

# AIDS-Related Dementia and Competency to Stand Trial: A Potential Abuse of the Forensic Mental Health System?

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Public health officials, hospital administrators, forensic directors, jail wardens, judges, prosecutors, and defense attorneys must confront the issue: how should cases of individuals with AIDS dementia be treated when they are found to be permanently incompetent to stand trial? Although charges are sometimes dismissed in advanced cases of dementia, the more common pattern involves placement of the defendant in a public facility while awaiting trial. The refusal of some state facilities to accept these patients raises a host of legal, moral, and medical questions that virtually every urban state's forensic system will have to consider in the near future.

On two occasions in the past two years, New York state trial court judges have dismissed felony charges against defendants suffering from acquired immune deficiency syndrome dementia (AIDS dementia) with an extremely limited life expectancy, holding that, given the uncontroverted medical testimony, it would be purposeless to try, convict, and imprison the defendant.<sup>1</sup> Although these cases have received little attention, the decisions promise to herald a new chapter in criminal procedure law: the disposition of cases of defendants incom-

petent to stand trial because of AIDS dementia.

Since 1981, AIDS and related disorders have grown from an unknown phenomenon into a tragedy of epidemic proportions.<sup>2</sup> It is estimated that the human immunodeficiency virus (HIV)<sup>3</sup> has already infected more than two million people in the United States alone, 99 percent of whom will develop AIDS.<sup>4</sup> Epidemiologists have substantiated that one extremely high risk group of candidates for these diseases are intravenous (IV) drug users, predominantly those whose abuse of illegal drugs and whose consequent adoption of a criminal lifestyle make them likely candidates for the criminal justice system. As the President's Commission recently reported, "The future course of the HIV epidemic depends greatly on the effectiveness of our nation's ability to address IV drug

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The editors wish to apologize for any reference style inconsistencies; complete correction would have delayed publication.

abuse.”<sup>5</sup> It is estimated that IV drug abusers constitute 25 percent of all AIDS cases in the United States.<sup>6</sup>

Thus, it is not surprising that prisons house a disproportionate number of persons with AIDS.<sup>7</sup> By mid-1987, there were over 2,000 confirmed AIDS cases in prisons across the country, marking “the most concentrated population in any setting.”<sup>8</sup> In New York, for instance, during the years 1982 to 1987, a total of 548 inmate deaths were attributed to AIDS.<sup>9</sup> A seroprevalence study of the New York state prison system tested blood samples of 494 consecutively admitted male inmates; 17.4 percent tested positive for the HIV virus, with higher rates found for inmates from New York City (20.2%) and for Hispanic inmates (24.7%).<sup>10</sup> Among inmates who acknowledged using IV drugs, the prevalence rate was 44.1 percent.<sup>11</sup> This 17.4 percent rate would thus yield a predicted incidence of 7,830 HIV infected inmates (of a population of about 45,000).

Predictably, these problems have not limited themselves to the criminal justice system.<sup>12</sup> The public mental health system in New York, a system whose clients frequently share many demographic and socioeconomic characteristics with correctional clients, has begun to face an emerging problem of AIDS infections within state psychiatric centers as well.<sup>13</sup> From 1983 until late 1988, of a total universe of between 15,000 and 20,000 patients, 104 patients in New York state psychiatric centers had confirmed AIDS diagnoses.<sup>14</sup> Most recently, a study has revealed that one in every 17 patients institutionalized in mental

hospitals in New York City may be infected with the AIDS virus.<sup>14a</sup>

It is virtually certain that problems shared by the criminal justice and mental health systems will also be experienced by that system that links the two—the forensic mental health system.<sup>15</sup> It is therefore not surprising that Central New York Psychiatric Center, the New York facility that provides inpatient psychiatric services for transfers from the state correctional system, has already treated eight cases of individuals with AIDS, and has attributed six deaths to that disease.<sup>16</sup> In addition, a small number of nonsentenced forensic patients—individuals hospitalized either following a verdict of not guilty by reason of insanity, or pursuant to a finding of incompetency to stand trial—have also developed symptoms leading to an AIDS diagnosis.<sup>17</sup>

The harsh reality that forensic units have traditionally been viewed as “a resource of last resort”—generally hidden from public view and interest<sup>18</sup>—has had four additional AIDS-related consequences: first, they become an appealing alternative to which local jails—traditionally overcrowded and understaffed<sup>18a</sup>—can seek to transfer their most “difficult” to manage AIDS patients; second, such facilities simply lack the expertise and the resources to provide the needed care to persons with AIDS who are thus likely to receive inadequate medical treatment; third, forensic units are now forced to provide closely rationed psychiatric resources to a population whose basic needs are medical care and dignified treatment. Fi-

nally, persons with AIDS in forensic units, often located far from urban population centers, are, like all other forensic patients, subject to the general internal rules and regulations governing such units. As a result, they have lessened opportunities for visits and social contacts with friends, families and loved ones,<sup>18b</sup> a problem that is exacerbated in cases of individuals with terminal illnesses. It is this set of problems—specifically, the plight of individuals suffering from “AIDS dementia” who are institutionalized while awaiting trial on criminal charges—that is in specific need of serious consideration.<sup>19</sup>

In an effort to examine these problems, we discuss the creation of AIDS dementia as a diagnostic category (Part I), give a brief account of the procedures that are followed when there is a question as to an individual’s competency to stand trial for a criminal offense (Part II), and examine the way these procedures “play out” in cases of AIDS dementia (Part III). Finally, we will examine some of the questions raised by this analysis in an effort to set a focus on those issues to which greater attention must be paid (Part IV).<sup>20</sup>

