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Mental Illness and Danger to Self

BY CYNTHIA V. WARD*

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The old way involves accepting a set of assumptions that are without factual basis Foremost on the list is the assumption that commitment for mental illness is a medical problem, not a legal problem. Therefore, since psychiatrists are the experts, their conclusions can be accepted without question. This fallacious assumption must be dispelled.

Judge P. Charles Jones¹

Michael is a single man in his forties. Sometimes Michael drinks too much alcohol and his alcohol consumption has landed him in a hospital detox unit twice before. During his third stay in detox Michael's family petitions the local district court to force him into a 30-day residential treatment program that takes place on the grounds of a local prison. Under order by the court, police bring Michael to the courthouse and place him in a holding cell while he awaits a hearing on his family's petition. At the hearing Michael is represented by an attorney. After four days in detox Michael is completely sober, and no one contends that he is unable to think clearly; that he has committed or is suspected of having committed a crime; or that he poses any sort of danger to other people. Michael tells the court that he opposes the commitment petition; that he does not want to be hospitalized; and that the hospital has provided him with the names and phone numbers of a substance-abuse counselor and a local contact from Alcoholics Anonymous if he wants help in controlling his alcohol consumption. Michael asks the court to release him so that he can go home. The judge calls the court psychologist to the stand and asks whether, under the terms of the state's involuntary commitment statute, Michael is an "alcoholic" whose use of alcohol is likely to cause "serious harm." She answers in the affirmative, whereupon the judge orders Michael to be committed for 30 days against his will. The police place Michael in handcuffs and take him away. Next case.

1. Thomas K. Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503, 503 (1976) (quoting Dane County, Wisconsin Judge Jones).

This is not merely a hypothetical. In a number of states, a person can be committed to a psychiatric facility against his will on grounds of “danger” or “risk of harm” to self as evidenced purely by the person’s consumption of alcohol or other intoxicating drugs, and the risk that continuing to ingest such substances will cause harm to the person, whether intended or not.² And the example raises a large and fundamental question for the law: When may a court force someone into psychiatric treatment against her will, based purely on the judgment—with which the patient herself expressly and coherently disagrees—that she needs

2. See, e.g., MASS. GEN. LAWS ch. 123, § 35 (2013) (defining “alcoholic” as “a person who chronically or habitually consumes alcoholic beverages to the extent that (1) such use substantially injures his health or substantially interferes with his social or economic functioning; or (2) he has lost the power of self-control over the use of such beverages”). The statute provides:

Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe is an alcoholic or substance abuse In the event of the person’s failure to appear [at a court-ordered hearing in response to the petition], the court may issue a warrant for the person’s arrest If after a hearing and based upon competent testimony, which shall include, but not be limited to, medical testimony, the court finds that such person is an alcoholic . . . and there is a likelihood of serious harm as a result of the person’s alcoholism . . . the court may order such person to be committed for a period not to exceed ninety days [with intermittent reviews by the state health department at thirty, forty-five, sixty, and seventy-five days] The person may be committed to the Massachusetts correctional institution at Bridgewater, if a male, or at Framingham, if a female, if there are not suitable facilities available under said chapter 111B; provided, however, that the person so committed shall be housed and treated separately from convicted criminals.

Id. See also COLO. REV. STAT. ANN. § 27-81-102, 112 (West 2013) (defining “alcoholic” as a person who habitually lacks self-control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered or his or her social or economic function is substantially disrupted; providing for the involuntary commitment of alcoholics who have threatened harm to themselves or others, or are “incapacitated by alcohol.”).

care? The laws of involuntary commitment typically specify that courts may do this when the person is “mentally ill” and poses a “danger” or “risk of harm” to self or others. But if “mental illness” can be defined as the voluntary consumption of intoxicating substances, and “danger” as risk of harm to the patient’s own health, what boundaries constrain the law’s power to force resisting individuals into treatment?

Compassion may argue that mental illness should be treated. But for the law, compassion alone cannot dictate the answer. There *is* a Law of Compassion, which finds powerful expression in our positive law, establishing public programs that assist needy families, the unemployed, the elderly, the mentally ill. Such voluntary programs pose no threat to beneficiaries’ fundamental rights and freedoms. But when the law is asked, on grounds of compassion, to forcibly incarcerate a human being who poses no danger to others and has committed no crime, that is another matter entirely. In that situation the law’s first job is to act not as an agent of compassion but as an agent of respect for the individual. When it comes to involuntary commitment of the mentally ill, the law’s unique and vital role is to guard the rights of the person whose freedom is at stake. In our national conversation about mental illness and involuntary commitment, we have forgotten this fact. We must remember it again. When presented with a petition that would force an innocent person into psychiatric treatment against her will, the law’s presumptive role is to defend the perspective and the preferences of that person against society’s contrary preferences, including the contrary preferences of those who would offer treatment that the person does not want and has clearly said that she does not want.

In this context the law’s job is very different— from and is sometimes in conflict with—the treatment imperative which dominates the mental health profession. That is worrisome, but may be necessary. In guarding the rights of the mentally ill, as in guarding the rights of all persons, the law must ask its own questions, enforce its own standards, and stand its ground against unjustified (although often well-intentioned) efforts that deprive innocent persons of basic freedoms.

When a court forces an unwilling person into psychiatric treatment, the law deprives that person of two very important rights—the right to refuse medical treatment and (in the case of involuntary hospitalization) the right to liberty itself. In cases

where a psychologically disturbed respondent is believed to pose a serious danger to others, the state clearly has a legitimate interest in confining the respondent, and most discussion concerns the issue of dangerousness—how it is defined; how accurately it can be determined; how vulnerable it may be to bias or mistake.³ In cases involving risk of self-harm but not harm to others, the law more openly wrestles with the values of autonomy and respect for individual rights. Should we allow courts to commit a person involuntarily on the ground that he poses a serious risk of harm, not to others but to *himself*? If so, under what conditions is this permissible against the conceptual backdrop of the person's presumptive rights to refuse treatment and to retain personal liberty?

Psychiatry and Law have different perspectives, and inherently different roles, with respect to this issue. The contemporary standard for involuntary commitment—requiring both a “mental illness” and “danger to self”—attempts to marry those roles but has succeeded only in confusing the courts, too often causing them to convert what is fundamentally a legal question about legitimate grounds for overruling individual rights into a psychiatric question about the need for treatment. Reform efforts over the last three decades have not changed this reality. Indeed, today the loudest voices on the issue hail from the mental health profession, arguing that existing legal constraints on involuntary commitment are too stringent and that legal barriers should be dismantled so that more patients deemed mentally ill will be forcibly treated.⁴ This Article opposes that stance. The standard for involuntary commitment on grounds of danger to self should be articulated in non-medical terms and should be adjudicated as a purely legal matter. In making the case for that position, I hope to illuminate a core tension between law and psychiatry.

3. See *infra* p.7 and notes 15–16.

4. For example, see *Eliminating the Barriers to the Treatment of Mental Illness*, TREATMENT ADVOC. CTR., available at www.treatmentadvocacycenter.org (2011) [hereinafter *Eliminating the Barriers*], summarizing the content and the history of this argument.

I. RIGHTS V. TREATMENT: A CONFLICT BETWEEN LAW AND
PSYCHOLOGY

For most of U.S. history, the standard for involuntary commitment required only that mental health professionals certify the person was “mentally ill” and “in need of treatment.”⁵ That changed during the 1970s, when advocates for the mentally ill successfully championed a new standard which required both a *psychiatric* finding of “mental illness” and a *legal* finding of “danger to self or others” in order to hospitalize or treat a person against her will.⁶ Grounded in both the Due Process revolution which had significantly expanded the rights of criminal defendants,⁷ and the Civil Rights movement which had

5. See, e.g., Eric Turkheimer & Charles D. Parry, *Why the Gap? Practice and Policy in Civil Commitment Hearings*, 47 AM. PSYCHOLOGIST 646, 646 (1992) [hereinafter Turkheimer & Parry, *Why the Gap?*].

Until the late 1960s most state commitment processes were medical rather than judicial. Under the State’s *parens patriae* powers, physicians had the authority to confine and treat the mentally ill. The most common form of commitment was the two-physician certificate, whereby patients could be hospitalized on the statement of two physicians, without advice of counsel, a hearing, or any recourse other than a writ of habeas corpus.

Id.

6. In addition to this change in the substantive standard for involuntary commitment, a number of procedural changes were built into the standard during this period. See, e.g., *id.* at 646.

The civil commitment reforms were both procedural and substantive. Procedurally, most states mandated due process safeguards, including prior notice, authority for judicial officials over clinicians, legal counsel, the right to call and confront witnesses, more rigorous standards of proof, LRAs, limited commitment periods, right to appeal, and regular court review. Substantively, the standards for involuntary commitment were changed from simple requirements for mental illness and need for treatment to legal standards of dangerousness to self or others and, in some states, grave disability or inability to care for self.”)

Id. (citations omitted).

7. See, e.g., *In re Gault*, 387 U.S. 1 (1967) (holding that delinquency proceedings involving juvenile defendants must comply with procedural Due Process requirements under the Fourteenth Amendment of the Constitution).

successfully fought for legislation outlawing discrimination,⁸ the new standard for involuntary commitment was designed to give courts an independent role in the commitment decision, a role which would honor the patient's presumptive right to refuse medical treatment.⁹ Under the dangerousness element, judges were to be the guardians of individual liberty, allowing forcible commitment only under circumstances in which a mentally ill respondent posed a clear and immediate risk of harm.¹⁰

In a series of cases during the Seventies, both state and federal courts argued for the addition of a "dangerousness" prong to the traditional "need for treatment" standard. Many saw the traditional standard as too vague, overly biased toward medical (as opposed to rights-based) values, and discriminatory toward the mentally ill.¹¹ California took the lead on the legislative front, passing the Lanterman-Petris-Short (LPS) Act in 1967. The LPS

8. See, e.g., Stephen M. Crow et al., *Who is at Greatest Risk of Work-Related Discrimination – Women, Blacks, or Homosexuals?*, 11 EMP. RESP. & RTS. J. 15 (1998) (discussing civil rights paradigm as basis for expanding rights of women, gays, and lesbians). See generally Paul S. Miller, *Disability Civil Rights & a New Paradigm for the Twenty-First Century: The Expansion of Civil Rights Beyond Race, Gender, and Age*, 1 U. PA. J. LAB. & EMP. L. 512 (1998).

9. See, e.g., VA Hiday & SJ Markell, *Components of Dangerousness: Legal Standards in Civil Commitment*, 3 INT'L J. OF LAW & PSYCHIATRY 405, 405 (1980) [hereinafter Hiday & Markell, *Components of Dangerousness*] ("Dangerousness seemed to provide a legally enforceable test that would with one stroke protect the public's safety and limit involuntary hospitalization to those who truly required confinement, while simultaneously allowing the non-dangerous mentally ill to be treated in the community"); VA Hiday, *Court Decisions in Civil Commitment: Independence or Deference?*, 4 INT'L J. L. & PSYCHIATRY 159, 160 (1981) ("[B]y specifying due process rights and requiring court hearings the new legislation is moving to check perfunctory or no court review. Essentially it is declaring that medical opinion alone is not enough to confine a person to a mental hospital; and thus, it is defining the role of the court to be independent of psychiatry. The court may accept medical recommendation[s]; but to achieve the desired independence from psychiatric expertise, the court must refuse to accept psychiatric conclusory statements without supporting facts").

10. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1087 (E.D. Wis. 1972) ("[U]nless constitutionally prescribed procedural due process requirements for involuntary civil commitment are met, no person should be subjected to 'treatment' against his will").

11. See, e.g., *id.* at 1086–104.

Act, which took full effect in 1972, required a finding of dangerousness specified as either (1) danger to others; (2) danger to self; or (3) grave disability (which the California courts defined as a form of “danger to self.”).¹² Other states followed suit, and by 1978 all but two states had built “dangerousness” into their standards for involuntary commitment.¹³

During the 1970s and 1980s, a sizeable literature in psychology analyzed the dangerousness-based standard in general, and its “danger to others” prong in particular. Abolitionists, some of whom had favored the reforms on grounds that they would restrict the power of the state to commit unwilling people for treatment, continued to fight for the abolishment or near-abolishment of such forced hospitalizations.¹⁴ Within the mental health profession, the new standard remained controversial among some psychologists and psychiatrists who worried that it prevented the mental-health system from helping patients who desperately needed (but sometimes opposed) hospitalization and treatment.¹⁵

12. See, e.g., SP Segal et al., *Civil Commitment in the Psychiatric Emergency Room*, 45 ARCH GEN. PSYCHIATRY 753 (1988); *Doe v. Gallinot*, 486 F. Supp. 983 (S.D. Cal. 1979), *aff'd* 657 F.2d 1017, (9th Cir. 1981) (grave disability element “implicitly requires a finding of harm to self”).

13. See, e.g., Hiday & Markell, *Components of Dangerousness*, *supra* note 9.

14. See generally RALPH SLOVENKO, *LAW IN PSYCHIATRY/ PSYCHIATRY IN LAW*, 433 (2009); BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW* (1972); *American Association for the Abolition of Involuntary Mental Hospitalization*, 127 AM. J. PSYCHIATRY 1698 (1971) (Letter to the Editor by AAAIMH founder Thomas Szasz); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982) [hereinafter Morse, *A Preference for Liberty*].

15. E.g., Paul Chodoff, *The Case of Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976); Pauline Rabin & David Folks, *Dangerousness as the Criterion for Involuntary Hospitalization: A Time to Reassess*, 246 J. AM. MED. ASS'N 990 (1981); Donald A. Treffert, *Dying With Their Rights On*, 2 PRISM 49, 49–52 (1974). As I explore *infra* Part II.C., this view has acquired considerable momentum in the wake of deinstitutionalization. For more contemporary iterations, see, e.g., PS Appelbaum, *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment*, 25 J. AM. ACAD. PSYCHIATRY L. 135 (1997); *Minds on the Edge: Facing Mental Illness: Fred Friendly Seminars*, Columbia University, New York (PBS television broadcast Oct. 2009) [hereinafter *Minds on the Edge*]. See also

Scholars analyzed various problems with implementing the new standard—for example, the difficulty of deciding which *kinds* of harm justified involuntary commitment; the difficulty of deciding what *degree* of risk justified forcibly committing someone against his will; and, the difficulty of assessing the *actual* risk that any particular respondent will inflict harm, particularly where the respondent had never in fact committed a violent harm and the fear was simply that he or she *might* do so in the future.¹⁶

Oddly, almost none of the discussion has specifically focused on the “danger to self” aspect of the modern test. Almost all states allow forcible commitment of a person on grounds of “danger” or “risk of harm” to self; yet most literature on the subject treats “danger to self or others” as a single concept and argues its virtues and vices in that manner.¹⁷

That is a mistake. Although there is sometimes significant overlap, the concept of “danger to self” is importantly different from that of “danger to others.” Even allowing for all the problems associated with forcibly confining someone on grounds of danger

Eliminating the Barriers, *supra* note 4, for a prominent voice in favor of involuntary commitment based on need for treatment (often referred to as “grave disability”) alone.

16. See, e.g., Morse, *A Preference for Liberty*, *supra* note 14; Edward P. Mulvey & Charles W. Lidz, *Back to Basics: A Critical Analysis of Dangerousness Research in a New Legal Environment*, 9 L. & HUM. BEHAV. 209 (1985); J. C. Phelan & B.G. Link, *The Growing Belief That People With Mental Illnesses Are Violent: The Role of the Dangerousness Criterion for Civil Commitment*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY, S7 (1998); SP Segal et al., *Civil Commitment in the Psychiatric Emergency Room: The Assessment of Dangerousness by Emergency Room Clinicians*, 45 ARCHIVES GEN. PSYCHIATRY 748 (1988); SA Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOL. 224 (1978); Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, 11 L. & SOC’Y REV. 629 (1976).

17. A partial, but notable, exception is Alan M. Dershowitz, *Psychiatry in the Legal Process: “A Knife That Cuts Both Ways,”* 51 JUDICATURE 370 (1967). Although Dershowitz’s main point is that the insanity and commitment standards should be purely legal and not medicalized, he does raise the libertarian argument (a la John Stuart Mill) as to involuntary commitment on grounds of “danger to self,” and he explores some interesting hypotheticals which are meant to test out the premises of that standard.

to others,¹⁸ few doubt that preventing foreseeable violence inflicted upon innocent others is a legitimate concern of the state. Not so when the question is whether the state should be able to force treatment on someone in order to prevent him from inflicting harm on *himself*. As to that question, our intuitions are more libertarian:¹⁹ At least presumptively, the state should refuse to interfere with the clearly expressed preferences of adult persons (e.g., the preference not to receive psychiatric treatment) even if the state disagrees with the wisdom of those preferences.

