ily (the *Frendak* inquiry), and the need for the court, *sua sponte*, to impose the insanity defense.

In *Phenis*, the appellate court ruled that several factors raised the question of Mr. Phenis' state of mind at the time of the crime and his capacity to waive the insanity defense intelligently and voluntarily. The appellate court further held that the only countering evidence was Dr. Richie's evaluation one year after the offense that concluded that Mr. Phenis could be held criminally responsible. The court ruled the report was lacking in substantiation, collaterals, details, and diagnostic clarity.

The appellate court concluded that though Mr. Phenis was competent to stand trial, it was not clear whether he was fully informed of the possibility and consequences of raising the insanity defense and freely chose to waive it. The court remanded the case with instructions to conduct a *Frendak* inquiry to determine whether Mr. Phenis intelligently and voluntarily waived the insanity plea. If the court is so convinced, the conviction stands. If, however, the court finds that Mr. Phenis did not competently waive the insanity defense, it must then determine whether there is clear evidence for the insanity defense, which if present would require the court to void Mr. Phenis' conviction and impose a new insanity defense trial over his objections. In the absence of clear evidence for an insanity defense, Mr. Phenis' conviction would stand.

Discussion

This case raises important concerns about competency to stand trial and the court's requirement for a unique assessment to determine capacity to waive an insanity plea through the *Frendak* inquiry. Competency to stand trial focuses on the contemporaneous ability to consult with counsel and to understand proceedings, including legal options, and consequences.

In this case, Mr. Phenis had been found competent several times before the trial date, but at trial, he showed evidence of a possible exacerbation of psychiatric symptoms. The ruling indicates that, at times, the courts may not recognize competency to stand trial as a fluid state, which does not assure continued capacity in the face of the stress of trial.

The legal and psychiatric views are also at odds in the second and central issue in *Phenis*, the need for a *Frendak* inquiry. The ruling in this case, as in *Frendak* and *Springs*, indicated that the court views competency to stand trial more narrowly than do forensic psychiatrists. Indeed, the court's ruling that the waiving of an insanity plea must be an intelligent and voluntary decision puts that component of the defense process at a higher standard than for competency to stand trial itself, creating an artificial distinction difficult to apply to a forensic psychiatric evaluation. A psychiatric examination for competency includes an assessment of decision-making on both prongs of competency, and forensic psychiatrists may appropriately consider an assessment of a defendant's appreciation of an insanity plea. On the other hand, in a *Frendak* inquiry, the court has neither clarified who shall conduct the assessment nor provided the guidelines. The rulings in *Phenis* and *Frendak* are also puzzling in view of the ruling in *Godinez v. Moran*, 509 U.S. 389 (1993), because the capacity to waive representation by an attorney does not require a separate hearing, but waiving an insanity defense does. It is unclear how courts determine which rights can be waived without further scrutiny.

Termination of Limited Guardianship

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Time Limit Requirements for Guardianship Appointment Not Applicable to Its Termination

In *In re Guardianship of E.L.*, 911 A.2d 35 (N.H. 2006), the Supreme Court of New Hampshire affirmed the decision of the Merrimack County Probate Court to deny a motion to terminate a limited guardianship of E.L., a ward of New Hampshire state prison, ruling that guardianship was the least restrictive intervention to ensure that E.L. continued to take medication for his bipolar disorder.

Facts of the Case

The state convicted E.L. of sexual assault in 1994, but then deemed him not competent for sentencing

and confined him to the Secure Psychiatric Unit at the New Hampshire State Prison, where he was restored to competence. In November 1995, after refusing to take medications and showing increasingly aggressive behavior that required his transfer to the most restricted unit, he was appointed a limited guardian to ensure that he would be compliant with medication and follow medical advice. By June 1996, he was deemed competent and sentenced to 7-½ to 15 years in prison. In August 1996, he was transferred to the general prison population, where he continued to take lithium for bipolar disorder. When he experienced psychotic symptoms, he was prescribed risperidone.

In 2004, after almost 10 years under the care of the limited guardian, E.L. requested that the probate court terminate the guardianship. In February 2005, Dr. Gerald Lazar, a psychiatrist, conducted an independent evaluation of him and agreed with the guardian that the court should deny his request because of his limited insight about his mental illness.

To continue guardianship, the guardian must prove that the grounds for appointment of a guardian still remain (N. H. Rev. Stat. Ann. § 464-A:40, II (c)(2004)). The guardian must prove beyond a reasonable doubt that E.L. remains incapacitated, guardianship is necessary, no suitable alternative resources exist, and guardianship is the least restrictive form of intervention.

The probate court decided that the conditions that existed when guardianship was granted still remained and denied E.L.'s request. E.L. appealed the decision to the state supreme court on the grounds that the probate court erred in finding that the guardian had met the burden of demonstrating beyond a reasonable doubt that he continued to meet the criteria for limited guardianship.