### I. AIDS Dementia

Although new drugs such as Zidovudine (AZT) have apparently begun to extend the lives of some AIDS-afflicted individuals, and while better health care has become available to some members of this class,<sup>21</sup> there is a cruelly ironic consequence of especial significance to forensic patients with AIDS: some now live long enough to develop “AIDS de-

mentia”<sup>22</sup> as a direct consequence of the disease.<sup>23</sup> AIDS dementia, a progressive deterioration of mental function, is now considered the most common nervous system disease associated with HIV infection.<sup>24</sup> According to Dr. Richard Johnson and his colleagues:

The dementia begins with apathy, memory loss, and involvement of the motor system characterized by an increase in tone, accentuated deep tendon reflexes, and clumsiness. This syndrome progresses to a global dementia with abulia, mutism, spasticity, and incontinence. This has been described as a subcortical dementia . . . with inappropriate behavior and problems with language and perception commonly seen with disorders such as Alzheimer’s disease.<sup>25</sup>

It is estimated that, eventually, 60 to 70 percent of all AIDS patients will develop AIDS dementia,<sup>26</sup> and that the mean survival time from onset of dementia to death is only six months (although some patients remain stable for prolonged periods of time).<sup>27</sup>

Thus, if such individuals are charged with a criminal offense while already suffering from AIDS, or, if they develop AIDS while incarcerated in jail awaiting trial, it is likely that, in a significant number of such cases, there will be a judicial determination of their competency to stand trial.<sup>28</sup> As will be discussed in Part II, if it is determined that an individual is unlikely to regain this trial competency in the “foreseeable future,” the state is constitutionally compelled to either release the person or initiate customary civil commitment proceedings against him.<sup>29</sup> It is critical that the potential outcomes of such proceedings be considered: what procedures must be invoked when there is a “bona fide

doubt<sup>30</sup> as to a defendant's competency to stand trial,<sup>31</sup> and what are the constitutional, social policy and medical ramifications of such proceedings in the specific context of individuals with AIDS dementia?<sup>31a</sup>

## II. Incompetency to Stand Trial Procedures<sup>32</sup>

**Statutory Procedures** One cannot be tried for a criminal offense if a judge determines that he lacks "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"; it is not enough for the judge simply to find that "the defendant is oriented to time and place and [has] some recollection of events [.]"<sup>33</sup>

The test is generally seen as a cognitive one; among the questions asked are: does the defendant have the mental capacity to appreciate his presence in relation to time, place, and things? Next, are the defendant's elementary mental processes such that he comprehends that he is in a court of justice charged with a criminal offense; that there is a judge on the bench; that there is a prosecutor present who will try to convict him of a criminal charge; that he has a lawyer who will undertake to defend him against that charge; that he will be expected to tell to the best of his ability the facts surrounding him at the time and place where the alleged violation was committed if he chooses to testify and understands the right not to testify; that there is or may be a jury present to pass

upon evidence adduced as to guilt or innocence of such charges or, that if he should choose to enter into plea negotiations or to plead guilty, that he comprehend the consequences of any guilty plea and that he be able to knowingly, intelligently, and voluntarily waive those rights that are waived upon such entry of a guilty plea; and, that he has the ability to participate in an adequate presentation of his defense.<sup>34</sup>

If a person is *not* competent to so stand trial, he can be institutionalized in a forensic facility until a determination is made as to whether he is likely to regain his competence to stand trial in the "foreseeable future."<sup>35</sup> If regaining competency is *not* likely in the foreseeable future, then, according to the U.S. Supreme Court's 1972 decision of *Jackson v. Indiana*, the state is constitutionally required to either release that person or institute the customary civil commitment proceeding that would be required to commit any other citizen. Likewise, if it is determined that the defendant "probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal."<sup>36</sup>

In New York State, for instance,<sup>37</sup> once the court is satisfied that the person is *not* competent to stand trial, it must issue a final or temporary order of observation committing the individual to the custody of the state commissioner of mental health or retardation for care and treatment in an appropriate institution for a period not to exceed ninety days from the date of the order.<sup>38</sup>

After a judgment of incompetency, the need for continued hospitalization is

subject to ongoing judicial review, a procedure analogous to civil commitment.<sup>39</sup> If, at the conclusion of the hearing,<sup>40</sup> the court is satisfied that the defendant is competent to stand trial, the criminal action against the defendant must proceed. On the other hand, if the court is satisfied that the defendant continues to be incompetent to stand trial, or if no demand for a hearing is made, the court must adjudicate him an incapacitated person and must issue an order of retention authorizing continued custody of the defendant by the commissioner for a period not to exceed one year.<sup>41</sup> Once a defendant has been committed to the custody of the commissioner, he must be placed in an appropriate institution operated by the department of mental health or retardation.<sup>42</sup>

### *Implications of AIDS Dementia*

Given the level of deterioration of functioning in individuals with AIDS dementia,<sup>43</sup> and the likelihood that such persons develop characteristics similar to patients suffering from such global subcortical disorders as Alzheimer's disease,<sup>44</sup> it is not surprising to suggest that most of this population would fit squarely within the language of the *Jackson* decision as unable to stand trial "within the foreseeable future."<sup>45</sup> At that point, the focus shifts to the next levels of inquiry: how are the underlying cases to be disposed of, and, simply, what happens to the defendant?