Should the law of involuntary commitment instantiate the libertarian view? Two extremes define the spectrum of answers to this question. At one end are Abolitionists, according to whom involuntary civil commitment is always wrong no matter what the circumstances. Abolitionists argue that no justification exists for treating mentally ill persons differently from any others—that forcing such persons to undergo treatment or incarceration against their will is not justified unless and until they have committed a crime.²⁰ We do not permit the state to engage in preventive detention of non-mentally ill persons simply on the grounds that they may be dangerous. Suicide (for example) is not a crime. Thus, to authorize civil preventive detention of those deemed mentally ill and a “danger to self” is to invidiously discriminate against the mentally ill.²¹

18. See sources cited *supra* notes 15–16.

19. In the sense that we incline more toward the view of John Stuart Mill in this famous passage from *On Liberty*:

The only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because . . . to do so would be wise or even right . . .

J.S. MILL, ON LIBERTY 68 (Penguin Books 1974).

20. See, e.g., Chodoff, *supra* note 15 (describing, though not favoring, the abolitionist position).

21. See, e.g., *id.*; see also ENNIS, *supra* note 14; Morse, *A Preference for Liberty*, *supra* note 14; Jacob Sullum, *The Legal and Moral Problems of Involuntary Commitment, Mental Health and the Law*, CATO UNBOUND, Aug. 24, 2012, <http://www.cato-unbound.org/2012/08/24/Jacob-sullum/legal-moral-problems-involuntary-commitment>; Jeffrey Schaler, *Strategies of Psychiatric*

At the other extreme are Paternalists, who argue that courts should be able to forcibly commit a person if and when mental health professionals determine that the person is in serious need of treatment. Such treatment, presumptively at least, would continue until the experts determine that the patient no longer needs it. Paternalists argue that the contemporary rights-based standard of involuntary commitment denies treatment to desperately needy persons for whom a period of enforced hospitalization might significantly improve, or even save, their lives.²² For such pro-treatment advocates, the refusal to hospitalize (or force outpatient treatment upon) mentally ill patients who cannot responsibly care for themselves is cruel and inhumane, and a legal standard which makes it difficult or impossible to force such treatment has created a society in which mentally ill people are “dying with their rights on.”²³

Some understanding of history will be helpful here. Part II of this essay traces the victory of the rights-based standard for involuntary commitment, and also the push-back from Pro-Treatment forces. Part III engages the bedrock conceptual issues presented by involuntary civil commitment in cases of “danger to self”, using two paradigmatic cases of foreseeable self-harm to examine the justifications for forcing persons into psychiatric treatment. Part III more closely engages the core concepts of “mental illness” and “danger to self”—the medical and the legal prongs of the test for involuntary commitment—and forces an examination of each prong separately and of the test as a whole. Like other legal tests (such as the tests for insanity) which attempt to marry law and psychology, the test for involuntary civil commitment highlights an important and recurring conflict between the law’s focus on individual rights and psychiatry’s focus on treating illness. I argue that where state coercion on grounds of danger to self is the core issue, the involuntary commitment

Coercion, Mental Health and the Law, CATO UNBOUND, Aug. 6, 2012, <http://www.cato-unbound.org/2012/08/06/jeffrey-schaler/strategies-psychiatric-coercion>.

22. See, e.g., sources *supra* note 15.

23. Treffert, *Dying With Their Rights On*, *supra* note 15; *Minds on the Edge*, *supra* note 15.

decision should be wholly grounded in legal, and not medical, principles.

II. LAW, PSYCHOLOGY, AND INVOLUNTARY COMMITMENT: SOME HISTORICAL BACKGROUND

Less than a decade after the nationwide adoption of the “mentally ill and dangerous” standard for involuntary commitment, scholars and commentators identified a troublesome “gap” between the letter and spirit of the new commitment laws.²⁴ One author summed up the issue as follows:

The failure of civil commitment procedures to meet statutory requirements is one of the more reliable findings in the applied social sciences. Most states now require specific legal procedures and behavioral standards for involuntary hospitalization. Nonetheless, empirical studies have demonstrated that commitment hearings are rarely adversarial and clinical concerns continue to take precedence over legal issues.²⁵

Thus, while reformers had envisioned a system in which attorneys for patients adopted an adversarial role in zealous defense of their clients’ interests and courts operated as independent guardians of patients’ rights, the reality was that attorneys often failed to adopt an adversary role; judges frequently failed to make respondents’ rights known to them in court; and, in direct contradiction to the role assigned them by statute, judges continued to defer to the recommendations of mental health experts on *both* the questions of “mental illness” and “dangerousness” required to commit respondents against their will.²⁶ And while reformers had predicted that the dangerousness-based standard would shrink the

24. See, e.g., Roger Peters et al., *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 L. & HUM. BEHAV. 73 (1987); Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, *supra* note 16.

25. Turkheimer & Parry, *supra* note 5, at 646.

26. *Id.* at 647.

number of involuntary commitments because it would offer greater respect and protection to a respondent's wish not to be treated, empirical research revealed that the new and supposedly stricter commitment statutes were having little if any effect on the rate of involuntary commitments across the country.²⁷ It seemed that the rights-based vision had succeeded in changing the language of state statutes but had failed to change the law on the ground, in court, where the fate of patients and commitment petitions was being decided under the supposedly new standard.

Why? What explains the emergence of a gap between the standards set out in commitment statutes and the courts' apparent failure to comply with those standards when faced with actual petitions for involuntary commitment? This Part re-examines the historical evolution of the dangerousness standard for involuntary commitment, looking for possible answers to these questions. I focus on three key participants in the legal and political debate which drove the passage of dangerousness-based statutes – (1) the anti-psychiatry movement, including lawyers and advocates for the rights of mentally ill people; ex-patients whose skepticism about psychiatry and psychiatric treatments fueled the abolitionist belief that involuntary civil commitment should simply not exist; and a relatively small number of renegade psychiatrists, the most prominent of whom was Thomas Szasz; (2) lawyers who viewed the old, “need for treatment” commitment procedures as a violation of patients' rights and sought to deploy the Due Process model of *In Re Gault* in order to change those procedures; and (3) the mainstream community of psychologists, psychiatrists, and other mental health professionals, many of whom opposed the incursion of procedural and substantive due process into involuntary commitment procedures on the ground that such procedures were bad for patients. On the surface, the nationwide move to a dangerousness-based commitment standard seemed to be a dramatic victory for the law and for the lawyer-driven fight to erase stigma and discrimination against the mentally ill. But beneath that surface

27. *Id.* See also James W. Luckey & John J. Berman, *Effects of a New Commitment Law on Involuntary Admissions and Service Utilization Patterns*, 3 L. & HUM. BEHAV. 149 (1979); J. Monahan et al., *Stone-Roth Model of Civil Commitment and the California Dangerousness Standard*, 39 ARCHIVES GEN. PSYCHIATRY 1267 (1982).

the debate between the rights-based dangerousness standard and the medical “need for treatment” standard played out in quite a different way.

A. Anti-Psychiatry Meets the Due Process Revolution

The anti-psychiatry movement took root in the widespread social and political unrest of the 1960s and 70s. Amid deepening skepticism and mistrust of social, religious, governmental, and military institutions, critics from both left and right depicted psychiatry – particularly its power to define mental illness and to justify and set in motion state coercion against those deemed mentally ill – as a tool of the oppressor state, a means of routing the different, the defiant, and the dissident into mental hospitals.²⁸ The voice linking psychiatry and justice was always implicit in this critique, but that voice became an open battle cry when four young lawyers – Bruce Ennis, Charles Halpern, Paul Friedman, and Margaret Ewing – formed the Mental Health Law Project (MHLP) in 1972. Drawing heavily on the views of libertarian psychiatrist Thomas Szasz, whose anti-psychiatry crusade caught fire in the United States about this time, Ennis and the MHLP took an abolitionist position on involuntary commitment. They sought not merely to constrain its availability or limit its effects, but to abolish it entirely. In a preface to Ennis’s book *Prisoners of Psychiatry: Mental Patients, Psychiatrists, and the Law*, Dr. Szasz praised Ennis for endorsing the abolitionist view “that individuals

28. This critique was highly ideological, from both ends of the political spectrum. See, e.g., Michel Foucault, *The Birth of the Asylum*, in THE FOUCAULT READER 141 (Rabinow ed., 1984); R. D. Laing, *The Schizophrenic Experience*, in THE POLITICS OF EXPERIENCE 100 (1967); ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); DAVID J. ROTHMAN, THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC (1971); THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1974); Andrew T. Scull, *Madness and Segregative Control: The Rise of the Insane Asylum*, 24 SOC. PROBS. 337 (1977). Perhaps the chief critic of psychiatry from the libertarian perspective was Thomas Szasz. See, e.g., THOMAS S. SZASZ, LAW, LIBERTY, AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES (1989); Thomas S. Szasz, *J’Accuse: Psychiatry and the Diminished American Capacity for Justice*, 2 POL. PSYCHOL. 106 (1980). See also, ENNIS, *supra* note 14; SLOVENKO, *supra* note 14.

incriminated as mentally ill do not need guarantees of treatment but protection against their enemies—the legislators, judges, and psychiatrists who persecute them in the name of mental health.”²⁹ And in a 1974 interview published in *Madness Network News*, Ennis declared: “My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit people against their will.”³⁰

Until abolition became politically possible, Due Process would have to do. Warren Court decisions such as *In Re Gault* offered the legal framework on which advocates for the mentally ill based a national campaign to make involuntary civil commitment more difficult, more time-limited, and less dependent on a psychiatric (and thus by definition oppressive and unjust) decision that the respondent “needs treatment.”³¹ In *Gault*, handed down in 1967, the United States Supreme Court decided that when a judgment of delinquency is at stake, states must offer juveniles the full panoply of procedures required under the Fourteenth Amendment Due Process Clause in adult criminal trials—including the right to timely notice of charges, the right against self-incrimination, the right to confront witnesses, and the right to defense counsel.³² The Court rejected the state’s argument that such due process protections should not apply to juveniles because the state acts as parent, not adversary, to juvenile defendants.

The Court’s decision in *Gault* offered an apt due process-based model for another legal setting involving the deprivation of liberty—involuntary commitment proceedings. As in *Gault*, states in commitment cases had long argued for a lower due process standard on the grounds that commitment is not a criminal adjudication, that the state acts not as an adversary to the respondent but instead as *parens patriae*.³³ In *Lessard v. Schmidt*, the court engaged, and rejected, the *parens patriae* argument,

29. *Id.*

30. SLOVENKO, *supra* note 14, at 433.

31. *In re Gault*, 387 U.S. 1; *see also supra* note 4 and accompanying text.

32. *Id.*

33. *See, e.g., Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wisc. 1972) (discussing and ultimately rejecting this argument).

expressly modeling its response on the High Court's opinion in *Gault*.³⁴

In *Lessard*, the Plaintiff, Alberta Lessard, was detained by police after what they believed was a suicide attempt. She was confined in a psychiatric hospital on a succession of petitions by police and medical personnel, was diagnosed as paranoid schizophrenic, and was repeatedly interviewed and examined without prior notice or opportunity to contest the various medical and legal judgments being made about her by the police, court personnel, judge, and psychiatrist involved in the case. Eventually Ms. Lessard hired her own attorney and was conditionally released under an ongoing 30-day commitment order. Ms. Lessard became the lead defendant in a class action suit against Wisconsin, alleging that the state's procedure for involuntary civil commitment denied her due process of law. In *Lessard*, the court agreed with her, holding that Wisconsin's statutory commitment procedure violated procedural due process in a number of respects that paralleled *Gault*. Like the statute invalidated in *Gault*, Wisconsin's commitment law failed to give detainees adequate notice of proceedings which could deprive them of the fundamental right of liberty; failed to mandate a hearing before commitment; failed to provide for the right to counsel or the right against self-incrimination; permitted involuntary commitment on an inadequate standard of proof; and failed to require that those petitioning for commitment consider less restrictive alternatives before seeking this drastic remedy.³⁵

B. *Lessard and the Standard of Dangerousness*

In addition to finding numerous procedural due process errors in the Wisconsin statute, the court in *Lessard* addressed and endorsed the need to add dangerousness to the substantive standard for involuntary civil commitment. The court traced the dangerousness standard back to the 1845 Massachusetts case, *Matter of Josiah Oakes*,³⁶ in which the state supreme court held:

34. *Id.*

35. *See generally id.*

36. *Matter of Josiah Oakes*, 8 Law Rep. 123 (Mass. 1845).

The right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those whose going at large would be dangerous to themselves or others And the necessity which creates the law, creates the limitation of the law. The questions must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. This is the limitation, and the proper limitation.³⁷

The court in *Lessard* went on to make a point that would become crucial to the development and application of the dangerousness standard in the reformed commitment statutes passed during the seventies. “Unfortunately,” the court noted:

neither the Massachusetts court in *Oakes*, nor other courts to follow felt much concern for either a definition of ‘dangerousness’ or the effects of deprivations of liberty upon those committed The erosion of the common law of dangerousness continued . . . with the result that *many statutes today permit commitment based upon a wide range of showings of ‘mental illness.’*³⁸

It was this perceived defect—the fact that most statutes allowed involuntary commitment upon a finding of mental illness and need for treatment, without more and without defining either “dangerousness” or “mental illness” in ways which clearly limited such confinement—that the legal advocates for the mentally ill sought to change in the 1970s. By adding back a vigorous requirement of dangerousness, making that requirement a separate element of the commitment standard, and assigning courts the role of assessing dangerousness as a legally-grounded, rights-focused

37. *Id.* at 125, cited in *Lessard*, 349 F. Supp. at 1085.

38. *Id.* at 1086 (emphasis added).

element of the standard, advocates hoped to make courts less deferential to psychiatric findings of “mental illness” and more attuned to the serious deprivations of liberty inherent in the act of committing a person to a mental institution against his will.

Three years after the landmark opinion in *Lessard*, the United States Supreme Court seemed to drive this point home. In *O'Connor v. Donaldson*,³⁹ the Court held that the Due Process Clause of the Fourteenth Amendment prohibits states from forcibly confining non-dangerous persons who are capable of surviving “safely” by themselves or with the aid of family and friends.⁴⁰ In the decades since that holding, discussion of *Donaldson* has focused heavily on the psychology side of the conversation, for example on the question of what (if anything) the *Donaldson* Court said about committed patients’ right to treatment, or what (if anything) it said about committing mentally ill persons who are not dangerous but who are deemed “in need of treatment”—for instance, whose condition may deteriorate if untreated; or who are mentally ill and lack family and friends to help them maintain a treatment regimen.⁴¹ Here, we look at *Donaldson* from a rights-focused perspective.

In January 1957, respondent Kenneth Donaldson was diagnosed paranoid schizophrenic and was committed to the Florida State Hospital at Chattahoochee. For the next fifteen years, Donaldson was held at the hospital against his will, despite his repeated attempts to secure release on the grounds that he was not dangerous to himself or others; that he was not mentally ill; and

39. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

40. *Id.* at 576 (“In short, a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends”). The Court vacated and remanded the judgment of the lower court on other grounds. *Id.*

41. See, e.g., Daniel Baldwin, *O'Connor v. Donaldson: Involuntary Civil Commitment and the Right to Treatment*, 7 COLUM. HUM. RTS. L. REV. 573 (1975); L. E. Kopolow, *A Review of Major Implications of the O'Connor v. Donaldson Decision*, 133 AM. J. PSYCHIATRY 379 (1976); Loren H. Roth, *Mental Health Commitment: The State of the Debate*, 31 HOSP. & CMTY. PSYCHIATRY 385 (1980); *O'Connor v. Donaldson*, TREATMENT ADVOC. CTR., available at <http://www.treatmentadvocacycenter.org/component/content/article/341> (calling the Court’s opinion in *Donaldson* “probably the single most important decision in mental health law”).

that he was not receiving treatment at the hospital.⁴² In 1971, Donaldson brought suit under 42 U.S.C.A. § 1983 (West 1996), alleging that hospital superintendent Dr. J.B. O'Connor, and others, had “intentionally and maliciously deprived him of his constitutional right to liberty.”⁴³ The jury agreed, awarding Donaldson both compensatory and punitive damages, after being instructed by the trial judge that it should award punitive damages only if “the act or omission of the Defendant or Defendants which proximately caused injury to the Plaintiff was maliciously or wantonly or oppressively done.”⁴⁴

The facts of the case powerfully reinforced the dangers of forcible commitment under a “grave need for treatment” standard.⁴⁵ Donaldson was hospitalized under a provision of the Florida law that then allowed such commitment for the purpose of “care, maintenance, and treatment.”⁴⁶ Testimony at the trial proved that Donaldson had never—either before or after he was committed—posed a danger to himself or others.⁴⁷ Dr. O'Connor himself acknowledged that he had neither personal nor second-hand knowledge of any dangerous act ever committed by Donaldson.⁴⁸ No evidence showed that Donaldson had ever been a suicide risk, and one of O'Connor's codefendants conceded that Donaldson had earned his own living outside the hospital for fourteen years before his commitment and that he was capable of supporting himself outside the hospital. Indeed, immediately after his release from the hospital in 1971, Donaldson got a responsible job in hospital administration.⁴⁹ Further, under the law and regulations at the time,

42. 422 U.S. at 564–65.

