generally entitled to protection from admission of un-Mirandized incriminating statements made to health care professionals in the context of a court-ordered evaluation or examination." In Mr. Mitchell's case, the court did not deny that he was entitled to protection from introduction of un-Mirandized statements made during his independent psychiatric evaluation; however, this protection was not extended to material informing defense psychiatric evaluations. Further, the state's expert was permitted to testify about evaluation results suggesting that Mr. Mitchell was malingering his PTSD symptoms, since these results were introduced to rebut the defendant's PTSD defense. This ruling highlights the need for experts to be aware of the background information that they put in their reports and how such information may be used during trial.

This case called on the court to contemplate how pleas of not guilty due to PTSD will be handled within the legal system in the future. To our knowledge, Nevada is the first state to deal with such a plea, and the court decided that PTSD should be treated in a manner similar to not guilty defenses based on other mental conditions such as insanity and battered-spouse syndrome. This case may have future legal and social implications, as an increasing number of combat veterans return home from Operations Iraqi Freedom and Enduring Freedom. It will be interesting to see how other courts resolve this issue and whether they agree with the Nevada Supreme Court's ruling that not guilty pleas that claim PTSD symptomatology are subject to the same psychiatric testing requirements as other mental disorders.

Mute but Competent?

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Mutism Does Not Preclude a Finding of Competent to Stand Trial or Trigger a *Frendak* Inquiry

In *Howard v. United States*, 954 A.2d 415 (D.C. Cir. 2008), the District of Columbia Court of Appeals considered whether the trial court erred in deeming a mute defendant competent to stand trial, in failing to explore the insanity defense, and in failing to suppress two show-up identifications. We will primarily focus on the first two issues related to forensic psychiatry.

Facts of the Case

In August 2003, while posing as a gas station window washer, Melvin Howard sprayed Susan Saffer in the face with window cleaner. He displayed a gun, and then forced her to give him her car keys. A police car chase immediately ensued. Mr. Howard crashed the car, fled on foot, and was apprehended while hiding behind a trash can. The police then conducted two show-up identifications with Ms. Saffer and her friend, who had also witnessed the events.

Upon his arrest, Mr. Howard became mute and nonresponsive. In November 2003, during a mental health evaluation ordered by the trial court, Mr. Howard did not respond to any of the inquiries. Therefore, a competency examination was ordered. Mr. Howard remained unresponsive to both verbal and written communications. He was admitted to St. Elizabeths Hospital in April 2004 for a court-ordered "full" competency evaluation.

At St. Elizabeths Hospital, Dr. Michael Sweda, clinical psychologist, gave Mr. Howard a diagnosis of schizophrenia, catatonic type, and personality disorder, not otherwise specified with antisocial features. At admission and during several subsequent evaluations, Mr. Howard was deemed incompetent to stand trial.

Mr. Howard began receiving psychotropic medication, and, in February 2005, he "suddenly" began speaking. That April, Dr. Sweda submitted a report that deemed him competent to stand trial, competent to waive the insanity defense, and criminally responsible for the offense. He was found competent to stand trial in several examinations leading up to the trial. Hospital reports showed that, although Mr. Howard was mute and nonresponsive during the preliminary hearings and at the time of the trial, he had been freely communicative with doctors and staff at the hospital. Dr. Sweda and a psychiatrist at St. Elizabeths Hospital concluded that Mr. Howard's muteness was volitional.

In July 2005, Mr. Howard once again became mute, and the hospital's finding of competent to stand trial was challenged. During the August 2005

competency hearing, Dr. Sweda testified as the expert witness. The government produced evidence in support of their claim that his muteness was volitional. Hospital records indicated that when asked if his behavior was "an act," Mr. Howard smiled and stated that "his silence was for his 'well being' " (*Howard*, p 419); that, although he had refused to explain his muteness, he had later conceded that it was volitional; and that he had told staff that he began talking so that they would not "kill him" with medication.

The trial court judge ruled that Mr. Howard was competent to stand trial. He was convicted of all charges: carjacking while armed, possession of a firearm during a crime of violence or dangerous offense, carrying a pistol without a license, possession of an unregistered firearm, unlawful possession of ammunition, and unlawful use of a vehicle.

On appeal, Mr. Howard challenged the trial court on its finding of competent to stand trial, its failure to obtain a waiver of the insanity defense or to explore the option of imposing one upon him, and its failure to suppress the two show-up identifications by the victim and her friend.

Ruling and Reasoning

The District of Columbia Court of Appeals struck down Mr. Howard's three arguments on appeal and affirmed his convictions.

First, with regard to the trial court's finding of competent to stand trial, the appellate court argued that the four successive reports by St. Elizabeths Hospital in 2005, the testimony at the competency hearing that described Mr. Howard's muteness as volitional, the trial judge's personal observations of and interactions with Mr. Howard, and the lack of contradicting evidence all supported that the trial court's findings were not erroneous. Referring to *Phenis v. United States*, 909 A.2d 138 (D.C. 2006), and to *Clyburn v. United States*, 381 A.2d 260 (D.C. 1977), the appellate court opined that "[t]he test for determining competence to stand trial is whether the defendant has a sufficient present ability to rationally consult with his attorney and to factually understand the nature of the proceedings against him" (*Howard*, p 419).