To the lay public, it might seem altogether appropriate that individuals with AIDS dementia remain incarcerated—for life—in forensic facilities, since such individuals (1) are afflicted with what is

generally viewed as a pernicious and highly communicable physiological disease, that has apparent psychological side effects, and (2) have been charged with the commission of serious crime. This apparently commonsensical approach, however, is deeply flawed.<sup>46</sup> First, the treatment goals of forensic patients are determined primarily by their legal status. For patients found incompetent to stand trial, the predominant goal of treatment is to restore the person's capacity to stand trial, and not to provide long-term psychiatric care.<sup>47</sup> One cannot simply be "banished" to such an institution because society is unable to conceptualize a better placement. Any decision as to long-term placement must be based on factors beyond the simple fact that the individual has been charged with some level of criminal offense.<sup>48</sup> Second, the United States Supreme Court made crystal-clear 17 years ago in *Jackson* that the federal constitution forbids holding a pretrial detainee "more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity [i.e., competence to stand trial] in the foreseeable future."<sup>49</sup> Third, these individuals have *not* been convicted of any criminal offense,<sup>50</sup> and thus are constitutionally not subject to punishment.<sup>51</sup> Fourth, forensic units are generally not staffed with professionals suitably trained in the medical treatment of neurological disorders such as AIDS dementia. Such units are not set up to serve as long-term facilities for nonambulatory patients, a category that encompasses

many individuals with AIDS dementia.<sup>52</sup>

All participants in the system—public health officials, hospital administrators, forensic directors, jail wardens, judges, prosecutors, and defense attorneys—must thus step back and confront this issue: how should cases of individuals with AIDS dementia be treated when they are found to be permanently incompetent to stand trial?<sup>53</sup>

### III. Recent New York Developments

As discussed above, state criminal trial court judges have recently dismissed criminal charges in felony cases involving defendants with AIDS dementia “in an advanced stage, with extremely limited life expectancies, and who were ‘not likely to recover.’”<sup>54</sup> In *People v. Quinn*, the judge heard uncontroverted testimony from the defendant’s supervising physician at a private hospital that the nonambulatory, wheelchair-bound defendant “could not withstand a trial of any duration.”<sup>55</sup> The court concluded that Quinn—who had been charged with attempted murder, assault, and weapons possession—was in an “extremely incapacitated state of health” with an “extremely bleak” prognosis.<sup>56</sup>

After balancing the defendant’s interests with those of the state, the court examined the statutory criteria (discussed in Part II, above) and ordered the charges dismissed. Although the defendant had been indicted for a “very serious crime” and the state alleged that it had “ample evidence of his guilt,” in view of the defendant’s “mentally impaired condition” and of his “progressive physical

deterioration,” it concluded that the likelihood of the defendant’s ability to stand trial was “at best remote.”<sup>57</sup>

Even if he *were* tried and convicted, the court continued, there would be no penological purpose in imposing a prison sentence “when he has been sentenced to a much harsher fate and indeed almost certain death from the AIDS disease.”<sup>58</sup> The decision to dismiss the indictment “should not impact upon the confidence of the public in the criminal justice system,” the court underscored, as the defendant, in his “dire circumstances” could not be considered a community threat “since it is most unlikely that he will ever walk the streets again.”<sup>59</sup>

In *People v. Ortiz*, the court ordered weapons and narcotics charges dismissed under a separate section of the state criminal procedure act that allows for such an action when there is “any compelling reason exist[ing] to demonstrate that conviction or prosecution of a defendant would result in an injustice.”<sup>60</sup> It concluded with a (rare for a judicial opinion) epigram from Longfellow: “Mercy more becomes a magistrate than the vindictive wrath which men call justice.”<sup>61</sup>

The court’s disposition of these cases appear totally consistent with both the constitutional framework set out in *Jackson* and the procedural scheme contained in the state statute (although *Ortiz* was ultimately decided on an “interests of justice” theory rather than on substantive competency law). It must be noted, however, that *Quinn* arose in the context of a *private* hospital patient, and

that Ortiz's sister promised the court that she would provide nursing care for her brother (whose life expectancy was less than 90 days).<sup>62</sup> What *additional* issues are raised in the more common fact pattern, where the defendant is in a *public* facility awaiting trial?

In the past several months, commitment has been sought by state trial courts to the New York State Office of Mental Health (OMH) after findings of incompetence to stand trial.<sup>63</sup> the defendants' incompetence stemming primarily from AIDS dementia.<sup>64</sup> Each of the three received intensive medical care while in jail before his transfer,<sup>65</sup> and at least one had received OMH services prior to the onset of AIDS dementia.<sup>66</sup> In each case, OMH resisted acceptance of the patient; and, in the one case where transfer was actually effectuated (and the one which in which the patient is still living), it was done only after protracted negotiations as a result of which the sending city jail agreed to provide the state with the needed requisite medical backup services.<sup>67</sup> In short, no state facility in New York was willing to accept—without more—forensic referrals of patients with AIDS who were also found incompetent to stand trial.<sup>68</sup>

#### **IV. Unanswered Questions**

This refusal raises a plethora of legal and related humanitarian issues.<sup>69</sup> First, was the incompetency mechanism properly invoked in these cases?<sup>70</sup> Under *Jackson* and New York's criminal procedure law, due process requires that the nature and duration of commitment bear "some reasonable relation to the

purpose for which the individual is committed."<sup>71</sup> In each of the three cases in question, clinical opinion was unanimous: the defendants were permanently and terminally incompetent, and there was thus no "reasonable likelihood" of restoration in the "foreseeable future": under these circumstances, is a post-incompetency commitment *ever* proper?<sup>72</sup> Second, if it were not proper, to what sort of facility should the defendants be committed?<sup>73</sup> Third, do hospitals—forensic or otherwise—have a right to refuse such patients? If they do not, what sanctions, if any, are available?

