K.*, 913 N.W.2d 627 (table), 2018 WL 1182532, *1 (Iowa Ct. App. 2018) (citing IOWA CODE § 633.552(2)(a)).

185. *State v. Lyman*, 776 N.W.2d 865, 874 (Iowa 2010). (“We presume a defendant is competent to stand trial. The defendant has the burden of proving his or her incompetency to stand trial by a preponderance of the evidence. If the evidence is in equipoise, the presumption of competency prevails. Moreover, once a court finds a defendant competent to stand trial, the presumption of competency continues unless and until the defendant produces new evidence to the contrary.”).

186. *State v. Lyman*, 776 N.W.2d 865 (Iowa 2010). (“At common law, the State could not try a criminal defendant if that person’s mental condition was such that he or she lacked the capacity to understand the nature and object of the proceedings, to consult with counsel, and to assist in preparing a defense. The Supreme Court has stated the test to determine if a criminal defendant is competent to stand trial is whether the person “‘has sufficient present ability to consult with [counsel] with a reasonable degree of rational understanding—and whether [the person] has a rational as well as factual understanding of the proceedings.’” (citing *Dusky v. United States*, 362 U.S. 402, 402, 80 S.Ct. 788, 789, 4 L.Ed.2d 824, 825 (1960) (per curiam)). “In Iowa, we define the test as whether ‘the defendant is suffering from a mental disorder which prevents the defendant from appreciating the charge, understanding the proceedings, or assisting effectively in the defense.’” (citing IOWA CODE § 812.3(1); *accord Lyon*, 293 N.W.2d at 9)). “The common thread running through these tests is that a criminal defendant must be able to effectively assist counsel in his or her defense. *See also* IOWA CODE 812.3.” *Id.* at 873-74. It also of note the burden of proof in a competency proceeding is a preponderance of evidence.

implementation. First, HIPAA must be revised with the intention of easing navigation for a lay person. Second, policy goals must shift in order to discourage the common negative response by health care providers by their attorneys when asked for information by creating an express exemption for actors in the criminal justice system that allows them to share information among themselves. Finally, a panel of medical professionals should be established to review HIPAA and state privacy statutes on a periodic basis to examine them for elimination of unnecessarily complex and confusing language. These tasks, of course, will be daunting given the number of interest groups with conflicting goals in HIPAA's revision.

The most important and long-term recommendation is the creation of body composed of mental health professionals that would meet on a periodic basis and evaluate all aspects of the mental health system in order to make recommendations regarding standards for competency, insanity, and diminished responsibility, as well as the procedures used by the criminal justice system. If policy makers persist in the repeated fallacy of trying to treat a mental health and medical problem with legal solutions, the criminal justice system will eventually collapse under its own weight.