43. *Id.* at 565.

44. *Id.* at 571 n.7.

45. It is assuredly no coincidence that Bruce Ennis, a leader in the move to introduce Due Process protections into civil commitment proceedings, argued the case for Donaldson. *Id.* at 564. *See also supra* text accompanying notes 28–30 (summarizing Ennis's role in the civil commitment reforms of the 1970s and 1980s).

46. *Donaldson*, 422 U.S. at 565–66 n.2.

47. *Id.* at 563.

48. *Id.* at 568.

49. *Id.* Dr. O'Connor had resigned as hospital superintendent by the time of trial. Shortly after that resignation, Donaldson—with the help of the hospital staff—successfully secured his release from the hospital—again, after a confinement of almost fifteen years.

the hospital staff had the power to release a mentally ill patient who was not dangerous to self or others. Apparently displeased with Donaldson's attempts to be released and his refusal to cooperate with hospital staff, Dr. O'Connor denied Donaldson's requests for such release, even when those requests were supplemented by a halfway house, Helping Hands, which offered to care for Donaldson, and by a letter from the respected Minneapolis Clinic of Psychiatry and Neurology, which supported Donaldson's release.⁵⁰ According to the Supreme Court's opinion:

O'Connor rejected the offer, replying that Donaldson could be released only to his parents. That rule was apparently of O'Connor's own making. At the time, Donaldson was 55 years old, and, as O'Connor knew, Donaldson's parents were too elderly and infirm to take responsibility for him. Moreover, in his continuing correspondence with Donaldson's parents, O'Connor never informed them of the Helping Hands offer.⁵¹

O'Connor also rejected an offer of help from a college classmate and longtime family friend of Donaldson's, John Lembcke, who petitioned for Donaldson to be released into his care.⁵² Dr. O'Connor testified that he rejected all these requests on the grounds of his conviction that Donaldson would not have made a "successful adjustment outside the institution"—but at trial O'Connor could not remember the basis for that conclusion.⁵³ Dr. O'Connor characterized Donaldson's care at the hospital as "milieu therapy"—custodial care that is not geared toward improving or

50. *Id.* ("The [halfway house] request was accompanied by a supporting letter from the Minneapolis Clinic of Psychiatry and Neurology, which a codefendant conceded was a 'good clinic'").

51. *Id.* at 568–69.

52. *Id.* at 569. The Court adds here: "The [trial] record shows that Lembcke was a serious and responsible person, who was willing and able to assume responsibility for Donaldson's welfare."

53. *Id.* at 568.

curing the patient's mental illness.⁵⁴ The conditions on the ward were hardly conducive to good care: Donaldson was frequently housed in a large room with 60 other patients, some of whom had been criminally committed.⁵⁵ Finally, shortly after Dr. O'Connor resigned as superintendent of the hospital, Donaldson—with the help of the hospital staff—successfully petitioned for restoration of his competency and for his release from involuntary care.⁵⁶

The facts in *Donaldson* gave credence to the abolitionist argument that the law should not permit forcible commitment based only on the discretionary judgments of mental health professionals.⁵⁷ Even assuming that Kenneth Donaldson had been correctly diagnosed with a serious “mental illness”—about which the Supreme Court expressed skepticism⁵⁸—the use of legal

54. *Id.* at 569 (“[W]itnesses from the hospital staff conceded that, in the context of this case, ‘milieu therapy’ was a euphemism for confinement in the ‘milieu’ of a mental hospital”).

55. *Id.*

56. *Id.* at 568.

57. *See, e.g., supra* main body text accompanying notes 20–21.

58. *Donaldson*, 422 U.S. at 584 (“There can be little responsible debate regarding ‘the uncertainty of diagnosis in this field and the tentativeness of professional judgment.’”) (quoting *Greenwood v. United States*, 350 U.S. 366, 375 (1956)). The Court’s view echoed a high degree of public skepticism about the reliability of psychiatric diagnosis at the time. Only two years before the Court’s decision in *Donaldson*, psychiatry had been greatly embarrassed by the publication in *Science* magazine of the now-famous Rosenhan experiment. David L. Rosenhan, *On Being Sane in Insane Places*, 179 *SCI.* 250 (1973). Rosenhan sent a group of healthy associates to twelve different mental hospitals in five states. *Id.* These pseudo-patients attempted to gain admission to the hospitals as patients by falsely claiming to suffer from auditory hallucinations. All were admitted and diagnosed with psychiatric disorders. *Id.* While in the hospital, all the patients behaved normally and informed the staff that they felt fine and were not experiencing any more hallucinations. *Id.* Nonetheless, Rosenhan’s pseudopatients spent an average of nineteen days in the hospital. *Id.* In order to gain release all were forced to agree to take antipsychotic medications, and all except one were diagnosed with schizophrenia “in remission.” *Id.* The uproar over the Rosenhan experiment was a significant factor in psychiatry’s subsequent turn toward diagnostic verifiability and reliability, a move which took center stage in the profession with the publication of the DSM III in 1980. *Id.*; *see, e.g.,* Mitchell Wilson, *DSM-III and the Transformation of American Psychiatry: A History*, 150 *AM. J. PSYCHIATRY* 399 (1993).

coercion to enforce the judgment of a psychiatrist, without giving courts an independent basis on which to question those judgments and guard the patient's presumptive right to refuse treatment, put vulnerable patients at the mercy of psychiatric professionals like O'Connor, whose judgments could be influenced by personal pique, personal dislike of a patient, or other reasons not relevant to the patient's welfare or legal rights. The hope of reformers was to give the law an independent basis—the “dangerousness” standard—upon which to ensure that involuntary commitment was confined to those mentally ill patients who really posed a serious risk of harm to themselves or others.

But the apparent victory of legal advocates for the mentally ill, whose arguments persuaded legislatures across the land to adopt dangerousness-based standards for involuntary commitment, has been replaced by a growing sense of failure. Whatever the statutes said, it soon became clear that in actual court proceedings, “dangerousness” was often treated either as synonymous with “mental illness,” or at least as primarily the concern of mental health professionals. In short, the courts were not using dangerousness as a way of limiting the reach of involuntary commitment or of staking the law's independence from psychiatric judgments.⁵⁹

In explaining this failure we should look to the crucial role played by those in the mainstream clinical community, especially (1) mental health professionals who evaluate detainees and testify in court as to their mental health and dangerousness; and (2) judges who, although charged with the statutory duty of making a final judgment about whether the law should force someone into treatment, frequently short-circuited the required legal judgment by deferring to the medical one.⁶⁰

59. See, e.g., Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT 265 (1994) [hereinafter *Mediating the Gap*] (discussing “vast formal expansion of procedural and substantive rights [in involuntary commitment proceedings, which] has led to continually disappointing results”).

60. See, e.g., Zander, *supra* note 1, at 503 (quoting a post-*Lessard* dialogue, at an involuntary commitment hearing, between a Milwaukee judge and defense attorney: *Defense attorney*: “But I just wonder if we are dealing with just family emotional-type problems. And, it's a little difficult for me to

C. *Revolt Against Process—the Pro-Treatment Side Rises Again*

Even in the 1970s, not everyone agreed with lawyer and ex-patient advocates that involuntary commitment was more evil than good. The pro-treatment voices were there, though subdued for a while by the reforms of that era. By the 1980s, however, pro-treatment forces were on their way back. In 1981, in their editorial *Dangerousness as the Criterion for Involuntary Hospitalization: A Time to Reassess*,⁶¹ Pauline Rabin and David Folks passionately argued for the loosening of the involuntary commitment standard on the ground that the “dangerousness” criterion prevented doctors from treating desperately suffering patients:

The present emphasis on dangerousness to self or others as the sole criterion on which a psychiatrist can enforce hospitalization of the mentally ill has been challenged by the physician who is confronted with an acutely psychotic patient and the social worker and community agencies on whom the burden of handling this group now falls Our dilemma as physicians is that we are forced to overlook the acute symptoms of mental illness and to intervene only if the patient’s behavior can be characterized as dangerous. The decision to hospitalize a patient involuntarily for evaluation, treatment, or both is a legal rather than a medical determination Is it not time to reassess the criteria for emergency involuntary hospitalization? How can we withhold treatment from an acutely ill patient? Whose freedom is compromised by the current standards? Should we not reintroduce broader options for emergency

understand how full-time inpatient hospitalization at this time would be the cure” *Court*: “I have the same feeling. However, I’m not expert in psychiatric matters. The experts have testified. My feelings are the same as yours, but I can’t disregard the expert testimony”).

61. Rabin & Folks, *supra* note 15.

commitment? We strongly urge that a comprehensive review of these questions be undertaken, directed toward reframing the standards for involuntary commitment while safeguarding the patient's fundamental civil rights.⁶²

Considering the subsequent empirical research indicating that the dangerousness standard had not, in fact, made significant changes in the rate or substantive proceedings in involuntary commitment cases, Rabin and Folks' concerns may seem a bit overheated. The real significance of these concerns, however, lies not in their factual accuracy but in the attitude and orientation they reveal—that of the psychiatrist on the ground, in the emergency room or in the courtroom, faced with a suffering patient who, in the professional's opinion, is in desperate “need of treatment.” While the law and the legal standard have remained focused on rights and procedures, many mental health professionals charged with implementing those standards continue to perceive involuntary commitment through a “need for treatment” lens. The pro-treatment voice became even more vocal in the 1980s and 1990s amid the controversies over deinstitutionalization⁶³ and homelessness, which eventually generated calls for expanded rights to treatment for the mentally ill.⁶⁴ As one author characterized the literature in 1994:

62. *Id.* at 980.

63. Deinstitutionalization refers to a set of government policies, during the mid-late twentieth century, which led to the downsizing or closure of most psychiatric hospitals nationwide and shrank the number of patients hospitalized for mental illness from more than 500,000 in 1955 to under 50,000 by 2002. *See, e.g.,* Tom Jackman, *Commitment Rule is Key to Changing the System: Interpretation of Criteria Varies Among Counties*, WASH. POST, Nov. 28, 2007, at A01, <http://www.washingtonpost.com/wp-dyn/content/story/2007/11/27/ST2007112702512.html> (“In 1955, 558,239 patients were in public psychiatric hospitals. By the mid-1990s, the number had dropped to fewer than 72,000. By 2002, the total had fallen below 50,000”).

64. *See, e.g.,* Haycock et al., *supra* note 59; Luis R. Marcos, *Taking the Mentally Ill Off the Streets: The Case of Joyce Brown*, 20 INT'L J. MENTAL HEALTH 7, 7 (1991) (“Hardly a section of the country, urban or rural, has escaped the ubiquitous presence of ragged, ill, and hallucinating human beings, wandering through our streets, huddled in alleyways, or sleeping over vents. . . . It now is apparent that a substantial portion of the homeless are chronically and

Reports on the failure of courts to abide by procedural and substantive standards, and regular criticism of that failure from mental health and legal scholars, have not appreciably advanced the practice of rights-based civil commitment . . . a number of practicing clinicians experience substantive and procedural guarantees as destructive of patients' treatment needs, and as misguided, one-sided interference with the treatment of persons with debilitating mental disorders. The simple reiteration of patients' substantive and procedural rights during a civil commitment hearing has neither ensured those rights, nor arguably advanced durable treatment relationships necessary to prevent rehospitalization.⁶⁵

It seems that the new standard made no one happy: It failed to invigorate the legal rights of mentally troubled patients, and it also raised a substantial obstacle to the effective treatment of patients who may need, but not want, psychiatric care.

In retrospect, this tension between the legal and psychiatric perspectives on the standard for involuntary commitment seems obvious, even inevitable. The two professions—reflected in the two parts of the standard—come to the policy problem with very different fears, very different nightmare scenarios. Nightmare #1,

severely mentally ill men and women who in years past would have been long-term residents of state hospitals”).

65. Haycock et al., *supra* note 59, at 266:

By far the largest body of literature consists of both professional and mass media material criticizing the impact of stringent commitment criteria on the care of the seriously mentally ill Distressed at the inability of clinicians to force treatment on thousands of severely mentally disabled persons, a number of clinicians and researchers have proposed modifications of procedural standards [that were] modeled on criminal due process, [and] a shift away from adversarial hearings, stringent due process requirements, and strict evidentiary standards.

Id.

represented by the facts in *Donaldson*,⁶⁶ envisions innocent patients forcibly incarcerated in a mental institution and held there by the ignorance, arrogance, or personal pique of the staff. By defending patients' presumptive right to refuse treatment and subjecting requests for forcible commitment to vigorous examination by attorneys and judges, reformers sought to prevent such injustices. Nightmare #2, expressed in Donald Trefferts's powerful phrase *Dying With Their Rights On*,⁶⁷ envisions seriously disturbed (even if not "dangerous") patients, helpless, unable to feed, clothe, or care for themselves, and left to languish on the streets because the law is so focused on protecting their rights that it turns away from their suffering. Both scenarios suggest real risks for the law. Under a "need for treatment" standard that relies solely on the judgment of mental health professionals, the risk is that the standard will give rise to more Kenneth Donaldsons—patients held in mental hospitals, for years, against their will while the doctor supposedly caring for them acts against, rather than for, their interests.⁶⁸ On the

66. And in fiction by such characters as Nurse Mildred Ratched in Ken Kesey's famous novel, *One Flew Over the Cuckoo's Nest*, KEN KASEY, *ONE FLEW OVER THE CUCKOO'S NEST* (1962), and Nurse Davis in the 1948 film *THE SNAKE PIT* (Twentieth Century Fox 1948).

67. Treffert, *supra*, note 15.

68. Reports of cases which confirming this fear are not difficult to find. See, e.g., Alicia Curtis, *Involuntary Commitment*, *BAD SUBJECTS*, Dec. 2001, <http://psychrights.org/states/Maine/InvoluntaryCommitmentbyAliciaCurtis.htm> (Curtis, a psychiatric social worker, reports that "[h]usbands ridding themselves of wives via the psychiatric institution was still enough of a problem in the 1930s that the first woman in Maine's legislature, Gail Laughlin, authorized a bill penalizing husbands for bringing false testimony in the involuntary commitment hearings of their wives"). More recently Curtis recalls:

I worked with a patient who in the 1960s had been brought to the hospital by her husband. The chief complaint listed on the admitting record was: 'Patient does not do her housework.' I think she did actually have a recurrent depression, a symptom of which was her inability to care for herself and her home, but here was obviously a large overlap conceptually between mental illness and not functioning in a prescribed social role. There is also a large history of the forced treatment of homosexuality as mental 'illness.' One gay man I know has a familiar story. He was brought, as a teenager, to a psychiatric hospital in the Midwest by his parents, when they found out he

other hand, under a vigorous standard which seeks to protect the presumptive rights of patients to refuse commitment even if doctors or court personnel see a “need for treatment” or “grave disability,” the risk is that seriously ill patients, unable to care for themselves but unwilling to be medicated or hospitalized, will be abandoned on the streets to be arrested, victimized, or even killed.

For the law, the core issue is which risk to take—or, alternatively, how to arrange the relevant legal architecture into a standard that minimizes both risks. The law’s options are limited, because law in our society is closely bound to the protection of individual rights. It is the law’s foundational job to protect those rights and, in the context of involuntary commitment, to treat the rights of the mentally ill with the same respect as the rights of others. The law *must* care about the flawed legal standard which allowed Kenneth Donaldson to be held against his will for fifteen years although he had committed no crime and presented no danger. For the law, any inquiry into involuntary commitment must begin there. Forcing a person into treatment against her will flies directly in the face of the individual’s right to refuse medical or psychiatric treatment whether or not medical professionals agree.⁶⁹ And where no harm to others is foreseeable or expected, the right of a respondent to refuse treatment is especially compelling. Further, once we embark on a course which allows the state to incarcerate a person against her will on grounds of “danger to self,”

was having gay sex. He was involuntarily committed to the institutional and treated for his homosexuality.