Fourth, what will happen if the defendant remains committed—awaiting trial—for a period of time longer than the maximum for which he could be sentenced had he been convicted of the underlying crime?<sup>74</sup> Fifth, no matter *where* the defendant is, does he have a right to medical care?<sup>75</sup> If so, does that contemplate expensive, experimental treatments such as AZT, treatments that may not yet be available to the general community? Sixth, *if the Jackson case* is invoked, and the defendant transferred to a civil hospital, of what applicability are such doctrines as the right to treatment,<sup>76</sup> the right to refuse treatment,<sup>77</sup> the right to least restrictive alternative,<sup>78</sup> or, conversely, the "right to die"?<sup>79</sup> Although these cases have generally been litigated in New York and elsewhere on behalf of individuals suffering from mental illness<sup>80</sup> or those who are mentally retarded,<sup>81</sup> there appear to be no principled reasons why the doctrines developed in such cases should not be similarly applicable to persons with AIDS

dementia. Seventh, what impact will the presence of such patients—largely untreatable through traditional psychiatric methods—have on the treatment-responsiveness of other “regular” psychiatric patients on the wards in question?

Eighth, how will the intractable *financial* issues be sorted out? Is Medicaid funding available in such cases?<sup>82</sup> If it is, what impact does forensic placement have on the possibility of such funding? Is it permissible for these factors to influence the disposition of the case? Ninth, is AIDS dementia, simply, “different”<sup>83</sup> (because of the additional layers of stigma and the special problems associated with contagion)?<sup>84</sup> If so, and if medical care is thus seen as a more pressing need than psychiatric care (if such “psychiatric care” as it is commonly thought of is even meaningfully possible), how will the quality of that care be assessed? Then, what are the goals of care: to sustain life, to extend life, to allow for death-with-dignity,<sup>85</sup> to protect the safety of others, to provide comfort?

Finally, what will happen in the case—unlike *Quinn* or *Ortiz*—where expert testimony is not as clear or as unopposed? Courts are increasingly more loath to settle so-called “battles of the experts,” especially where the expert testimony deals with psychiatric diagnosis and/or predictions of future dangerousness.<sup>86</sup> How will they construe expert testimony in an area as volatile as the disposition of alleged criminal offenders with AIDS?

It is clear that the criminal justice system is finally becoming aware of the scope of the problem it faces. Recently,

a New York state supreme court justice has called on the state legislature to amend the Criminal Procedure Act to attempt to deal with the issues under discussion here.<sup>87</sup> In dismissing reckless endangerment against a criminal defendant (in a case characterized by the judge as the product of a “stormy gay relationship [with] apparent sado-masochistic overtones”), Justice William D. Friedmann placed the case in a social context:

Recent criminal justice system experience with AIDS infected persons should inspire considerable procedural and substantive changes in the years to come. As AIDS-infected people impact all aspects of the system, our courts and local correctional authorities must contend with these persons who are charged with crime and who are awaiting trial and/or sentence with little or no prospect of being able to participate in these procedures.<sup>88</sup>

The problems raised here are overwhelming ones, and may appear, at first blush, to be intractable and insurmountable. Whereas the goals of mental health care have been fairly clearly articulated in both statute and case law,<sup>89</sup> there has been no serious consideration—either episodic or broad-based—as to how such issues “play out” in the AIDS dementia context. Yet, they are problems with which virtually every urban state’s forensic system will have to deal in the all-too-near future. Our national AIDS policy has for too long been characterized by a “head in the sand” approach,<sup>90</sup> and the catastrophic results of that policy are now being played out. We cannot allow such an attitude of “willful blindness”<sup>91</sup> to color our treatment of individuals who face desolation and, perhaps, inev-



itable death as unwanted participants in the criminal justice system.

## Acknowledgments

The authors wish to gratefully acknowledge the helpful comments and critique of Professor Arthur Leonard and Henry Dlugacz, the invaluable research assistance of Randolph Frank Iannacone, New York Law School '90, and the comments of three anonymous reviewers. The conclusions are strictly the authors' own.

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17. See generally, *infra* note 64.
18. See Mental health and human rights: report of the Task Panel on Legal and Ethical Issues.

- 20 Ariz L Rev 49, 62 (1978) (residents of hospitals for the criminally insane unlikely to have access to any form of legal counsel); see generally, German J, Singer A: Punishing the not guilty: hospitalization of persons acquitted by reason of insanity. 29 Rutgers L Rev 1011-83 (1976).
- 18a. See Dvoskin J: Jail-based mental health services, in *Effectively Addressing the Mental Health Needs of Jail Detainees*. Edited by Steadman H. (in press) 1990.
- 18b. See *e.g.*, Johnson by Johnson v. Brelje, 701 F. 2d 1201, 1208 n.7 (7 Cir. 1983) (discussing importance of telephone access to inmates and patients who may live hundreds of miles from the site of their institutionalization).
19. *Cf* People v. Napolitano, 138 A.D. 2d 414, 525 N.Y.S. 2d 698 (1988) (fact that defendant had AIDS not, by itself, an appropriate ground for reducing plea bargained-for sentence).
20. We recognize that the listing of problems without attendant suggested responses may appear to beg the question. Because there has been practically *no* attention paid to either the narrow question that we discuss here (application of criminal incompetency determinations to individuals with AIDS dementia) or the broader transsystemic policy issues that must be addressed once the narrow question is answered (*e.g.*, application of the body of law governing the rights of the institutionalized mentally handicapped to such individuals), we feel that the raising of such questions will still serve both a social and a scholarly purpose. In a future article, we hope to address more directly some of the specific sub-issues, see *infra* text accompanying notes 69-88. It seemed to us, however, to make little sense to do this at this time until there had been *some sort* of a policy debate on these questions. We hope that this article helps to inspire this debate.
21. In addition, many individuals with AIDS have already suffered poverty and prejudice. The presence of an AIDS diagnosis frequently precipitates crises related to job loss, social stigma, and difficulties in obtaining legal and medical services. See Ellison JM, Hughes DH, White KA: An emergency psychiatry update. *Hosp Community Psychiatry* 40:250-60, 1989, and sources cited.
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26. Dintzer J: The effect of acquired immune deficiency syndrome (AIDS) on testamentary capacity. *Prob J* 8:157-82, 171, 1988, quoting Richard Johnson of The Johns Hopkins University School of Medicine, as cited in Barnes DM: AIDS-related brain damage unexplained. *Science* 232:1091-3, 1986 (60%); Johnson, McArthur, Narayan, *supra* note 24, at 2971 (67%). Compare Prockop, *supra* note 25 at 510 (incidence of AIDS-related nervous system illness underestimated).
27. Johnson, McArthur, Narayan, *supra* note 24, at 2971; McArthur, *supra* note 23
28. For a helpful survey of issues relating gener-