The appellate court ruled that by not communicating with his attorney, Mr. Howard "may not have rationally consult[ed] with his attorney and thus may have been less likely to factually understand the nature of the proceedings against him. . .but the test for competency hinges solely upon whether there was a sufficient present *ability* [emphasis in original] to do so" (*Howard*, p 419). Mr. Howard had "such sufficient present ability and was thus competent" (*Howard*, p 420). Furthermore, in response to Mr. Howard's contention that the question of his muteness (whether volitional or a product of mental illness) should have been explored further, the appellate court concluded that the trial court had no such obligation to seek competency *sua sponte* without any raised issue of doubt.

Second, with regard to Mr. Howard's assertion that the trial court failed *sua sponte* to obtain a waiver of the insanity defense or explore the option of imposing one upon him, the appellate court ruled that the trial court did not err. The court referred to the landmark case of *Frendak v. United States*, 408 A.2d 364 (D.C. 1979), which held that a judge could not impose an insanity defense upon an unwilling defendant if a defendant intelligently and voluntarily wishes to forgo the defense. The *Frendak* ruling instructed trial courts to conduct a three-part inquiry whenever the defendant's mental condition is at issue. A *Frendak* inquiry examines whether a defendant who has been found competent to stand trial can intelligently and voluntarily waive the insanity defense or, if not, whether the court *sua sponte* should impose the insanity defense.

The appellate court held that the trial court did not need to conduct a *Frendak* inquiry, because the expert's report found Mr. Howard not only criminally responsible for the offense but also opined that a "causal link" between Mr. Howard's diagnosis and the crime could not be established. According to Mr. Howard's treating psychologist at St. Elizabeths, his symptoms included "mutism and nonresponsivity to environmental stimuli" and "waxy flexibility" (*Howard*, p 422) suggestive of catatonia, which he believed were not present during the carjacking. The appellate court emphasized the "reliability" of the expert's report, citing *Robinson v. United States*, 565 A.2d 964, 967 (D.C. 1989), and *Phenis*. In the latter case, the appellate court had held that the trial court had erred by not conducting a *Frendak* inquiry, as the report that the court relied on was "conclusory" and "not well-supported or documented" (*Phenis*, p 158). Finally, the burden of proving insanity is on the defendant; since the expert's report was not con-

tested, the trial court was not obligated to conduct the special inquiry.

Discussion

This case raises several questions stemming from Mr. Howard's mute condition. First, can a mute defendant be found competent to stand trial? *Dusky v. United States*, 362 U.S. 402 (1960), established the standard to test whether a defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him" (*Dusky*, p 402). While it is not difficult to imagine a case of a volitionally mute defendant who is malingering and subsequently found competent to stand trial, the expert should remember that competency is a present ability. In this case, the court seems to have arrived at a final opinion of competency, not by assessing Mr. Howard's present abilities and deficits, but by contrasting his past ability to communicate with his present mutism.

The second question focuses on the ethics-related dilemma of dual agency. The American Academy of Psychiatry and the Law (AAPL) guidelines recommend that treating psychiatrists should try to avoid conducting forensic evaluations on their own patients (Mossman D, *et al*: AAPL practice guideline for the forensic psychiatric evaluation of competence to stand trial. *J Am Acad Psychiatry Law* 35:S24–5, 2007). The conflicting duties of attending to the patient's best interests while trying to serve the legal system objectively could be problematic. The legal role would not only compromise the therapeutic relationship, but access to inculpatory information could result in a violation of confidentiality. The guideline recognizes, however, that there are situations in which dual roles cannot be avoided and offers suggestions of strategies to mitigate the conflicts. Alternatively, if issues of confidentiality and agency could be clearly delineated, one could argue that the better expert may not be an independent evaluator but the treating physician who had been successful in establishing a therapeutic alliance and enabling Mr. Howard to participate in an interview.

Finally, the case describes Mr. Howard as mute and noncommunicative, not as a result of mental disease or defect, but because he purposefully and intentionally sought to deceive the court. Three months elapsed between Dr. Sweda's report and Mr. Howard's competency hearing—certainly enough time for his clinical presentation to change, necessitating a new competency evaluation. The court does not appear to have attended to the clinical understanding that psychotic symptoms, mutism included, may fluctuate depending on treatment response and stress and that competency to stand trial is not a global, static state of mind.

Degree of Proof Necessary to Establish Proximate Causation of Suicide

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"Probability of a Possibility" of Suicide Is Insufficient to Prove a Psychiatrist's Negligence in a Malpractice Suit

In *Thompson v. Patton*, 6 So.3d 1129 (Ala. 2008), the Supreme Court of Alabama reviewed the trial court's decision to grant a motion for summary judgment in favor of the defendant in a malpractice suit alleging negligence by a psychiatrist who discharged a patient from the hospital three days before the patient's suicide. At issue was whether the testimony of the plaintiff's expert that "it was highly probable that [the patient] might do something to herself" (*Thompson*, p 1135) was sufficient to establish proximate causation between the psychiatrist's actions and the patient's death. The court decided that "the probability of a possibility" of suicide did not establish proximate causation and affirmed the trial court's decision (*Thompson*, p 1135).

Facts of the Case and Procedural History

Peggy Sue Ellis, who was 53 years of age, had been psychiatrically ill for approximately 30 years when she was admitted to Baptist Medical Center Montclair on November 11, 1999, following a suicide attempt. She was treated by Dr. Rita Patton, a psychiatrist who had also treated her during three previous hospitalizations in 1999. Ms. Ellis was placed on a