Id. (The treatment didn’t work). See also Mike Riggs, *Lost in the Madhouse: Three Stories of Involuntary Confinement*, THE DAILY CALLER, Jan. 21, 2011, <http://dailycaller.com/2011/01/21/lost-in-the-madhouse-three-stories-of-involuntary-confinement> (recounting the story of “Eric,” a Florida college student who in 2008 was involuntarily committed, or “Baker Acted” under Florida’s forcible commitment statutes, apparently on extremely flimsy grounds).

69. See, e.g., O’Connor v. Donaldson, 422 U.S. 563, 575 (1975) (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the ‘mentally ill’ can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom”). See also A. Stone, *The Right to Refuse Treatment: Why Psychiatrists Should and Can Make it Work*, 38(3) ARCH. GEN. PSYCHIATRY 358 (1981).

the definitional question—what constitutes an actionable danger under the standard—becomes both vitally important, and enormously difficult, to resolve coherently.

Can the reigning conceptions of “mental illness” and “dangerousness” resolve this issue? If we define “danger to self” in the usual way—as “posing a significant risk of serious physical harm” to oneself—then adventurers like Steve Fossett, who engage in risky activities because they love to confront and overcome the risk, are just as committable as the depressed person who drinks poison with the express purpose of ending his life. But should the concept be defined so expansively? And if not, does the “mental illness” prong of the test establish a rationally defensible boundary line?

III. REDEFINING “DANGER TO SELF”

Consider the following three scenarios. Scenario One: Alice has decided to kill herself and proceeds to the roof of her twenty-story apartment building, intending to jump off. Alarmed bystanders grab Alice just as she jumps, pull her to safety, and phone the police who deliver her to the psychiatric wing of a nearby hospital. Despite Alice’s clearly expressed wish to be released from the hospital so that she can accomplish her own death, her concerned family petitions the court to have her forcibly committed on grounds of danger to self.

Scenario Two: Bruce⁷⁰ is a senior partner at a large urban law firm. Bruce works seven-day, eighty-hour weeks, and has always believed that his life is his work. Bruce suffers a major heart attack and is informed by his doctors that unless he dramatically reduces his workload and stress level, he will almost certainly suffer a second and fatal heart attack in the near future. Despite Bruce’s clearly expressed preference to return to work at his normal pace, his concerned family petitions the court to have him committed on grounds of danger to self.

Scenario Three: Christopher⁷⁰ suffers from atherosclerotic dementia, a condition that causes periods of confusion interspersed

70. The characters of “Bruce” and “Christopher” are renamed versions of cases described in Alan Dershowitz, *Psychiatry in the Legal Process: “A Knife that Cuts Both Ways,”* 51 JUDICATURE 370, 375 (1968) (discussing the cases of “Mrs. Lake” and of Supreme Court Justice Robert Jackson).

with periods of rationality. Christopher is neither suicidal nor dangerous to others. He has no close family or friends, and lives alone. One night the police find him wandering the streets, confused but not endangering anyone. They bring Christopher to the psychiatric wing of the local hospital and petition the court to have him committed for treatment. At the commitment hearing Christopher petitions for release and coherently testifies that he knows about his illness, understands its risks, but that he has spent time in a psychiatric facility before and prefers to take the risk of living on his own rather than be hospitalized again.

First, consider Scenario Three. Should the law grant the petition and commit Christopher for treatment against his will? In more than half the states the law permits forcible commitment not only in cases where a court finds a mentally ill respondent to be dangerousness to self or others, but also in cases involving mental illness and grave disability or need for treatment.⁷¹ But what should “count” as a grave disability? The law must have a role in deciding this because the answer determines when courts may overrule the express preference of a respondent not to be hospitalized (or forcibly treated, for example with drugs, on an outpatient basis).

By hypothesis, Christopher is not “dangerous” in the sense that he intends to do violence either to other people or himself. But the answer to the “grave disability” question must nonetheless depend on a concept, which is closely related to dangerousness—the concept of harm, or risk of harm, to self. Christopher’s dementia, while not disposing him toward violent behavior, risks self-harm in the sense that he might, in a confused state, be unable to provide for his own basic needs or wander into a dangerous situation where he is vulnerable to assault by violent others. Should that kind of risk be a proper basis on which to overrule Christopher’s clearly expressed desire not to be treated for his dementia?

71. See, e.g., *Legal Resources in Your State: Maine*, TREATMENT ADVOC. CTR., http://www.treatmentadvocacycenter.org/index.php?option=com_content&view=article&id=215&Itemid=150 (last visited Jan. 15, 2014) (noting that Maine is one of twenty-three states whose involuntary treatment standard is based on a person’s “need for treatment” rather than only the person’s likelihood of being dangerous to self or others).

To answer that, we need to know what risk of harm means in the involuntary commitment context; what kinds of risk, and of risked harm, should “count” for purposes of evaluating someone under the standard;⁷² and what degree of harm, or risk of harm, justifies a court in acting against a respondent’s desire not to be treated. “Grave disability,” in this sense, is another name for “danger to self.”⁷³ Assessing such disability necessarily involves assessing the degree of harm, or risk of harm, to the self if the respondent is not hospitalized/forcibly treated. In this important sense, investigating the content of the “danger to self” standard is conceptually prior to defining the boundaries of the “grave disability” one.

How, then, should the law of involuntary commitment view the two “danger to self” cases of Alice and Bruce? Should the law treat those two cases the same, or differently? If the same, should a court force both Alice and Bruce into treatment, or neither? If the two cases call for different legal dispositions, what would justify that result, and which way should the relevant differences cut? By analyzing the range of possible answers to these questions, this Part illuminates some problems with the “danger to self” rule and articulates the basis for a fairer, more just standard, one which holds true to the *legal* values which necessarily arise when a person is forced into treatment against his will.

In the cases of Alice and Bruce, four resolutions are possible. First, the court could grant both commitment petitions, forcing both respondents into treatment. Second, the court could deny both petitions, refusing to force either respondent into treatment. In choosing either of these two options, the court would be treating Bruce and Alice the same for purposes of involuntary commitment.

Alternatively, the two petitions should be decided differently, an option that offers the third and fourth possible resolutions. Thus, the petition for involuntary commitment could be

72. For example, what about alcohol abuse? Consider the case of “Dan” that opened this Article. *See supra* text accompanying note 2.

73. And some courts have expressly defined grave disability in those terms. *See, e.g., Doe v. Gallinot*, 486 F. Supp. 983, 991 (S.D. Cal. 1979) (grave disability “implicitly requires a finding of harm to self”).

granted as to Alice but not as to Bruce, or it could be granted as to Bruce but not as to Alice.

The next Section considers these four options.

A. *An Abolitionist Premise*

Again: In a legal system that takes individual rights seriously, the law must always have good reason to overrule a person's desire to be left alone. Thus, we begin with the premise that unless there is good reason to force Alice, Bob, or both into treatment, neither one should be committed against their will. Further discussion becomes necessary only if we determine that the abolitionist position is wrong—only if there are in fact cases where the law clearly *should* order someone to be committed despite their contrary preference.

Against that conceptual backdrop, what should happen to Alice and Bruce? The abolitionist premise would dictate that neither respondent should be forced into treatment. Should the court, then, deny both petitions?

Consider this response: The cases of Alice and Bruce are not similarly situated; in fact they are polar opposites. Alice, who attempted suicide, represents the paradigm case in which a respondent *should* be forcibly committed, while Bruce, the workaholic, represents an equally obvious case in which the law should respect the respondent's preference *not* to receive treatment—in which the family's petition for commitment should be denied. What might justify this view? To answer we need to think more deeply about what the commitment standard is, and to what factual situations it applies.

Three core elements animate the “danger to self” standard: that, absent intervention: (1) There is a risk of serious harm to the self, (2) there is a high degree of likelihood that the harm will occur, and (3) the threatened harm is imminent, will occur within a very short time. Alice's case satisfies all three elements. There is a risk of serious self-harm from failing to hospitalize Alice—if she is not forcibly hospitalized she will probably die by her own hand. Second, Alice's behavior on the roof demonstrated a firm determination to kill herself, and she continues to demand that she be released so that she can try again. Thus, there is a high degree of likelihood that the serious harm in question—Alice's death by suicide—will occur if Alice is not forcibly committed. And third,

Alice's recent behavior indicates that this serious and likely harm is imminent—if she is not hospitalized Alice will try to kill herself again very soon.

It seems to follow that Alice is among the most compelling cases for forcible confinement of a person on grounds of “danger to self.” Such cases involve respondents who are likely to inflict imminent death or serious bodily harm upon themselves in the absence of intervention. In this context the phrase “danger to self” is a summary way of describing the factors of (1) threatened serious harm, (2) high probability of such harm, and (3) imminence of such harm.

If this is correct, then the three criteria are *sufficient* to justify hospitalization against the respondent's will. Are these criteria also *necessary* to justify such commitment? Would dropping any one of the three elements sink the case for involuntary commitment below the normative threshold at which the law is justified in overriding a person's presumptive right *not* to be incarcerated against her will?

A brief thought experiment will test this out. First consider element (1), and suppose that the imminent threatened harm from *not* hospitalizing a respondent is far less serious than the person's death. If the respondent was captured not while attempting to kill herself but while lying on a summer beach without sunscreen, few would feel comfortable incarcerating her against her will for attempting to inflict such “harm” on herself. The harm must be serious, amounting to a threat of death or serious self-injury.

The same is true for element (2). Even a person who has threatened to do serious and imminent harm to herself will not be forcibly committed if the *likelihood* he will actually do the harm is not very high. In fact mental health professionals make this kind of judgment all the time. Does a depressed client who says he wants to die really mean to kill himself, or is he merely using references to death as a means of expressing the sadness, emptiness, and hopelessness he feels while experiencing a very black mood? If the former, presumably the person is a candidate for hospitalization; if the latter, presumably not. The degree of likelihood that the serious and imminent harm will occur is an indispensable element of the calculus.

Finally, the case for forcible commitment would fall below the requisite threshold if the threatened danger to self is admittedly serious and credible, but is not *imminent*—not about to happen in

the immediate future. Consider the case of a forty-year-old person who has an inordinate fear of aging. The person believes that life has no meaning after age fifty, and she tells her therapist that she intends to kill herself on the night before her fiftieth birthday. Even if the client's intent is real and the therapist believes her, the therapist lacks adequate cause to have the patient forcibly committed now, because although the client may very well follow through on the threat at the time she indicates, the ten-year delay between threat and time of harm would, and should, defeat any effort to have the person hospitalized against her will. The factor of imminence, in this sense, is a way of assuring that the threatened danger to self is almost certain to occur, right now, unless the person is hospitalized. Understood in this way, the imminence requirement can be seen as an adjunct to the likelihood element—both seek to limit the law of involuntary commitment to cases in which failing to commit someone involuntarily will almost certainly lead to serious injury or death of that person.

The three elements—serious harm to self, high likelihood/probability of such harm in the absence of hospitalization, and imminence of the harm—are thus both necessary and sufficient to commit a person involuntarily on grounds of danger to self. In the case of Alice, all three exist, and this explains the intuition that Alice is a proper candidate for forcible commitment on grounds of danger to self.⁷⁴

But consider that the above test may come out exactly the same way in Bruce's case as it does in Alice's. As to element (1), risk of serious harm to self, Bruce's case is quite similar to Alice's. Like Alice, Bruce's choice to refuse treatment carries the serious and foreseeable (actually foreseen) risk of his own death. As for element (2), the likelihood element, there may be a difference between Alice and Bruce—on the other hand, there may not. People sometimes live much longer than their doctors expect them to. But severely depressed people sometimes behave in unpredicted ways. Statistics indicate, for example, that between eighty-five and ninety-five percent of people who attempt suicide are still alive

74. Some state statutes also contain requirements that (1) treatment be available and/or that (2) the patient is likely to benefit from such treatment. *See, e.g.,* N.Y. MENTAL HYG. LAW 9.60(C).

fifteen years later.⁷⁵ Statistics also indicate that the five-year survival rate from congestive heart failure is only fifty percent—half of those who suffer massive heart attacks die of heart failure within five years of diagnosis.⁷⁶ The difference in likelihood of serious and imminent harm between Alice and Bruce may be negligible, or even non-existent. Further, even if there is some difference here, we can't know that Bruce's case falls below the likelihood threshold unless and until we know what that threshold is.⁷⁷ Just how likely must the threat of serious and imminent harm to self be in order to justify involuntary commitment? On its face the “danger to self” standard offers no answer to this. It should.

Finally, with respect to element (3), the imminence criterion, again no necessary difference divides the cases of Alice and Bruce. In the real-life scenario on which Bruce's hypothetical case is based—that of Supreme Court Justice Robert Jackson—the patient (Justice Jackson) suffered a serious heart attack; was warned that if he continued his demanding work schedule that he risked a fatal heart attack at any time; and in fact suffered a fatal heart attack shortly after he rejected the advice of his doctors and returned to his pre-illness schedule.⁷⁸ The harm to self was in fact imminent, as Jackson's doctors had warned him. Once again, even if this were not clear, we can't know whether the threatened self-harm in Bruce's case is imminent *enough* to justify forcing him into treatment until we know what the threshold level of imminence actually is.

75. Catherine E. Bonn, *Suicide and the State: The Ethics of Involuntary Hospitalization for Suicidal Patients*, 3 INTERSECT 40, 44 (2010), available at <http://ojs.stanford.edu/ojs/index.php/intersect/article/view/197/101> [hereinafter Bonn, *Suicide and the State*].

76. See, e.g., *Statistics: Heart Failure*, HEART AND STROKE FOUNDATION OF CANADA, <http://www.heartandstroke.com/site/c.ikiQLcMWJtE/b.3483991/k.34A8/Statistic.htm> (last visited Jan. 15, 2104).

77. In his perceptive article *Psychiatry in the Legal Process*, Alan M. Dershowitz made this point in 1968. Dershowitz, *supra* note 17, at 376 (discussing an “important question which rarely gets asked in the civil commitment process: how likely should the predicted event have to be to justify preventive incarceration? Even if it is agreed, for example, that preventing a serious physical assault would justify incarceration, an important question still remains: how likely should it have to be that the person will assault before incarceration is justified?”).

78. *Id.* at 375.

Thus, if the three-pronged “dangerousness” test justifies the involuntary commitment of Alice, then forcing Bruce into treatment too may be at least equally legitimate.

But consider a second intuition, which seems to distinguish the cases of Alice and Bruce: a difference in their intent. One factual difference between Alice’s case and Bruce’s is that at the time her family petitions the court to have her forcibly committed, Alice has the conscious purpose and the primary intent of causing the serious, likely, and imminent harm in question—her own death. On the other hand Bruce’s course of action, although in fact it poses a high *risk* of his death and Bruce knows of that risk, was chosen despite that risk, not because of it. Is the presence of conscious purpose in Alice’s case, and its absence in Bruce’s, a valid basis on which to grant the family’s petition for commitment as to Alice and deny it as to Bruce?

The answer must be no. To the extent that Alice’s intent to cause her own death makes it more *likely* that she will accomplish that result, or makes the result more *imminent*, perhaps such intent should be relevant to the court’s decision in her case (and, by reference, perhaps the absence of such intent should count as one factor in favor of denying the family’s petition in Bruce’s case) under the three prongs of the dangerousness standard. But intent alone is *not* a valid basis for distinguishing between Alice and Bruce. A moment’s thought makes this clear and also moves the discussion in an important new direction.