- ally to competency to stand trial, *see* Project: Criminal procedure. 76 Geo L J 707, 867-77 (1988). Although the subject of this article has not yet received substantial attention, scholars are beginning to examine the impact of AIDS on substantive criminal law issues, related to intent and culpability. *Compare, e.g.,* Field, Sullivan MA: AIDS and the criminal law. L Med Health Care 15:46, 1987-88, with Robinson D: AIDS and the criminal law. traditional approaches and a new statutory proposal. 14 Hofstra L Rev 91 (1985). In addition, a recent article has explored the impact of AIDS on testamentary capacity: Dintzer, *supra* note 26.
29. *See Jackson v. Indiana*, 406 U.S. 715, 738 (1972). The defendant in *Jackson* was a severely retarded deaf mute individual who was incapable of communicating by almost any means. *Id.* at 717.
30. *United States v. Hollis*, 569 F. 2d 199, 205 n. 8 (3rd Cir. 1977)
31. *See generally*, Perlin M: Mental Disability Law: Civil and Criminal, chapter 14, Charlottesville, Michie, 1989; Perlin M, Overview of rights in the criminal process, in Legal Rights of Mentally Disabled Persons. Edited by Friedman P, NYC, Practicing Law Institute 1979.
- 31a. To be sure, the same questions could theoretically apply to a defendant suffering other forms of dementia in advanced states, such as Alzheimer's. However, it is our sense that, politically and empirically, it is more critical to focus specifically on AIDS dementia cases for the purpose of this article. First, the costs of treating persons with AIDS dementia in forensic settings are extreme. Second, the stigma attached to an AIDS dementia diagnosis remains more profound than that associated with any other neurological disorder. Finally, there has been no indication that the type of issues we address here are likely to surface with any frequency in a forensic setting in cases involving patients with other forms of dementia.
32. *Jackson v. Indiana*, *supra*, served to "constitutionalize" procedures governing incompetency to stand trial determinations, *see generally*, Perlin M, *supra* note 31, §§14.15-14.16, and, to a great extent, the New York procedures described in this section follow the *Jackson* model. *See text infra* accompanying notes 37-42. The simplicity and clarity of the *Jackson* holding, *see infra* text accompanying notes 35-36, should not be read to suggest that *Jackson* has solved all of the underlying problems attendant to incompetency decisionmaking. *See infra* note 70.
33. *Dusky v. United States*, 362 U.S. 402 (1960); *see also, e.g., United States v. Holmes*, 671 F. Supp. 120, 122 (D. Conn. 1987) ("To be found competent [to stand trial] the defendant must be able 'to understand the nature and the consequences of the proceedings against him' and must be able 'to assist properly in his defense. . .'" 18 U.S.C. § 4241(d).
34. *See, e.g.,* N.J. Stat. Ann. § 2C:4-4 (West 1982); Model Penal Code §4.04 (Official Draft 1962); *see also* *People v. Valentino*, 78 Misc. 2d 678, 684, 356 N.Y.S.2d 962, 964-65 (Cty. Ct. 1974) (itemized discussion of and references for criteria used in determining competency to stand trial).
35. *Jackson*, 406 U.S. at 738
36. *Id.*
37. *See generally*, N.Y. Crim Proc Law §§730.10-730.70 (McKinney 1988) (hereinafter cited by section number); *see also* Cooper: Fitness to proceed: a brief look at some aspects of the medicolegal problem under the New York Criminal Procedure Law. Neb L Rev 52:44-68, 1972 (convenient explanation and discussion of §§730.10-730.70); *People v. Villaneuva*, 139 Misc. 2d 751, 528 N.Y.S. 2d 506 (Sup. Ct. 1988) (explaining procedures).
38. §730.40(1). The court must issue a "final" order when the accusatory instrument filed against the defendant is other than a felony complaint. *Id.* The issuance of a "final" order constitutes a bar to any further prosecution of the charge or charges contained in the accusatory instrument. §730.40(2) When the defendant is charged with a felony, the order is a "temporary" one; however, with the consent of the district attorney, a "final" order may be issued. §730.40(1). This procedure has been declared unconstitutional in *Ritter v. Surles*, 144 Misc. 2d 945, 545 N.Y.S. 2d 962 (Sup. Ct. 1988), which held that, in order for an individual whose indictment has been dismissed to be admitted to a state psychiatric hospital, he or she must meet the involuntary civil commitment standard.
39. §730.50(1)
40. The hearing is mandatory where requested by the defendant or counsel. §730.50(2).
41. *Id.* When the defendant is in the custody of the commissioner, immediately before the expiration of the period prescribed in the order of retention, the same procedure governs any application for or issuance of any subsequent order of retention except that any subsequent orders of retention must not ex-