Ruling and Reasoning

The Supreme Court of New Hampshire affirmed the probate court's finding that the guardian presented sufficient evidence to prove beyond a reasonable doubt that E.L. continued to demonstrate incapacity to make his own health care decisions. The court did not find convincing E.L.'s contention that his years of medication compliance, continued consultations with mental health providers, and reasonable concerns about the side effects of his medications were indications of his improved capacity to make medical decisions, that he was not as ill as the state contended, and that he did as well off medications as on them. The state argued that his primary motivation for terminating guardianship was to discontinue the medications that had helped stabilize him and had decreased his dangerousness to himself and others.

The supreme court further upheld the probate court's ruling that the state had presented sufficient evidence to suggest that E.L. had poor insight and judgment and agreed that E.L.'s history of physical violence, evidenced by prison fights, the beatings and sexual assault of his wife, and willful cruelty toward children raised reasonable concern that discontinuation of his medications would result in dangerousness to others.

E.L. also argued that N. H. Rev. Stat. Ann. § 464-A:40, the statute for terminating guardianship, requires that the state rely on only those acts that occur within six months of the application for termination, and, therefore, the violent acts in question, all of which had occurred before that period, should be disallowed. The supreme court rejected that argument and held that the court, as "final arbiter of the intent of the legislature" (*E.L.*, p 43), would avoid an interpretation that resulted in an "absurd result" by limiting the guardian's evidence for proof of incapacity to events of only the previous six months. The court further held that the statute was written to allow flexibility in proceedings for termination versus appointment of guardianship by the use of the phrase "similar to," meaning that a termination hearing would be similar to one for appointing a guardian. Therefore, evidence for present inability to make health care decisions could be past acts, statements or occurrences outside of the time limitation.

E.L.'s last argument was that the probate court did not have sufficient evidence to rule out the less restrictive alternatives that E.L. had presented at the evidentiary hearing. The first alternative was the creation of a medical power of attorney. The probate court found this alternative ineffective because E.L. could cancel it. The second was the springing guardianship, in which, with the occurrence of certain symptoms or events, "a guardianship would 'spring' into effect" (*E.L.*, p 44). The probate court rejected that alternative because the guardian could be appointed only after E.L. decompensated. The supreme court concurred with the probate court's decision.

Discussion

Many psychiatric illnesses are chronic and recurrent, and insight is an especially elusive quality in patients with severe mental illness. Patients with mental disorders who are not compliant and decompensate soon after discharge often frustrate psychiatric teams. However, patients with other medical illnesses, such as diabetes mellitus and hypertension, face the same challenges. Noncompliance is such a large problem in all of medicine that multiple efforts are often made by treatment teams to simplify medication regimens with the goal of increasing compliance. Compliance, however, has to be voluntary. Many legal safeguards protect persons against involuntary treatment. For persons with mental illness, forced medication or treatment is permitted only in situations in which dangerousness to oneself or to others is present. In *E.L.*, the state's interest and E.L.'s exercise of free choice conflict. The court in this case made a decision similar to one faced frequently by psychiatrists: client choice versus risk to public safety. E.L initially lacked decisional capacity in the presence of clear dangerousness to others, thus allowing for medicating him involuntarily. However, even after his condition stabilized, he was required, against his will, to take medication. Although it is understandable that each state has the responsibility of protecting its citizens from violence, a loss of the freedom to make one's own medical decisions for an indefinite period of time seems to be at odds with the Eighth Amendment protection against cruel and unusual punishment.

The state supreme court's affirmation of the probate court's decision and reasoning sets a precedent that dangerousness is a permanent state despite treatment, maturation, punishment, and other factors usually associated with change. E.L. can never undo his past. The power of this precedent is evident in *In re Christopher K.*, 923 A.2d 187 (N.H. 2007), in which the Supreme Court of New Hampshire cited *In re Guardianship of E.L.* and held that the statute for renewal of conditional discharge does not require any new acts of violence during the period of conditional discharge. The justices stated that the spirit of the statutes of interest in *In re Christopher K.* and *In re Guardianship of E.L.* are similar. Both were crafted with the understanding that lower dangerousness while under supervision and a therapeutic regimen is expected and irrelevant to future dangerousness when supervision ends and treatment is no longer required. Both cases dismissed the evidentiary value of current dangerousness because of what the court views as the artificial effects of treatment.

In re Guardianship of E.L. is further complicated by E.L.'s ambivalence about treatment and his declaration that he did not need medication, despite a history of dangerousness when not in pharmacologic treatment. Although both the courts and psychiatry would view E.L. as a high-risk client, the legal and psychiatric approaches to managing the risk differ. The court by its decision in *In re Guardianship of E.L.* seems to view management of risk as the imposition of permanent conditions of guardianship and forced treatment. Psychiatry would usually take a different approach, a titrated trial with the imposition of treatment and confinement based on exacerbation of symptoms. Ironically, psychiatry came to this flexibility in treatment through court decisions that made illegal the permanent institutionalization of persons with mental disorders. *In re Guardianship of E.L.* seems to invoke, through guardianship and forced medication, a form of permanent institutionalization without the structure of hospitalization. Indeed, the alternative interventions proposed by E.L. to the trial court, the medical power of attorney (a form of psychiatric advanced directives) and the springing guardianship, represent new and creative mental health initiatives that create a safety net for the client and the public.