The fundamental question in “danger to self” cases is whether the state has adequate reason to override the person’s preference not to seek treatment. Intent to cause harm to oneself, even a drastic harm like one’s own death, does not offer adequate reason to override that preference. The reason is that we can easily imagine situations in which a person’s choice to end her own life is rational; makes sense; is supported by reasons we can understand and with which we can sympathize (though of course we might ultimately disagree with it on religious or moral grounds). In Alice’s case, for example, what we need to know is not merely that she intends to kill herself, but *why*. If Alice intends to end her life because she believes that Martians have invaded her town and are

planning to kidnap and transport her to another planet,⁷⁹ a fate worse than death, then (for all except abolitionists) Alice's delusional motive for wanting to kill herself might give the state adequate reason to step in and prevent her from carrying out her suicide plan. On the other hand, if Alice wants to end her own life because she is in the end-stage of an incurable and excruciatingly painful form of cancer and has been told by her doctors that there is nothing they can do either to prolong her life or to diminish the suffering she will experience as the disease progresses further, then this is a rational and understandable motive which might merit respect from the state and the courts—*whatever* the nature of the contemplated self-harm, its likelihood, and/or its imminence.⁸⁰

79. Unfortunately, such cases do happen. For example, in 1998 Russell Weston shot and killed two Capitol Hill police officers in the United States Capitol. Weston, who had been diagnosed with paranoid schizophrenia some years before the killings, shot the officers because he believed they were blocking access to a device which would stop the United States from being annihilated by cannibals. *See, e.g.*, Bill Miller, *Capitol Shooter's Mind-Set Detailed*, WASH. POST, Apr. 23, 1999, at A1, available at <http://www.washingtonpost.com/wp-srv/national/longterm/shooting/stories/weston042399.htm> (“Russell Eugene Weston Jr. told a court-appointed psychiatrist that he stormed the U.S. Capitol last summer, killing two police officers, to prevent the United States from being annihilated by disease and legions of cannibals. ‘He described his belief that time was running out and that if he did not come to Washington, D.C., he would become infected with Black Heva,’ wrote Sally C. Johnson, the psychiatrist who examined Weston last fall. Weston called this imaginary ailment the ‘most deadliest disease known to mankind’ and said it was spread by the rotting corpses of cannibals’ victims, Johnson wrote. Weston told Johnson he went to the Capitol to gain access to what he called ‘the ruby satellite,’ a device he said was kept in a Senate safe. That satellite, he insisted, was the key to putting a stop to cannibalism”). *See also* Clark v. Arizona, 548 U.S. 735, 743 (2006) (discussing defendant Eric Clark’s “undisputed paranoid schizophrenia” at the time he shot and killed a police officer). Witnesses testified that paranoid delusions led Clark to rig a fishing line with beads and wind chimes at home to alert him to intrusion by invaders, and to keep a bird in his automobile to warn of airborne poison. There was lay and expert testimony that Clark thought Flagstaff was populated with ‘aliens’ (some impersonating government agents), the ‘aliens’ were trying to kill him, and bullets were the only way to stop them.

Id. at 745.

80. *See, e.g.*, Bonn, *Suicide and the State*, *supra* note 75.

Notice that the same analysis applies to Bruce. If Bruce chooses to continue working at his pre-heart attack pace because he delusionally believes that his doctors and his family are plotting his murder and his only chance of escape is to remain at the office,⁸¹ that irrational motive might justify state intervention and forced treatment. But if Bruce's choice to reject his doctors' advice and continue to work is based on his belief that work is the most valuable thing in his life—or even (is this a closer case?) that all doctors are quacks and his own judgment about his health is more reliable than theirs—then, while we might personally disagree with his decision, the motive behind it is comprehensible and not irrational in the same sense as it would be in the first scenario. In that instance, perhaps, the state should respect Bruce's decision.

But if this analysis is correct, it dramatically shifts the argument. What now becomes crucial to the legal standard of involuntary commitment is not the three elements of dangerousness, but the *reasons* offered by the respondent for wanting to harm himself. The nature and coherence of those reasons—not merely the characteristics of the harm—emerge as

81. Again, such events do occur. For example, seventeen-year-old Eric Clark murdered a police officer and then challenged Arizona's insanity defense on constitutional grounds in *Clark v. Arizona*. *Clark*, 548 U.S. 735. Clark had previously been diagnosed as paranoid schizophrenic and had come to believe that his own parents were aliens and that he was in constant danger of being attacked or killed. See, e.g., *Was Eric Clark Insane or Just Troubled?*, CNN, April 15, 2008, available at http://sentencing.nj.gov/downloads/pdf/articles/2006/0426_14_cnn.pdf; John Gibeaut, *A Matter Over Mind*, A.B.A. J., Apr. 22, 2006, available at http://www.abajournal.com/magazine/article/a_matter_over_mind (“‘It started with the water,’ David [Clark, Eric’s father] says. Terry [Clark, Eric’s mother] explains:

He thought it contained lead. He thought he was going to be poisoned, and we couldn’t convince him otherwise.’ Then came the aliens. Clark believed that Flagstaff had been invaded by them, and that he and the city were in danger. Though he still recognized David and Terry as his parents, he also believed they were aliens. ‘But he couldn’t tell us who they were or why we would be in danger,’ David says. He recalls his son’s matter-of-fact response when he asked Eric how he knew his parents were aliens: He said, ‘Bring me some tools and I’ll show you.’

Id.

central to the legitimacy of state coercion. Thus, in addition to a dangerousness component consisting of the three-pronged analysis outlined above, a defensible involuntary commitment standard contains a “rational motive” or “rational capacity” requirement commanding the state to uphold a respondent’s decision to forego psychiatric treatment unless and until the state affirmatively concludes that the respondent lacks the capacity to rationally deliberate about his own situation and to articulate reality-based reasons for his decision not to seek treatment.

But the current standard for involuntary commitment does not require that the respondent fail a rational motive/capacity test. Instead, (in addition to a finding of dangerousness) it requires that a respondent suffer from “mental illness.”⁸² Is the presence of “mental illness” an accurate proxy for the lack of reasoning and deliberative capacity that could justify committing someone against their will? Section B engages that question.

B. Mental Illness As Grounds for Involuntary Commitment

If the term “mental illness” refers only to cases in which a respondent’s thinking is so disordered that (s)he is unable to assess the risks and benefits of hospitalization, and/or to articulate a rational basis for declining treatment, then there is no gap between the actual standard and the rational basis one. Thus, clarifying the relevant meaning of “mental illness” is a crucial step in the analysis.

1. The Problem of Definition

How, then, is “mental illness” defined for purposes of involuntary commitment? A first response is to consult psychiatry and psychology and to borrow their conception of the term. But this turns out to be quite difficult, in large part because psychiatric and

82. See, e.g., *State Standards for Assisted Treatment: Civil Commitment Criteria for Inpatient or Outpatient Psychiatric Treatment*, TREATMENT ADVOC. CTR., Jan. 2013, http://www.treatmentcenter.org/storage/documents/Standards_The_Text_June_2011.pdf (“All states and the District of Columbia have laws governing court-ordered hospital (inpatient) commitment of individuals with severe mental illness . . .”).

psychological terms are formed for very different purposes than are legal ones.

As a first try, we might refer the concept of mental illness to the “bible” of psychiatric diagnosis—the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).⁸³ The DSM is produced by the American Psychiatric Association and is the most widely accepted diagnostic instrument among clinicians in the United States of America.⁸⁴ DSM-5 defines “mental disorder” as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.”⁸⁵ DSM-IV-TR and DSM-5 include more than 300 possible diagnoses, ranging from psychological conditions which are universally viewed as serious (such as major depression, bipolar disorder, and schizophrenia) to conditions (for example, “impairment in written expression,”⁸⁶

83. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5]. The most recent version of the manual, DSM-5, took effect in May 2013. Most of the statutes and cases discussed in this Article were enacted during earlier versions of DSM. *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter, DSM-IV-TR]; *see also* Allen Frances, Op-Ed., *Diagnosing the DSM*, N.Y. TIMES, May 11, 2012, available at http://www.nytimes.com/2012/05/12/opinion/break-up-the-psychiatric-monopoly.html?_r=0 (evaluating “revisions to what is often called the ‘bible of psychiatry’—the Diagnostic and Statistical Manual of Mental Disorders, or D.S.M.”).

84. *See, e.g.*, Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 PSYCHIATRIC SERVICES 1089 (Sept. 2002).

85. DSM-5, *supra* note 83, at 20.

86. *Id.* at 67 (a form of “Specific Learning Disorder” characterized by problems in spelling accuracy, grammar and punctuation accuracy, and clarity or organization of written expression). In DSM-IV-TR, “Disorder of Written Expression” defined as follows:

- A. Writing skills, as measured by individually administered standardized tests (or functional assessments of writing skills), are substantially below those expected given the person’s chronological age, measured intelligence, and age-appropriate education.
- B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living

“impairment in mathematics”⁸⁷ and “caffeine intoxication”⁸⁸) which seem much less disabling to the threshold capacities for deliberation and reason that are at issue here. In short, the range of conditions to which DSM attaches the word “disorder” is quite wide, including at one end of the spectrum the schizophrenic person who suffers from psychotic delusions and hallucinations,⁸⁹

that require the composition of written texts (e.g., writing grammatically correct sentences and organized paragraphs).

DSM-IV-TR, *supra* note 83, at 56.

87. *Id.* (a form of Specific Learning Disorder characterized by problems with memorization of arithmetic facts, accurate or fluent calculation, number sense, and accurate math reasoning). In DSM-IV-TR, “Mathematics Disorder” is defined as follows:

- A. Mathematical ability, as measured by individually administered standardized tests, is substantially below that expected given the person’s chronological age, measured intelligence, and age-appropriate education.
- B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living that require mathematical ability.

DSM-IV-TR, *supra* note 83, at 54.

88. *Id.* at 503 (recent consumption of high dose caffeine which is accompanied or followed by signs/symptoms, such as restlessness, nervousness, excitement, insomnia, psychomotor agitation.) *See also* DSM-IV-TR, *supra* note 83, at 232 (defining “Caffeine-induced Sleep Disorder”). A Caffeine-Induced Sleep Disorder is a variant of Substance-Induced Sleep Disorder characterized by the following:

- A. A prominent disturbance in sleep that is sufficiently severe to warrant independent clinical attention.
- B. There is evidence from the history, physical examination, or laboratory findings of (1) or (2): (1) the symptoms in Criterion A developed during, or within a month of, [Caffeine] Intoxication or Withdrawal
- C. The disturbance is not better accounted for by a Sleep Disorder that is not [caffeine] induced.

DSM-IV-TR, *supra* note 83, at 660.

89. *See, e.g.,* DSM-5, *supra* note 83, at 87–88 (Schizophrenia Spectrum and Other Psychotic Disorders characterized by “key features” including delusions, hallucinations, and disorganized thinking). *See also* DSM-IV-TR, *supra* note 83 (Defining schizophrenia). Schizophrenia in relevant part, is defined as follows:

- A. *Characteristic symptoms:* Two (or more) of the following,

and at the other end the person whose over-consumption of coffee or soda interferes with his sleep. Indeed, recent research suggests that almost half the U.S. population will meet the criteria for a DSM diagnosis during their lifetimes.⁹⁰ Although DSM explicitly cautions that its diagnostic categories “may not be wholly relevant to legal judgments,”⁹¹ many states and the federal government have

each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these should include 1, 2, or 3. (1) delusions; (2) hallucinations; (3) disorganized speech; (4) grossly abnormal psychomotor behavior, including catatonia; (5) negative symptoms, e.g., diminished emotional expression or avolition.

DSM-IV-TR, *supra* note 83, at 312.

90. According to Ronald Kessler, Professor of Health Care Policy at Harvard Medical School, almost half the United States population becomes “eligible” for a DSM-IV diagnosis at some point in their lives. *See, e.g.*, Wynne Parry, “Normal or Not? New Psychiatric Manual Stirs Controversy,” *LIVESCIENCE.COM*, May 19, 2013, www.livescience.com/34496-psychiatric-manual-stirs-controversy (“More than 46 percent of the U.S. population will meet the criteria for at least one DSM-IV diagnosis during their lifetimes, according to research published by [Kessler and his colleague Philip Wang]”).

91. The phrase is from the Cautionary Statement in DSM-IV-TR, *supra* note 83, at xxxvii.

The Cautionary Statement’s purpose is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.

Id. DSM-5, *supra* note 83 at 25 also contains a “Cautionary Statement for Forensic Use of DSM-5,” which states in relevant part:

Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental

used the manual as the definitional referent in legislation relevant to “mental illness” in a variety of contexts.⁹²

Of course DSM categories are primarily designed to detect mental disorders for the purpose of treating them. And in that context—a context in which there is no question of weighing the costs of rights violations against the benefits of psychological treatment—they make perfect sense. If diagnosis and treatment are the goals, then defining “mental illness” should be about identifying treatable conditions whether or not they involve dangerous or risky behavior.

That changes radically, however, in a legal setting where a respondent’s very freedom may depend on the presence or absence of a diagnosable “mental illness.” The problem is made more acute by the ambiguity surrounding causation in those state commitment statutes which set out the two elements—“dangerous to self or others” and “mental illness”—without specifying any particular causal relationship between them.⁹³ Must the diagnosed “mental illness” or “mental disorder” be the primary *cause* of the

disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals.

Id. The statement goes on to say that DSM-5 diagnostic categories can be useful to courts and legislatures, “[f]or example, when the presence of a mental disorder is the predicate for a subsequent legal determination (*e.g.*, involuntary civil commitment).” *Id.* Of course the question addressed here is whether the legal standard for involuntary commitment should contain a predicate that renders the law dependent on the conception of “mental disorder” developed by the mental health profession. I argue that it should not.

92. *See, e.g.*, Peck & Scheffler, *supra* note 84, at 1090 (making the point that in federal legislation the phrase “mental illness” has been interpreted to include all disorders in the D.S.M.).

93. *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-498(c) (West 2009)(stating “. . . If, on such hearing, the court finds by clear and convincing evidence that the person complained of has psychiatric disabilities and is dangerous to himself or herself or others . . . it shall make an order for his or her commitment, considering whether or not a less restrictive placement is available, to a hospital for psychiatric disabilities”). *See also id.* § 17a-495(a) (stating that “dangerous to himself or herself or others” means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person. . .).

respondent's dangerous behavior? If not, then courts, perhaps convinced of a respondent's dangerousness, might be tempted to force the person into treatment as long as *any* mental illness can be identified by the court psychologist or psychologist. Suppose, for example, the respondent threatens to harm himself, and also happens to suffer from mathematics disorder or disorder of written expression. Can the court commit him for treatment whether or not the disorder is a causal factor in the respondent's behavior or treatment preferences? Or suppose the respondent undoubtedly has a serious mental illness—suffers from schizophrenia and is actively psychotic at the time of the petition. Should the presence of an active psychosis suffice to satisfy not only the mental illness requirement but also the requirement of dangerousness?⁹⁴ These are core questions for the law, questions that the treatment-focused diagnostic categories of psychiatry cannot (and were not intended to) answer.

2. In Search of a Legally Intelligible Standard

On two variants of the abolitionist view, either (1) there is no such thing as “mental illness” and those who defend involuntary commitment based on that concept are agents of social oppression

94. See, e.g., Dershowitz, *supra* note 17, at 374. The involuntary commitment statutes

authorize preventive incarceration of mentally ill persons who are likely to injure themselves or others. Generally, ‘injure’ is not further defined in the statutes or in the case law, and the critical decision—whether a predicted pattern of behavior is sufficiently injurious [in today's terms, “dangerous”] to warrant incarceration—is relegated to the psychiatrist's unarticulated judgments. Some psychiatrists are perfectly willing to provide their own personal opinions—often falsely disguised as expert opinions—about which harms are sufficiently serious. One psychiatrist recently told a meeting of the American Psychiatric Association that ‘you’—the psychiatrist—have to define for yourself the word danger, and then having decided that in your mind. . . look for it with every conceivable means. . .

Id. The Dershowitz article was published in the late 1960s. Has the reformed “dangerousness” standard that took hold in the 1970s and 1980s sufficiently strengthened the rights of patients since then? This Article suggests that the answer is “no.”

against the different and the powerless;⁹⁵ or (2) even if “mental illness” *does* exist, the mentally ill should be treated in exactly the same manner as others for purposes of involuntary commitment.⁹⁶ Absent a previous or impending criminal charge, civil preventive detention on grounds of dangerousness alone is strongly disfavored in the law.⁹⁷ Abolitionists believe that the preferences of mentally disordered people should be accorded equal respect—that their choice to refuse psychiatric treatment should be as dispositive as it would be for any person.⁹⁸ Thus, abolitionists would argue that even a severely depressed respondent who is openly suicidal should *not* be forced into treatment despite her continuing and clearly serious wish to kill herself. If that suicidal person is released without treatment and then kills herself, a true abolitionist argues

95. See generally, from opposite ends of the political spectrum: (1) the views of Thomas Szasz, SZASZ, *supra* note 28; and (2) the views of R.D. Laing, R.D. LAING, *THE POLITICS OF EXPERIENCE* 1, 118–40 (1967).