- ceed a period of two years. §730.50(3). Additionally, the New York state system provides that the aggregate of the periods prescribed in the temporary order of observation, the first order of retention, and all subsequent orders of retention, cannot exceed two-thirds of the authorized maximum term of imprisonment for the highest class felony charged in the indictment. *Id.*
42. §730.60(1) No person so committed to the custody of the commissioner or who is afterwards continuously retained in custody, can be discharged, released on condition, or placed in any less secure facility or on any less secure facility or on any less restrictive status, unless advance written notice has been delivered by the commissioner to a series of specified individuals. This includes the district attorney, the superintendent of the state police, the sheriff of the county where the mental health facility is located, the police department where the facility is located, any person who might reasonably be expected to be the victim of any assault or any violent felony offense, which could be carried out by the committed person, and any other person the court may designate. §730.60(6) (a).
43. See sources cited *supra* notes 22–27.
44. See Johnson. MacArthur, Narayan, *supra* note 23, at 2971.
45. *Jackson*, 406 U.S. at 738
46. On the dangers of applying “ordinary common sense” (OCS) to intractable problems of constitutional criminal procedure, see Sherwin R: Dialects and dominance: a study of rhetorical fields in the law of confessions. 136 U Pa L Rev 729 (1988). On the ways that OCS “trumps” social science in judicial decisionmaking, see Woolhandler A: Rethinking the judicial reception of legislative facts. 41 Vand L Rev 111 (1988). On the ways that OCS “trumps” empiricism, science and rationality in insanity defense decisionmaking, see Perlin M: Psychodynamics and the insanity defense: ‘ordinary common sense’ and heuristic reasoning. 69 Neb L Rev (in press), 1990; Perlin M: Unpacking the myths: the symbolism of insanity defense mythology. 40 Case West Res L Rev 599–731 (1990). On the way OCS “trumps” due process in cases involving the refusal of medication by mentally disabled criminal defendants, see Perlin M: Are courts competent to decide competency questions? Stripping the facade from *United States v. Charters*. 38 U Kan L Rev 957–1001 (1990). On the way OCS “trumps” due process values in legislation and litigation involving the mentally ill homeless, see Perlin M: Competency, deinstitutionalization, and homelessness: a story of marginalization. 28 Houston L Rev (in press) (1990).
47. Dvoskin J: Administration of treatment of mentally disordered offenders. (unpublished manuscript)
48. As of the writing of this article there is only one alleged misdemeanor awaiting trial in a New York state forensic facility; all others are charged with felony offenses. See also, *Ritter, supra*.
49. *Jackson*, 406 U.S. at 738. *Jackson* is certainly facially applicable to all incompetency to stand trial cases, including those involving persons with AIDS dementia.
50. *But see* *People v. Braga*, Nos. 105066 and 126924 (Calif. Super. Ct., San Francisco Cty., Aug. 18 & 19, 1988), discussed *infra* note 65.
51. *See* *Bell v. Wolfish*, 441 U.S. 520 (1979).
52. The explosion of contemporaneous research into the course, diagnosis, and treatment of AIDS demands the type of specialization typically found in settings that exclusively treat patients with AIDS Dementia. Personal communication with Renata Wack, Dipl. Psych., Executive Director, Kirby Forensic Psychiatric Center, New York, NY (July 19, 1989).
53. The entire incompetency-to-stand-trial determination process has been subject to severe criticism in recent years (on the grounds that it frequently involves serious liberty deprivations), leading to proposals either to abolish the plea, see Burt R, Morris M: A proposal for the abolition of the incompetency plea. U Chi L Rev 40:66, 1972, or to allow for the waiver of incompetency status by defendants who wish to plead guilty, see Winick B, Restructuring competency to stand trial. 32 UCLA L Rev 921–85 (1985). But see Wexler D: Criminal Confinement and Dangerous Mental Patients: Legal Issues of Confinement, Treatment, and Release. New York, Plenum, 1976 (questioning Burt and Morris’ proposal). Both recommended modifications are discussed critically in Perlin M, *supra* note 31, at §14.18.
54. *People v. Quinn*, *supra* note 1, at 29
55. *Id.*
56. *Id.* See generally, DSM-III 290.xx (listing diagnostic criteria for dementia).
57. *People v. Quinn*, *supra* note 1, at 29
58. *Id.*
59. *Id.*
60. See *Ortiz*, *supra* note 1, at 9, discussing NY Crim Proc Law §210.40.
61. *Id.* n. 4. The roots of Longfellow’s aphorism

can be found in the Talmud. See Soncino (ed.): Berakoth [7a], at 30 (small ed.) ("What does [the Holy One] pray?—R. Zutra b. Tobi said in the name of Rab: 'May it be My will that My mercy may suppress my anger, and that My mercy may prevail over My [other] attributes, so that I may deal with My children in the attribute of mercy and, on their behalf, stop short of the limit of strict justice'"). We wish to thank Dr. Thomas Litwack for calling our attention to the Talmudic roots of this quotation, and Aron Rosenbaum for providing the accurate Talmudic citation.

62. *Ortiz*, *supra* note 1, at 9

63. Pursuant to NY Crim Proc Law §§730.10-.70

64. Patient A was admitted to a forensic psychiatric center after charges of robbery, weapons possession, and parole violation from a county jail that made no reference to his medical condition in its transmittal documents. After the forensic center accepted responsibility for the patient, it immediately transferred him to a general hospital (because the forensic facility could not provide the requisite medical care). The general hospital, in turn, transferred the patient to a second general hospital that had been designated to provide backup care for persons with AIDS. Despite the patient's nonambulatory status, the forensic hospital provided 24-hour-per-day guard service, pursuant to its custodial responsibilities under NY Crim Proc Law §730 *et seq.* The patient died within a month of his admission. Patient B was ordered committed to OMH after a determination of incompetency to stand trial on felony charges of sodomy, reckless endangerment, and endangering the welfare of a child. At the time of the incompetency finding, the patient was receiving appropriate medical treatment pursuant to a contractual agreement entered into between the city jail (in which he was first lodged following arrest) and a medical long-term care facility with specific expertise in caring for persons with AIDS. OMH refused to accept the patient, based on its inability to provide adequate medical care as well as the ability of the long-term facility in which he had been housed to provide such appropriate care. The patient died two weeks after the finding of incompetence. Like Patient B, Patient C was similarly ordered committed to OMH after an incompetency declaration in a case charging second degree murder. Unlike the cases of Patients A and B, Patient C

had a prior record of psychiatric hospitalization, and there was no dispute as to whether this was the *sole* cause of his incompetence. Although OMH initially refused to accept the patient (for reasons similar to those offered in the case of Patient B), the sending jurisdiction demanded that the post-incompetency finding transfer be effectuated. After lengthy negotiations, it was agreed that the state would accept the patient at the Forensic Psychiatric Center and that the city would provide necessary backup medical care. The patient has been so housed since October 1988 (20 months as of the date of submission of this revised article) and is still alive.