96. See, e.g., Rabin & Folks, *supra* note 15, at 990 (describing this abolitionist view).

97. See, e.g., Stephen J. Morse, *Blame and Danger: An Essay on Preventive Detention*, 76 B.U.L REV. 113, 114 (1996) (“The strong presumption against preventive detention and the relatively limited means to accomplish it ensure that, in absolute terms, the dangerous undetainables are vastly greater in number than the dangerous detainables . . .”). The state’s power of preventive detention has greatly expanded when founded upon a pre-existing criminal charge, or prior criminal history of a defendant. See, e.g., Paul H. Robinson, *Punishing Dangerousness: Cloaking Preventive Detention as Criminal Justice*, 114 HARV. L. REV. 1429, 1429–30 (2001). Laypersons have traditionally thought of the criminal justice system as being in the business of doing justice: punishing offenders for the crimes they commit. Yet during the past several decades, the justice system’s focus has shifted from punishing past crimes to preventing future violations through the incarceration and control of dangerous offenders. Habitual-offender laws, such as “three strikes” laws, authorize life sentences for repeat offenders . . . “Sexual predator” statutes provide for the civil detention of sexual offenders who remain dangerous at the conclusion of their criminal commitment. New sentencing guidelines increase the sentence of offenders with criminal histories because these offenders are seen as the most likely to commit future crimes. These reforms boast as their common denominator greater official control over dangerous persons, a rationale readily apparent from each reform’s legislative history. *Id.* (citations omitted).

98. See, e.g., Paul Chodoff, *Involuntary Hospitalization of the Mentally Ill as a Moral Issue*, 141 AM. J. PSYCHIATRY 384 (1984) (contrasting the stance of “medical model” with that of civil libertarians on the issue of involuntary commitment).

that this potential consequence must be accepted as a cost of respecting the civil rights of the mentally disordered—just as we ought to respect the right of Justice Jackson to continue a stressful work schedule despite the knowledge that doing so risks his demise, or the right of adventurers such as Steve Fossett who choose to go solo ballooning around the world because they love and embrace the risk.

To be sure, even some who are generally sympathetic to the abolitionist perspective balk at the prospect of releasing an actively psychotic respondent (for example, a delusional schizophrenic who plans to jump from a building because he believes he will sprout wings and fly) without treatment. In his perceptive essay *What is So Special About Mental Illness?*,⁹⁹ the philosopher Joel Feinberg articulated a quasi-abolitionist position, which incorporates this exception. According to Feinberg, when a person's mental illness "so affect[s] the cognitive processes that [s]he is unable to make inferences or decisions,"¹⁰⁰ the state may exercise its "sovereign power of guardianship"¹⁰¹ in the person's behalf and force the person into treatment.

On its face, Feinberg's standard—which would make only those mental disorders which render the person "unable to make inferences or decisions" a proper basis for involuntary commitment—sounds a lot like the rational motive standard articulated above. But Feinberg then further defines the standard in a way that draws a bright, but inaccurate, line between cognitive disorders, which he argues *can* serve as psychological predicates for state intervention against a person's preferences, and "emotional" or "volitional" disorders, which should not. Feinberg states:

By no means all mentally ill persons . . . suffer from defects of reason. Many or most of them suffer from emotional or volitional disorders that leave their cognitive faculties quite unimpaired. To impose compulsory therapy on such persons *would be as objectionably paternalistic as imposing*

99. Joel Feinberg, *What Is So Special About Mental Illness?*, in *DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 272 (1970).

100. *Id.* at 279.

101. *Id.*

*involuntary cures for warts or headaches or tooth decay.*¹⁰²

Thus, for purposes of forcible commitment Feinberg conceptualizes two clearly distinct groups of mental illnesses: (1) those which deprive the person of his or her rational faculties and can justify involuntary commitment when such commitment is in the rational best interest of the patient, and (2) those—“many or most”—which involve “emotional or volitional disorders that leave [the person’s] cognitive faculties quite unimpaired” and thus render involuntary commitment unjustifiably coercive in the same way that forcing a person into treatment for warts or tooth decay would be coercive.

Feinberg’s position implies that a respondent who suffers from a severe mood disorder (without psychotic features) should be treated as autonomous and rational for purposes of the commitment statutes. The state should respect that person’s preference not to be hospitalized, since in such cases the person’s disorder is “emotional” rather than “cognitive.” Thus, a person who is severely depressed and thinks constantly of killing himself suffers merely from an “emotional” problem and should be treated as fully rational and competent for the purposes of involuntary commitment. A court would have no legitimate cause to interfere with such a person’s decision to reject hospitalization so that he may kill himself.

Feinberg’s model rests upon a background dichotomy between the cognitive and the emotional, between mind and mood. And for the law this model has great intuitive appeal. It adopts a generally rights-oriented, abolitionist stance while also carving out a category of serious, cleanly defined mental disorders which disable the core cognitive capacities that merit respect and deference from the liberal state.

Further, the Feinberg standard would easily adjudicate some involuntary commitment cases, those at the extremes. Thus, suppose that Alice wants to jump off a building because her internal voices are telling her she can fly; or that Bob works all the time because he delusionally believes that his family are Martians

102. *Id.* (emphasis added).

in disguise and if he goes home they will kill him.¹⁰³ Both cases involve psychotic disorders that interfere with the patients' thinking and ability to make reality-based inferences and decisions. Under the Feinberg model, the state could justifiably intervene, in the rational best interest of respondents, and force both Alice and Bruce into psychiatric treatment. On the other hand, if Alice wants to jump in order to end the excruciating, escalating, and unavoidable pain from her terminal illness; or Bob continues his full-tilt work schedule because work is the most important thing in his life and he would rather be able to work all the time for a few months than live for years without the work he loves; those desires (although many might disagree with them) are rationally comprehensible and coherent. Thus, the courts in such cases should respect respondents' preferences to refuse treatment and deny the commitment petitions.

If all mental disorders did clearly fall into distinct and separate "cognitive" and "emotional" categories, Feinberg's quasi-abolitionist model would be a natural solution to the problem of balancing need for treatment with respect for individual rights. But reality is much messier than this. Contemporary psychological science convincingly argues that no firm boundary divides the cognitive from the emotional, nor does such a clean separation divide normality from mental illness.¹⁰⁴ Even schizophrenia, the mental disorder most closely associated (at least in the public mind) with impairment of a person's cognitive abilities, does not neatly fit this paradigm. For one thing, schizophrenia has an important emotional component. The so-called "negative" symptoms of the disorder, characterized by depression, low energy, and flat emotional affect, can be extremely disabling, and may be more resistant to treatment, than the "positive" or cognition-disabling symptoms such as hallucinations and delusions.¹⁰⁵ And when we

103. Again, such events do occur in ways that affect legal rights. *See, e.g., supra* notes 79, 81 (describing cases of Russell Weston and Eric Clark).

104. *See, e.g.,* Jeffrey A. Gray, *Brain Systems That Mediate Both Emotion and Cognition*, 4 *COGNITION AND EMOTION* 269 (1990). *See generally* Mick Power & Tim Dalgleish, *COGNITION AND EMOTION: FROM ORDER TO DISORDER* (2d ed. 2008).

105. *See, e.g.,* S.M. Stahl & Peter F. Buckley, *Negative Symptoms of Schizophrenia: A Problem That Will Not Go Away*, 115 *ACTA PSYCHIATRICA SCANDINAVICA* 4 (2007); Stephen M. Erhart et al., *Treatment of Schizophrenia*

begin to consider the most serious emotional disorders such as major depression,¹⁰⁶ Feinberg's dichotomy completely breaks down. Like schizophrenia, major depression is defined *both* by cognitive and emotional symptoms—by thoughts and by moods. The DSM-IV-TR defined “major depressive episode”, the basis for a diagnosis of Major Depressive Disorder, to include a variety of physical and cognitive symptoms—the former including emotions such as sadness, insomnia, significant weight changes; the latter including “feelings of worthlessness or excessive or inappropriate guilt . . . nearly every day,” “diminished ability to think or concentrate, or indecisiveness, nearly every day,” and “recurrent thoughts of death . . . recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.”¹⁰⁷ At another end of the mood spectrum, DSM also

Negative Symptoms: Future Prospects, 32 SCHIZOPHR BULL 234 (2006); P.F. Liddle, *The Symptoms of Chronic Schizophrenia: A Re-examination of the Positive-negative Dichotomy*, 151 BRIT. J. PSYCHIATRY 145 (1987). See also DSM-5, *supra* note 83, at 87–88 (Schizophrenia Spectrum and Other Psychotic Disorders characterized by “key features” including “negative symptoms” such as “diminished emotional expression”).

106. DSM-IV-TR categorized the Depressive and Bipolar Disorders as “mood disorders.” DSM-IV-TR, *supra* note 83, at 382, 369. DSM-5 categorizes the two types of disorder separately: “Depressive Disorders” and “Bipolar and Related Disorders.” DSM-V, *supra* note 83, at 155, 123.

107. DSM-IV-TR, *supra* note 83, at 160–61. For purposes here, DSM-5 closely parallels DSM-IV-TR in this respect. DSM-5 defines “major depressive disorder” in distinctly (though not exclusively) emotional terms:

Diagnostic Criteria [:]

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

defines Generalized Anxiety Disorder as a mixture of emotional and cognitive symptoms (e.g., “Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance.”).¹⁰⁸

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3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
 4. Insomnia or hypersomnia nearly every day.
 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Id. at 160–61.

108. DSM-IV-TR, *supra* note 83. Similarly, among the Anxiety Disorders in DSM-5, Generalized Anxiety Disorder is defined as follows:

Diagnostic Criteria 300.02 (F41.1) [:]

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going

The DSM definitions of these two paradigmatic “emotional” disorders reflect a foundational belief in modern psychology and psychiatry: That mental disorders are not cleanly separable into “emotional” and “cognitive” categories, and (by implication) that rules grounded in such a separation do not reflect current thinking or the best science in the mental health professions.¹⁰⁹

blank.

4. Irritability.

5. Muscle tension.

6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

DSM-IV-TR, *supra* note 83, at 222.

109. See, e.g., Alice M. Isen, *Some Perspectives on Positive Feelings and Emotions: Positive Affect Facilitates Thinking and Problem-Solving*, in FEELINGS AND EMOTIONS: THE AMSTERDAM SYMPOSIUM 263 (Antony Manstead, Nico Frijda, & Agnetta Fischer eds., 2004):

The work reviewed in this chapter indicates that positive affect facilitates careful, thorough thinking and problem solving, and promotes a flexible, responsive approach to situations that fosters new learning as well as utilization of existing knowledge. Evidence indicates that these processes also

For the law of involuntary commitment, this matters. It matters because once we acknowledge the impossibility of separating “cognitive” from “emotional” disorders—that mental disorder almost always involves both cognitive and mood-related components and the two are intricately bound up with each other—then we are forced to admit that a very wide range of disorders could form the psychological predicate for a finding of “mental illness” in the involuntary commitment context. Someone suffering from a serious mood disorder—say, Major Depression—may be prey to mental confusion, a slowing of cognitive processes generally, and/or constant thoughts of suicide, thoughts which are as integral a part of her disorder as the sad mood which accompanies them.¹¹⁰ Such thoughts can interfere with normal cognitive functioning in serious and dramatic ways, and it is hard to see how the law would be any more justified in ignoring such cognitive deficits than it would be in ignoring the disabled mental processing of the schizophrenic whose cognitive abilities are distorted by delusions. Of course, confusion, sadness, and other symptoms of depression can be more or less severe depending on the case. But that is also true with schizophrenia, whose sufferers may display a wide variety of positive and negative symptoms and who possess varying levels of ability to cope with such symptoms.¹¹¹ If schizophrenia “qualifies” under the mental illness

facilitate pro-social behavior and flexibility in social perception Thus, the chapter argues for a conceptualization that integrates affect, cognition, and behavior/motivation (the traditional trichotomy of mind) and recognizes the fact that they mutually influence one another. The chapter argues against the common assumption that affect and cognition are separate, competing systems or approaches, and shows, instead, that they have mutual influence and are subject to similar processes.

Id.

110. See *supra*, note 107 (DSM description of Major Depressive Disorder).

111. DSM-5, in fact, speaks of a “schizophrenia spectrum,” reflecting a current belief in psychiatry that many mental disorders are best conceptualized along a continuum as opposed to the “there or not there” categorization featured in the previous editions of DSM. DSM-5, *supra* note 83, at 87–88 (defining Schizophrenia Spectrum). Further, recent research suggests that some schizophrenic patients can benefit from Cognitive Behavioral Therapy, which

criterion of the forcible commitment standard, then so should any illness which can potentially disable the patient's normal cognitive functioning. Thus, the person suffering from Major Depression, who is tormented by convictions of worthlessness as well as constant thoughts of killing himself, and eventually tries to act on those thoughts, is potentially of as much concern as the person who decides to jump off a building because she is delusional and convinced that, even if the fall kills her, she will immediately come back to life.

This realization helps greatly to focus the argument because it confirms the importance of the rational capacity theory suggested above. What should concern the law of involuntary commitment is not the presence or absence of a "mental illness," but (1) the presence or absence of the threshold capacities to deliberate about options and choose a rational course of action; and (2) the clear presence of a causal link between the lack of such threshold capacities, on the one hand, and the state's justification for overriding the person's refusal of treatment on the other. Persons whose behavior presents a risk of serious self-harm and who lack the capacity to make rational choices about whether or not to accept treatment may be committed against their will for the purpose of restoring such capacities and returning the decision about further treatment back to them. Testimony from mental health professionals—for example, as to the respondent's actual level of cognitive functioning and ability to deliberate and reason, or the availability of treatments which could alleviate or cure any cognitive deficits—may be helpful to the law in such cases. But no formal finding of "mental illness" should be required since "mental illness," by itself, is not what the law should care about; the capacity to reason and deliberate is.

can help them learn to control their hallucinations and delusions and the behavior results therefrom. *See, e.g.*, Douglas Turkington, David Kingdon & Peter J. Weiden, *Cognitive Behavior Therapy for Schizophrenia*, 163 *AM. J. PSYCHIATRY* 365 (2006) (reporting that "[a] growing body of evidence supports the use of cognitive behavior therapy for the treatment of schizophrenia" and concluding: "The strength of the evidence supporting cognitive behavior therapy for schizophrenia suggests that this technique should have more attention and support in the United States."). *See generally* DAVID KINGDON & DOUGLAS TURKINGTON, *COGNITIVE-BEHAVIORAL THERAPY OF SCHIZOPHRENIA* (1994).

One significant potential benefit of changing the rules in this way is that it promises to end the subliminal tug-of-war between the legal (rights-focused) and psychiatric/psychological (treatment-focused) halves of the commitment standard as it exists today. In the 1970s, lawyers led the reform effort which created the two-pronged “danger and mental illness” standard that still dominates state commitment statutes across the nation. The idea was to give courts a doctrinal basis (through the dangerousness prong) on which to guard the rights of respondents who chose not to receive hospitalization or psychiatric treatment. But the standard’s “mental illness” prong seems to command the input of the mental health profession, whose conception of mental disorder has been formed with the primary goal of treating patients, not of assessing their ability to decide matters relevant to their legal status. Although in particular cases the application of the commitment standard can be informed by testimony from mental health professionals, the standard must ultimately speak in terms that are wholly accessible to legal, rather than medical, judgments.

What we need, in short, is a purely legal standard which contains (1) a *dangerousness element*; (2) a *cognitive capacity element* designed to gauge the respondent’s ability to exercise autonomous judgment on the question of hospitalization or other psychiatric treatment; and (3) a *causal element* explicitly linking the legitimacy of state intervention to the respondent’s deliberative and reasoning capacities.

This might seem to be an alien idea—the search for a purely legal standard whose fundamental purpose is to assess a defendant’s cognitive abilities. But to find an instructive analogy we need only look across the border from the civil to the criminal law, to the criminal law’s defense of insanity. In Part C, I pursue such an analogy.

C. *Comparing Insanity*

The criminal law applies a strong presumption that defendants are responsible—that they possess the threshold capacities necessary in order to obey the law and to deserve blame (and therefore punishment) if they do not.¹¹² The law admits a

112. See, e.g., Julian N. Eule, *The Presumption of Sanity: Bursting the Bubble*, 25 UCLA L. REV. 637, 637 (1977–78) (“It was Lord Chief Justice

small number of affirmative defenses—defenses that might excuse or justify what would otherwise be a crime—on grounds either (1) that the defendant did the right thing under the circumstances (*e.g.*, self-defense and necessity) or (2) that the defendant did the wrong thing but could not help it because, for example, at the time of the otherwise criminal act the defendant suffered from a mental disease or defect which rendered her unable to understand what she was doing, to know it was wrong, or to control her impulse to do it (*e.g.*, insanity).¹¹³ Thus, in insanity cases the law admits the possibility that a person might not be responsible if her mental defect was such that it caused her to lack threshold cognitive or moral capacities at the time of the act.¹¹⁴

“Insanity” is now considered a purely legal term; both lawyers and psychologists are taught this, and it is repeated so often on both sides as to be a cliché.¹¹⁵ But for most of its long life,

Tindal, responding to the questions posed by the House of Lords in *Daniel M’Naghten’s Case*, who first popularized the principle that ‘every man is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes.’ This so-called presumption of sanity is operative and unquestioned in every American jurisdiction today.”)