65. See *supra* note 64.

66. *Id.*

67. *Id.*

68. *Compare* Ass'n of the Bar of the City of NY: AIDS and the criminal justice system: A final report and recommendations. 236, 1989 (recommending, at a minimum, the establishment of formal liaisons and cooperative agreements among all institutions engaging in providing medical and psychiatric care to those in custody).

69. Beyond the scope of this article is the related question of the use of AIDS dementia as a mitigating factor to lower a first degree murder charge to second degree murder. See First AIDS dementia defense helps acquit murder defendant. AIDS Policy and Law (Sept. 21, 1988) 5, discussing *People v. Braga*, *supra* note 50. On the difference in mental states in homicide generally. see LaFave WR<sup>1</sup>: Modern Criminal Law (ed 2). St. Paul, MN, West, 1988.

70. Notwithstanding the clear direction of *Jackson*, it is now clear that it is *not* a palliative for all problems that arise in this area. See M. Perlin *supra* note 31, §14.16 at 251-52 (discussing problems caused by Supreme Court's failure to specify limits of "reasonable period" of time during which charges could be left open, and concomitant problems of over-lengthy hospitalizations); see generally, Winick B, *supra* note 53, at 941-42; Gobert J: Competency to stand trial: a pre- and post-*Jackson* analysis. 40 Tenn L Rev 659-88 (1973).

71. *Jackson*, 406 U.S. at 738

72. In an ordinary case of a patient *not* likely to be restored to trial within such a time, the patient must be released or civilly committed. *Jackson*, 406 U.S. at 738. In cases where the defendant's dementia appears to be transitory or in the event of the discovery of

- emerging treatments that would significantly prolong the life expectancy of a person with AIDS, it might be entirely appropriate to hospitalize such an individual pending either restoration to competency or a determination that competency was not restorable within the foreseeable future, in accordance with the mandates of *Jackson*.
73. Because state statute requires OMH to maintain custody of such patients and to produce them for trial upon restoration of competency, see §730.40, it is the internal policy of OMH to place all individuals being held for trial in a secure, forensic facility, notwithstanding the fact that there is no explicit statutory bar in New York prohibiting civil hospitals from accepting IST patients.
  74. Notwithstanding *Jackson*, about half of all jurisdictions still statutorily permit indefinite hospitalization based solely on a finding of continuing incompetency to stand trial. Winick, *supra* note 53, at 704; see also, M. Perlin, *supra* note 31, at §14.16. Subsequent to *Jackson*, the New York system permits incompetent felony defendants to be hospitalized for two-thirds the maximum sentence for the offense charged. §730.50(3); *Brown v. Warden, Great Meadow Correctional Facility*, 683 F.2d 348, 353 & n.3 (2d Cir. 1982); see also Choper JH: The Supreme Court and individual rights. 83 Mich L Rev 1-222 (1984) (discussion of pre- and post-*Jackson* cases involving commitment of the mentally ill in, context of competency to stand trial and continued involuntary institutionalization). Nonetheless, at least one commentator has questioned the constitutionality of New York's current comprehensive statutory scheme for disposing of the "incapacitated accused." Lewin T: Criminal law procedure. 24 Syracuse L Rev 75, 77 (1973) ("On the surface it appears that New York's new procedures pertaining to incapacitated persons charged with committing *misdemeanors* are in compliance with *Jackson*, for this class of accused has had its charges dismissed and is treated as civil patients. Accused felons, however, are a different matter") (footnote omitted). Generally, if the defendant becomes competent to stand trial after being detained for a period of time in a mental facility, New York decisions have held confinement to a state facility must be credited against a later sentence of imprisonment if the formerly incompetent defendant is subsequently found guilty. *Negro v. Dickens*, 22 A.D.2d 406, 413-14, 255 N.Y.S.2d 804, 810-11 (1965); *People v. Pugh*, 51 A.D.2d 1407, 1408, 381 N.Y.S.2d 417, 418 (1976) (eight years of confinement in Matteawan State Hospital, after judicial determination that a defendant convicted of second degree burglary and petit larceny who subsequently became mentally ill while incarcerated and awaiting sentencing and therefore lacked the mental capacity to be sentenced, credited as "jail time" upon his certification as a sane person, capable of being sentenced). Moreover, the prevailing view in most jurisdictions is the abolishment of the enumeration of different types of incarceration and their merger into a single concept of "jail time", including time spent in "custody," no matter where the time was spent. *Id.* at 418; see, e.g., *State v. Johnson*, 167 N.W.2d 696, 701-02 (Iowa 1969); *In re Bennett*, 71 Cal. 2d 117, 119, 454 P.2d 33, 35, 77 Cal. Rptr. 457, 459 (1969); *In re Stearns*, 343 Mass. 53, 55, 175 N.E.2d 470, 472 (1961); *Ex parte Wright*, 31 Wash. 2d 905, 908, 200 P.2d 478, 481 (1948).
  75. Compare *People ex rel. Kaganovitch v. Wilkins*, 23 A.D.2d 178, 259 N.Y.S.2d 462 (1965) (failure to provide treatment is cruel and unusual punishment for sex offender who was sentenced to indeterminate sentence from one day to life following guilty plea to second-degree assault with intent to commit sodomy); see also NY Correct Law §70(2) (b)-(c) (McKinney 1988) (directing that correctional facilities may establish and maintain any type of program of treatment, not inconsistent with other provisions of law, but with due regard to the health, safety and right of every person in the custody of the department of corrections to receive humane treatment).
  76. See, e.g., *People v. Darry P.*, 96 Misc. 2d 12, 26-31, 408 N.Y.S.2d 880, 889-92 (Crim. Ct. 1978) (indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be cruel and unusual punishment). On the general question, see Albert N: A right to treatment for AIDS patients? 92 Dick L Rev 743-76 (1988). Spece R: AIDS: due process, equal protection, and the right to treatment. *Issues in Law Med* 4:283-344, 1988.
  77. *Rivers v. Katz*, 67 N.Y.2d 485, 498, 495 N.E.2d 337, 344, 504 N.Y.S.2d 74, 81 (1986) ("neither mental illness nor institutionalization *per se* can stand as a justification for overriding an individual's fundamental right to refuse [treatment] . . . Rather, due process