113. See, *e.g.*, the so-called M’Naghten test for insanity (which follows the standard laid down by Justice Tindal in M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.) (“[T]o establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.”); and the American Law Institute (ALI) insanity test, according to which “A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law.” MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962). Most American jurisdictions have adopted one or another of these tests in some version. See, *e.g.*, *Clark v. Arizona*, 548 U.S. 735, 749–52 (Souter, J., for the majority) (discussing the various incarnations of the insanity defense among the states).

114. See, *e.g.*, the M’Naghten test for insanity (which follows the standard laid down by Justice Tindal in M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.); see also MODEL PENAL CODE § 4.01 (Proposed Official Draft 1962).

115. See, *e.g.*, Ryan Howes, *The Definition of Insanity is...*, PSYCHOLOGY TODAY (July 27, 2009), <http://www.psychologytod-ay.com/blog/in-therapy/200907/the-definition-insanity-is> (“To be clear, insanity is a legal term pertaining to

insanity was a medical term—one that defined the realm of mental illness and was proudly worn by those who sought to treat it. Some facts about insanity’s journey from medicine to law will inform the attempt to articulate the proper civil standard for involuntary commitment.

1. The Battle Over Insanity, or Why Psychiatry “Gifted” Insanity to the Law

In a fascinating article, *What’s in a Name? A Brief Foray into the History of Insanity in England and the United States*, historian Janet Tighe details the early twentieth-century battle between law and psychiatry over the concept of insanity.¹¹⁶ Tighe attempts to put this struggle in historical perspective, arguing that “[u]ntil well into the [nineteenth] century the word insanity was ubiquitous, not only in medical writing but in that of the legal and lay world as well. It was the general term used by both professions and the public to refer, in the words of the 1851 *Webster’s Dictionary*, to the ‘state of being unsound in mind’ and ‘applicable to any degree of mental derangement from slight delirium or wandering, to distraction.’”¹¹⁷ Medical texts, law texts, and court opinions freely used the word,¹¹⁸ as did the organizations and publications of those who treated the mentally ill.¹¹⁹ Both the

a defendant’s ability to determine right from wrong when a crime is committed.”).

116. Janet Tighe, *What’s in a Name? A Brief Foray into the History of Insanity in England and the United States* 33 J. AM. ACAD. PSYCHIATRY & LAW 252 (2005) [hereinafter Tighe, *What’s in a Name?*].

117. *Id.* at 253.

118. M’Naghten’s case, (1843) 8 Eng. Rep. 718, is only one famous example.

119. See, e.g., Tighe, *What’s in a Name?*, *supra* note 116, at 253 (“Use of the term [“insanity”] appears to have been relatively unproblematic for members of the legal and medical profession. Law texts, legislation, and cases are littered with it, as are medical texts in which the term is used interchangeably with unsound mind, deranged, crazy, *non compos mentis*, lunacy, madness, and alienation Even the first bodies of nationally organized medical professionals in the United States and Great Britain, the asylum superintendents, proudly used the word . . . in the name of their organizations (e.g., the Association of Medical Superintendents of American Institutions for the Insane)

medical and legal professions shared a sense that, if they did not always agree about the meaning of insanity, it was nonetheless important to share the term and to have a common language by which to understand and articulate the nature of mental illness in both the asylum and the courtroom.¹²⁰

That began to change in the late nineteenth century, partly as a result of growing rifts within what would become the professions of psychiatry and forensic psychology, and partly as a result of substantive debates over particular concepts, particularly the idea of “moral insanity,” which highlighted the varying needs and approaches toward mental illness of medical professionals on the one hand and the law on the other. The emerging field of neurology, which sought dominance of psychiatry around this time, viewed insanity as an unscientific concept that belonged to a receding era of failed asylum treatments.¹²¹ In 1909, the American Institute of Criminal Law and Criminology deputized its committee on Insanity and Criminal Responsibility—which included prominent medical figures such as William A. White and Adolf Meyer—to create and propose a joint vision of the insanity defense. “Over and over again, their efforts broke down as the lawyers . . . and the physicians tried to explain to each other what they meant by insanity. Ultimately agreeing to disagree, the committee drafted model legislation, which all the physicians felt was woefully inadequate.”¹²² The failure to agree on common language to describe mental illness foreshadowed the ejection of the term “insanity” from the psychiatric realm—the outright “gifting” of insanity to the law:

and in their journal titles, such as the *American Journal of Insanity* (which is the parent of the *American Journal of Psychiatry*) (citations omitted).

120. *Id.* at 254 (“Initially taking for granted the shared language of insanity, [American Physician Isaac] Ray and many others interested in the topic, including legal scholars, such as Frances Wharton, saw this sharing as a good thing. The first versions of Ray’s text and Wharton’s . . . underlined the need to have the law, medicine, and the public all speaking the same language. That they could find situations in which this was not the case, particularly in the courtroom, dismayed both of them and inspired their efforts to educate and reform the insanity defense.”) (citation omitted).

121. *Id.* at 254–55.

122. *Id.* at 255.

By the 1930s, their dream of a shared medical-legal language and a common object of analysis was nothing more than ceremonial rhetoric. Embedded in their very word choice was the belief that law and psychiatry were focusing on very different things. The law was developing mechanisms by which knowledge about mental illness could be introduced into a legal proceeding and used with other relevant information to make decisions about such legal categories as responsibility and competence. Psychiatry, on the other hand, was developing mechanisms for diagnosing and treating illness and disease. To confuse the two would only spell disaster or at least more years of . . . the pointless wrangling in the courtroom that psychiatrists like White and Meyer so abhorred.¹²³

Unlike insanity, involuntary commitment is not a criminal concept or process, and that substantive distinction should not be forgotten. But speaking structurally rather than substantively, the history of insanity is enormously instructive here, for at least two reasons. First, it illuminates a problem that lies at the core of the law-and-psychiatry dialogue not only in the insanity context but also in the civil commitment one: the difficulty of marrying concepts of mental disorder and disease that are formed for the purpose of diagnosis and treatment, with the conceptions of individual rights and responsibility that animate our law. This is a problem that eventually proved unsolvable in the insanity context, with the result that insanity came to be viewed as a legal and *not* a psychiatric concept. The criminal law, of course, calls on mental health professionals for their assessments and expert testimony in cases where the insanity defense is at issue. But both professions now understand that although psychiatric assessment and input can be helpful, the ultimate judgment as to a defendant's insanity is a legal decision that can, and should, be made in terms intelligible and responsive to the law's central concerns about blameworthiness and responsibility, not to psychiatry's concern about treatment or cure.

123. *Id.* at 256.

Second, the terms and the structure of the criminal insanity defense ought to inform the legal-psychiatric conversation about involuntary civil commitment. Both the *M’Naghten* and the American Law Institute (ALI) versions of the insanity defense¹²⁴ contain three fundamental requirements: (1) the presence of a mental disease or defect; (2) a causal link between such disease or defect and the defendant’s mental state at the time of the crime; and (3) a description of the mental capacities at issue in assessing the defendant’s responsibility for the act (s)he committed. Thus, the M’Naghten Rule prescribes:

[T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong.¹²⁵

And, the ALI version states:

A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.¹²⁶

Important differences exist between the two formulations. Again, I focus here on three structural requirements they share: (1) presence of a mental disease/defect; (2) which has caused psychological disabilities¹²⁷ that (3) deprived the accused of relevant threshold

124. See *M’Naghten’s Case*, (1843) 8 Eng. Rep. 718 (H.L.); see also MODEL PENAL CODE § 4.01(Proposed Official Draft 1962).

125. *Id.*

126. *Id.*

127. In a sense the insanity standard contains *two* causal elements: (1) a requirement that the defendant’s incapacities were caused by “mental disease or defect,” and (2) a requirement that it is those incapacities which deprived the defendant of the relevant knowledge/appreciation of what he or she was doing

knowledge (or, under the ALI test, “appreciation”)—such as the knowledge that the defendant was squeezing someone’s neck, not a lemon, or the knowledge that (s)he was doing something that is considered morally wrong; or of threshold capacities such as the capacity to control his/her impulse to break the law.

Consider the first requirement, that defendant suffer from a “mental disease or defect.” On its face this seems to raise the same problem that we saw with the involuntary commitment standard—it seems to call for a medical judgment rather than a legal one. But appearances are deceiving in this instance. At least in part, the “mental disease or defect” requirement is a hangover from bygone days when insanity was widely used in both the medical and legal worlds.¹²⁸ But a second fact is even more important. To the extent it inescapably refers to the medical understanding of psychological disorder, the insanity test’s mental disease/defect element continues to cause the same problems which led to psychiatry’s “gifting” of insanity to law a century ago—the problems of disagreement and confusion over whose conception of “mental disease” should govern, and over the precise meaning of “mental disease or defect” in the context of each particular case.¹²⁹ In fact, the mental disease element is best understood structurally rather than substantively—that is, it functions simply to rule out insanity claims by certain defendants, such as those whose mental disabilities at the time of the criminal act were self-inflicted by intoxication or other means.

when he or she did the act. It is not clear that these two conceptions of cause are identical. At the very least, the second formulation seems crucial to construction of a purely legal commitment standard. *Id.*

128. For example, M’Naghten’s Case was published in 1843. M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.).

129. See *State v. Guido*, 191 A.2d 45 (N.J. 1963) (court-appointed psychiatrists examined defendant and found her to be legally sane. After meeting with defendant’s attorney the psychiatrists changed their opinion, finding defendant insane. On appeal, the New Jersey Supreme Court found that the change was thoroughly consistent with honesty however mistaken it might be. . . . Specifically, the doctors originally understood that the “disease of the mind” required by [M’Naghten] means a *psychosis* and not some lesser illness or functional aberration. As the result of their pretrial debate with [the defense attorney], the doctors concluded that they had too narrow a view of M’Naghten and that the “anxiety neurosis” they had found did qualify as a “disease” within the legal rule, and hence . . . defendant did not know right from wrong and she did not know what she was doing was wrong because of that “disease.” *Id.*

On that interpretation, the requirement of mental disease or defect may be the law's way of restricting the defense to those persons who suffer relevant psychological incapacities through no fault of their own. Read in this way, the element remains entirely explicable in law language, focusing on blameworthiness and responsibility.

It is the remaining two elements of the insanity tests that are most illuminating for the civil commitment standard. Those two elements (2) articulate the incapacities that may excuse a defendant from responsibility, and (3) require that those incapacities be the *cause* of defendant's lack of threshold knowledge or self-control at the time of the act. In the next section I argue that these two prongs offer a compelling model for involuntary civil commitment.

2. Toward a Purely Legal Standard for Involuntary Commitment

Consider, again, the basic structural elements of such a standard – elements that, if satisfied, justify the state in overruling a respondent's preference not to be hospitalized or receive psychiatric treatment. Those elements are: (1) danger/risk of harm to self; (2) the presence of cognitive and deliberative incapacity that (3) deprives the respondent of the capacity to make a rational decision about treatment. *Contra* Feinberg, any mental illness, mental disorder, or mental condition could be the basis for these disabilities—but mental illness or disorder *per se* is not required.

The elements can be translated into a civil standard that, like the criminal insanity defense, refers the involuntary commitment decision entirely to the law and thus ends the tug of war between rights and treatment that has characterized the standard for decades.

A standard crafted along these lines would require two primary findings: that the respondent poses a serious, likely, and imminent risk of harm to self, and that he or she lacks the capacities to understand his/her difficulties; deliberate about the benefits and costs of treatment; and make a rational decision in his/her own best interests. Such incapacity would justify state intervention to force treatment over the respondent's objection. Thus, a model statute might provide:

A person shall be eligible for involuntary hospitalization if the court finds based upon clear and convincing evidence, that:

(1) the respondent is unable to make a rational and informed decision as to whether or not treatment would be desirable, and

(2) the respondent poses a serious and imminent risk of harm to self¹³⁰

The clear and convincing standard of proof would require a persuasive demonstration (not merely more likely than not, as a preponderance standard would allow) of the respondent's lack of capacity, thus offering some protection against the possibility that the mere refusal to be treated would be taken as proof of the respondent's lack of ability to make a rational decision. And, the "danger to self" criterion would filter out cases in which the defendant's incapacity does not pose a serious threat to his or her well-being or that of others. Psychiatric/psychological testimony could of course be relevant to proving either or both elements, but no explicit finding of "mental illness" or "mental disorder" would be necessary. The ultimate judgment about whether to confine someone against their will would reside where it belongs: with the law, attuned to the language of rights and accustomed to assessing the harm and the cognitive capacities of persons who come before it.

130. Compare this hypothetical model statute with ALA. CODE § 22-52-10.4 (1975), which contains the "rational and informed decision" language above, but also mandates a finding of mental illness:

(a). A respondent may be committed to inpatient treatment if the probate court finds, based on clear and convincing evidence that (i) the respondent is mentally ill; (ii) as a result of the mental illness the respondent poses a real and present threat of substantial harm to self and/or others; the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iv) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

Id.

The proposed standard honors core intuitions that inform our law. One is that the state should not forcibly incarcerate someone only because he or she is mentally ill; there should be a strong presumption that mentally disordered persons, as persons, are generally able to make their own decisions and act in their own best interests. Under the proposed standard, before being committed against her will a person must lack certain cognitive and deliberative capacities to make a rational and informed decision about treatment.¹³¹

A second intuition is that the law should not lock people up only for doing things that pose a “danger to self”—things that risk self-harm or even risk life. Only if the respondent poses such a risk *and* lacks the capacity to make his/her own decisions about treatment would the law be justified in stepping in. Thus, the standard could not force Dan the heavy drinker into treatment. It could not force adventurers like Steve Fossett into treatment. It could not force Justice Jackson, who continued working against medical advice, into treatment. And, it could not force Bruce or Alice into treatment as long as they possessed capacity to make rational decisions about whether or not to receive psychiatric care.¹³²

Third, the proposed standard steps away from the requirement of “mental illness” and focuses the inquiry squarely on the capacities, which ought to determine the limits of state intervention.

Finally, the proposed standard clarifies the cases of Alice and Bruce in ways that match our intuitions about the role of law both as the guardian of individual rights and as *parens patriae*—again, without reference to the presence or absence of “mental

131. Compare the insanity defense, which operates in a similar way. Everyone acknowledged, for example, that Eric Clark, the defendant in *Clark v. Arizona* (discussing defendant Eric Clark’s “undisputed paranoid schizophrenia” at the time he shot and killed a police officer), was mentally ill and actively psychotic at time of the crime. *Clark v. Arizona*, 548 U.S. 735, 743 (2006). Yet, the trial court determined Clark was not insane, but was mentally ill and was aware of what he was doing and that it was wrong. *Id.*

132. What counts as a “rational decision” is, of course, fundamental in this context. What the law tries to gauge is a respondent’s threshold capacity to make decisions, not whether his or her particular decision about treatment is approved by, or dovetails nicely with, the intuition of the court.

illness.” Thus, if Alice (a) refuses treatment because she fears an imminent Martian invasion and wants to die before it occurs, the state may intervene on the grounds that her delusional thinking demonstrates a lack of capacity for making a rational choice about treatment. But if (b) Alice chooses to take her own life because she can no longer bear the pain of her terminal disease and there is, in fact, no chance she will get better or that her pain level will drop significantly, then the state should not intervene—even if most people, including the court, believe they would choose differently in her place. If Bruce (a) decides to shorten his life by working because he delusionally believes he cannot go home since his family is plotting to kill him, the commitment petition could be granted. But if Bruce, like Justice Jackson, simply (b) values his work above everything else in life and chooses to take the risk that his work schedule will hasten his death, the state would not intervene—even if most people, including Bruce’s family and the court, believe that his values are wrong and that he should choose differently.¹³³ Decisions (a) demonstrate the lack of capacities to

133. A potential problem arises when courts focus on assessing the content of a respondent’s reasons in order to gauge their capacity to make choices about treatment. In the examples above, content seems obviously relevant in assessing capacity. But, the standard should prevent courts from conflating reasons with capacity in the sense that disagreement with a respondent’s reasons proves respondent’s lack of capacity. Reasons are relevant to, but not dispositive of, capacity and the commitment standard must clearly establish that distinction. But in many cases it would seem quite possible to do this. See Dershowitz, *supra* note 17, at 375. Dershowitz discusses the case of sixty-two-year-old Mrs. Lake, who “suffers from arteriosclerosis which causes periods of confusion interspersed with periods of relative rationality.” *Id.* One day she was found wandering around downtown Washington looking confused but bothering no one, whereupon she was committed to a mental hospital. She petitioned for release and at her trial testified, during a period of apparent rationality, that she was aware of her problem, that she knew that her periods of confusion endangered her health and even her life, but that she had experienced the mental hospital and preferred to assume the risk of living—and perhaps dying—outside its walls. *Id.* Mrs. Lake’s petition for release was denied. *Id.* Under the standard articulated in this context, the petition for release would have been granted on the grounds that although her illness produced confusion and clearly interfered with her cognitive capacities generally—and although the courts and most people might disagree with her decision to refuse hospitalization—the reasons she gave for refusing treatment demonstrate a capacity to think clearly about her illness and its potential consequences and to

deliberate and choose in a rational way; decisions (b) demonstrate the presence of such capacities although the actual choice produced may be unusual or unpopular. The proposed standard achieves the appropriate goals and according to the right (legal) values—protecting rights; guarding individual autonomy; and showing strong respect for a respondent’s capacity to act in his or her own best interest.