- requires that a court balance the individual's liberty interest against the State's asserted compelling need on the facts of each case to determine whether . . . [treatment] may be forcibly administered."'). *Rivers* is discussed extensively in Perlin M: State constitutions and statutes as sources of rights for the mentally disabled: the last frontier? 20 Loy LA L Rev 1249-327 (1987), and M. Perlin, *supra* note 31, at §5.45 *Compare* Washington v. Harper, 110 S. Ct. 1028 (1990) (limiting right to refuse treatment in cases involving convicted prisoners).
78. See, e.g., *Rivers*, 504 N.Y.S.2d at 81 (proposed involuntary treatment must be "narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment, and any less intrusive alternative means. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria."').
79. N.Y. Pub. Health L. §§2504, 2805-d (McKinney 1988) (statutory right to control course of treatment); N.Y. Civ. Prac. L. & R. §4401-a (McKinney 1988) (same); *In re Storar*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70-71, 438 N.Y.S.2d 266, 272-73 (1981) (the right to refuse treatment is fully embraced in the common-law right to self determination); see also, Cantor N: A patient's decision to decline life-saving medical treatment: bodily integrity versus the preservation of life. 26 Rutgers L Rev 228-264, 236-38 (1973). But cf. *Von Holden v. Chapman*, 87 A.D.2d 66, 70, 450 N.Y.S.2d 623, 626 (1982) (state may prohibit individuals from engaging in specified activities which are inherently hazardous to their lives, e.g., "hunger strikes"). See generally, M. Perlin, *supra* note 31, chapter 18.
80. See e.g., *Rivers*, 504 N.Y.S. 2d at 77 (class consisted of involuntarily committed mental patients) (right to refuse).
81. *NY State Ass'n for Retarded Children v. Rockefeller*, 357 F. Supp. 752, 755, 768-70 (E.D.N.Y. 1973) (class consisted of residents of state institution for the mentally retarded) (right to habilitation).
82. Because incarcerated persons are ineligible for Medicaid, see 42 U.S.C. §1396d; 42 C.F.R. §435.1009, the administrative transfer of persons with AIDS to other health care facilities might enable these individuals to become eligible for Medicaid financial assistance.
83. On the ways in which AIDS dementia is, for purposes of testamentary capacity assessment, like other neurological disorders, see Dintzer, *supra* note 26, at 168-70 (discussing cases involving testators with epilepsy and Parkinson's Disease).
84. See Dintzer, *supra* note 26, at 175 n. 116, citing Morin SF, Charles KA, Malyon AK: The psychological impact of AIDS on gay men. *Am Psychologist* 39:1288-93, 1984 (additional psychosocial stress caused by social ostracism). Compare Messitte P: AIDS: a judicial perspective. *Judicature* 72: 205, 206, 1988 ("judges do not face something so very new and different in the AIDS phenomenon" (emphasis added) (author of article is a state court trial judge)).
85. Compare *supra* note 79.
86. Compare *Barefoot v. Estelle*, 463 U.S. 880 (1983), to *id.* at 916 (Blackmun, J., dissenting). See generally, Perlin M: The Supreme Court, the mentally disabled criminal defendant, and symbolic values: random decisions, hidden rationales, or doctrinal abyss? 29 Ariz L Rev 1-98 (1987). On the question of the strategic and tactical issues to be confronted in the representation of persons with AIDS from a client needs perspective, see Rivera: Lawyers, clients, and AIDS: some notes from the trenches. 49 Ohio St L J 883-928 (1989).
87. See Anderson: Judge asks new criteria for AIDS cases. *NY L J*, Jan. 31: 1, 1989.
88. *People v. Hammond*, Misc. 2d N.Y.S. 2d (Sup. Ct., Jan. 31, 1989); reprinted in *NY L J* 1989. 26, Jan. 31: Specifically, Justice Friedmann urged the legislature to amend Article 730 to mandate physical as well as mental examinations for Article 730 to mandate physical as well as mental examinations for defendants with AIDS symptomatology. *Id.*
89. See, e.g., *Vinokur v. Balzarette*, 62 A.D. 2d 990, 403 N.Y.S. 2d 316 (1978) (state public policy is one of "rigorous protection" of the rights of the mentally disabled); see also, *NY Mental Hygiene L §33.02 to .03* (McKinney 1988) (notice of rights of the mentally disabled; quality of care and treatment).
90. See, e.g., Shilts R: *And The Band Played On*. New York, Penguin, 1987.
91. See, e.g., *Griffin v. Illinois*, 351 U.S. 12, 23 (1956) ("This Court would have to be willfully blind not to know that there have in the past been prejudicial trial errors which called for the reversal of convictions of indigent defendants . . .") (emphasis added).