IV. CONCLUSION

In the decades since legal advocates for the mentally ill successfully fought for a rights-based dangerousness element in the standard for involuntary commitment, that success has come under continuous attack from the treatment-focused side of the conversation. From the perspective of the mental health profession, whose primary concern is that mentally disordered people get the treatment they need, a rights-based standard for involuntary commitment threatens to leave vulnerable patients unprotected.¹³⁴ And, as deinstitutionalization emptied state psychiatric hospitals in the mid-to-late twentieth century, that fear seemed to become reality. Deinstitutionalization generated a fierce debate not only about the relationship between mental illness and homelessness but more generally, about the availability of treatment for persons with serious mental illness.¹³⁵ This, in turn, has led to a significant shift in focus, in both the scholarly and popular media, away from the need to win legal rights for the mentally ill and toward getting them treated.¹³⁶ State statutes have shifted focus accordingly; most now allow a person to be committed for inpatient treatment against

weigh the costs and benefits of inpatient treatment against those of living outside the hospital.

134. Thus, the phrase “dying with their rights on.” Treffert, *supra* note 15.

135. See H. Richard Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984).

136. See, e.g., *Minds on the Edge*, *supra* note 15; “Frontline: The New Asylums,” www.pbs.org/wgbh/pages/frontline/shows/asylums (2005) (jails and prisons have become “the new asylums” for mentally-ill persons who commit crimes); FRONTLINE: THE RELEASED, www.pbs.org/wgbh/pages/frontline/shows/released (2009) (tracing the experiences of mentally ill inmates released into the community). See generally, *Eliminating the Barriers*, *supra* note 4 (advocating legal rules that would make it easier to commit mentally ill persons involuntarily).

his/her will on grounds of “grave need for treatment” or something similar—the standard that predated the reforms of the 1970s.¹³⁷ Further, more than half the states now allow involuntary *outpatient* treatment, permitting courts to order compliance with an out-of-hospital psychiatric treatment regime that the patient does not want.¹³⁸ The widespread adoption of involuntary outpatient commitment potentially expands the reach of forced treatment regimes to cover a much larger group of mentally ill persons than would be reachable under the standard for involuntary inpatient treatment.¹³⁹

137. See, e.g., Treatment Advocacy Center, *Improved Treatment Standards*, TREATMENT ADVOC. CTR., www.treatmentadvocacycenter.org/solution/improved-treatment-standards (majority of states allow commitment on grounds of need for treatment such as “grave disability”).

138. See *supra*, note 82.

139. See, e.g., ALA. CODE § 22-52-10.2 (1975). The Alabama statute states that:

A respondent may be committed to outpatient treatment if the probate court finds, based upon clear and convincing evidence that: (1) the respondent is mentally ill; (ii) as a result of the mental illness the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently; and (iii) the respondent is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable.

Id.; GA. CODE ANN. § 37-3-61(2) (West 2013) (“Any person may file with the court a petition executed under oath alleging that a person within the county is a mentally ill person requiring involuntary treatment.”); GA. CODE ANN. § 37-3-1(12.1) (West 2013). The Georgia statute states that:

‘Outpatient’ means a person who is mentally ill and: (A) who is not an inpatient but who, based on the person’s treatment history or current mental status, will require outpatient treatment in order to avoid predictable and imminently becoming an inpatient; (B) Who because of the person’s current mental status, mental history, or nature of the person’s mental illness is unable voluntarily to seek or comply with outpatient treatment; and (C) who is in need of involuntary treatment.

Id.; N.Y. MENTAL HYG. LAW § 9.60(C) (McKinney 2013). The New York statute states that:

A person may be ordered to receive assisted outpatient treatment if the court finds that such person: (1) is eighteen

This Article, therefore, bucks the winds of current opinion by arguing for a renewed focus on rights rather than treatment. But that change in focus is necessary. It is time to end the tug of war between psychiatry and law that underlies the “mental illness and danger to self” standard. Forcible commitment is a legal decision that must be fully articulated in legally relevant language and justified by a legally comprehensible rationale.

For the law, such a rationale must be grounded in respect for individual autonomy, including the autonomy of those who may suffer from mental disorder. The argument for a purely legal commitment standard must rid itself of the more extravagant anti-psychiatry claims which characterized this debate in the 1960s and 1970s—for example, the claim that psychiatry is shilling for the capitalist establishment by forcing people into hospitals in order to maintain a docile and compliant proletariat;¹⁴⁰ that involuntary commitment is a method society uses to enforce bourgeois values and silence the creative, the diverse, and the different by labeling them as “deviant”;¹⁴¹ or that mental illness itself is a myth created

years of age or older; and (2) is suffering from a mental illness; and (3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and (4) has a history of lack of compliance with treatment for mental illness. . . . and (5) is, as a result of his or her mental illness, unlikely to voluntarily participate in the outpatient treatment that would enable him or her to live safely in the community; and (6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others as defined in section 9.01 of this article; and (7) is likely to benefit from assisted outpatient treatment.

Id.

140. See *id.* at 150 (“The asylum reduces differences, represses vice, eliminates irregularities. It denounces everything that opposes the essential virtues of society . . .”). See, e.g., Foucault, *supra* note 28; Andrew T. Scull, *Madness and Segregative Control: the Rise of the Insane Asylum*, 24 SOC. PROBS. 337 (1976) (rise of the insane asylum as social control mechanism to enforce capitalist social order); GOFFMAN, *supra* note 28 (psychiatric labels subject the “deviant” to depersonalizing and stigmatizing practices).

141. See, e.g., Rael Jean Isaac & Virginia C. Armat, *The Origins of Anti-Psychiatry*, in MADNESS IN THE STREETS: HOW PSYCHIATRY AND LAW ABANDONED THE MENTALLY ILL (1990).

by psychiatry to increase its own power and influence in society at the expense of the most vulnerable.¹⁴²

Shed of over-heated political rhetoric, fundamental principles reveal themselves. There *is* such a thing as mental disorder. Mental disorder can be disabling and can involve such severe distortions of thought and reality perception that a person might not be able to know his or her own best interest. There is no clean line dividing cognitive from emotional disorder; mental disorder may involve cognitive impairment accompanied by emotional deprivations, as in schizophrenia, or disturbances of thought and cognition that originate in mood or emotional disruption, as in major depression. In a small number of cases a person's psychological disorder can be so severe, and can be accompanied by such substantial risk of self-harm, as to deprive the person of the capacity to make rational choices about treatment. In such cases, the state may hospitalize a person against his will. But forced hospitalization cannot be justified by a mere diagnosis of mental illness; of behavior that poses risk of harm to self; or of both together. Only where a person poses a serious risk of self-harm *and* is unable to make a rational and informed decision about whether or not to receive treatment, may the law force him or her into psychiatric care.

142. See, e.g., *supra* note 28. For an argument that the theoretical innovations brought to DSM-III were in part a reaction to these anti-psychiatry critics, see Wilson, *supra* note 58, at 402–03.

Firearm Laws Redux—Legislative Proposals for Disarming the Mentally Ill Post-Heller and Newtown

BY SHAUNDRA K. LEWIS*

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“In the wake of another horrific national tragedy, it’s easy to talk about guns. But it’s time to talk about mental illness.”¹

INTRODUCTION

On December 14, 2012, a mentally disturbed twenty-year-old man shot his mother in the head several times as she lay in bed.² He then drove to Sandy Hook Elementary School (Sandy Hook) with his military-style assault rifle and unleashed a fusillade on everyone in sight, murdering twenty schoolchildren aged six to seven years old and six educators.³ To date, this has been the deadliest school shooting in American history, second only to the Virginia Tech shooting massacre.⁴

The thought that children in such an affluent, picturesque town like Newtown, Connecticut,⁵ could be randomly killed for just going to school shook the nation to its very core. For if a mass shooting could happen there, no one was safe from a madman intent on indiscriminately killing.⁶ This incident, coupled with the

1. Liza Long, *I Am Adam Lanza’s Mother: A Mom’s Perspective On The Mental Illness Conversation in America*, HUFFINGTON POST, Dec. 16, 2012, http://www.huffingtonpost.com/2012/12/16/i-am-adam-lanzas-mother-mental-illness-conversation_n_2311009.html (republished from *The Blue Review*).

2. OFFICE OF THE CONNECTICUT STATE’S ATTORNEY JUDICIAL DISTRICT OF DANBURY, REPORT OF THE STATE’S ATTORNEY FOR THE JUDICIAL DISTRICT OF DANBURY ON THE SHOOTINGS AT SANDY HOOK ELEMENTARY SCHOOL AND 36 YOGANANDA STREET, NEWTOWN, CONNECTICUT ON DECEMBER 14, 2012, 5, 24 (Nov. 25, 2013) [hereinafter REPORT OF THE STATE’S ATTORNEY]; Susan Candiotti et al., *Newtown Shooting Details Revealed in Newly Released Document*, CNN, Mar. 29, 2013, <http://www.cnn.com/2013/03/28/us/Connecticut-shooting-documents/>.

3. REPORT OF THE STATE’S ATTORNEY, *supra* note 2 at 24; Candiotti et al., *supra* note 2.

4. Becky Bratu, *Connecticut School Shooting is the Worst in U.S. History*, NBC NEWS, Dec. 14, 2012, http://usnews.nbcnews.com/_news/2012/12/14/15909827-connecticut-school-shooting-is-second-worst-in-us-history?lite.

5. Eliza Shapiro, *Sandy Hook, Connecticut: A Small Town Devastated*, THE DAILY BEAST, Dec. 15, 2012, <http://www.thedailybeast.com/articles/2012/12/15/sandy-hook-connecticut-a-small-town-devastated.html>.

6. While some may be surprised that shootings of this magnitude would occur in such a town, school rampage shooting experts are not surprised as most school rampage shootings occur in small, rural towns and not in the inner cities.

alarmingly growing list of “public mass shootings,”⁷ reignited a national debate about the mentally ill and firearms since everyone presumed the shooter had to be mentally unstable to commit such an atrocity. In the fourteen months since Newtown there have been too many occurrences of people randomly opening fire in public places to count, including at schools, an airport, parades, and a shopping mall.⁸ These incidents make one thing perfectly clear—public mass shootings are now ubiquitous in America.⁹ Unfortu-

See KATHERINE S. NEWMAN ET AL., *RAMPAGE: THE SOCIAL ROOTS OF SCHOOL SHOOTINGS* 57 (Basic Books 2004).

7. This Article adopts the definition of “public mass shootings” recently established by the Congressional Research Service in a report to Congress. JEROME P. BJELOPERA ET AL., CONG. RESEARCH SERV., R43004, *PUBLIC MASS SHOOTINGS IN THE UNITED STATES: SELECTED IMPLICATIONS FOR FEDERAL PUBLIC HEALTH AND SAFETY POLICY* 4 (2013). The report defines “public mass shootings” as “incidents occurring in relatively public places, involving four or more deaths—not including the shooter(s)—and gunmen who select victims somewhat indiscriminately.” *Id.* To qualify, the shootings must occur in a short time frame without a significant cooling off period. *Id.* Excluded from the definition of “public mass shootings” are mass shootings stemming from terrorism, gang activity, drug dealing, and domestic violence. *Id.* at 3–4. According to this Report, since 1983, there have been seventy-eight public mass shootings that have claimed 547 lives and injured 476 other victims. *Id.* at 2.

8. See, e.g., Nancy Dillon et al., *LAX Shooting Spree: TSA Worker Dead After Assault-Type Rifle Rampage Inside Los Angeles International Airport Terminal 3*, DAILY NEWS, Nov. 1, 2013, <http://www.nydailynews.com/news/national/lax-gunman-opens-fire-la-airport-article-1.1503916>; William Welch, *19 Hurt at New Orleans Mother’s Day Parade Shooting*, USA TODAY, May 12, 2013, <http://www.usatoday.com/story/news/nation/2013/05/12/shooting-new-orleans/2154071/>; Barbara Starr et al., *12 Victims Slain in Navy Yard Shooting; Dead Suspect ID’d*, CNN, Sept. 16, 2013, <http://www.cnn.com/2013/09/16/us/dc-navy-yard-gunshots/>; Christina Lafferty Hassinger, *Breaking the Cycle of School Shootings*, WASH. POST, Jan. 30, 2014, http://www.washingtonpost.com/opinions/breaking-the-cycle-of-schoolshootings/2014/01/30/0eaffa70-853a-11e3-bbe5-6a2a3141e3a9_story.html?tid=hpModule_6c539b02-b270-11e2-bbf2-a6f9e9d79e19 (counting 39 school shootings since Newtown); Evan Perez & Shimon Prokupecz, *Maryland Mall Shooter Darien Aguilar Wrote of Plan to Kill People, Police Say*, CNN JUSTICE, Jan. 29, 2014, <http://www.cnn.com/2014/01/29/justice/maryland-mall-shooting/>.

9. Some scholars and the media claim that public mass shootings are not on the rise and are still a relatively remote event. For example, shortly after the Newtown shootings, Dr. Jack Levin, a Sociology and Criminology professor at Northeastern University in Boston, pointed out that while there are approximate-

nately, the all too familiar storyline behind nearly every shooting spree, prior to the shootings, the gunman exhibited clear signs of mental illness.¹⁰

These incidents illuminated the gaping hole in most firearm laws when it comes to the mentally ill. Specifically, the overwhelming majority of firearm laws prohibit only persons who have been adjudicated mentally ill by a court or involuntarily committed to a mental institution from possessing firearms, allowing persons who are mentally ill but have not been diagnosed as such to slip through the cracks.

To close this gap, this Article proposes that states should enact legislation that would prohibit persons who have displayed clear signs of mental instability from possessing a firearm, regardless of whether they have been diagnosed, treated, or adjudicated as mentally ill or found to be dangerous. To be effective, such legislation must include a policing mechanism that would require, among other things, those with a special relationship with mentally ill persons (loved ones, school officials, mental health professionals) to report suspected mentally ill persons to the proper authorities. Those who are reported should be identified on a list available only to law enforcement as persons prohibited from possessing or purchasing a firearm, at least temporarily, until their mental fitness to possess a firearm can be established. Additionally, persons who are informed by a mentally disturbed person that the mentally disturbed person plans on committing violence against another should be required to report the incident to the police, regardless of

ly twenty mass killings every year with about 100 to 150 victims, this “pales” in comparison to the 15,000 single-victim homicides. *Many Mass Killers Have Had Chronic Depression*, NPR.ORG, Dec. 12, 2012, www.npr.org/2012/12/12/14/167287373/many-mass-killers-have-hadchronic-depression; see also Josh Blackman & Shelby Bard, *The Shooting Cycle*, 46 CONN. L. REV. (forthcoming 2014). In my humble opinion, these statistics (which have more than doubled by my count since Newtown) may show that public mass murders happen less frequently than other homicides, but it certainly does not reflect that mass shootings rarely occur. If anything, the statistics show just how violent our nation has become. While we cannot prevent all homicides, some, including public mass shootings, are preventable. To prevent it, however, some tough legislative proposals like the ones discussed *infra* Section III of this Article must be considered.

10. See, e.g., *infra* Part I, A.

whether they are a licensed mental health professional or not. As explained in more detail later, these measures will not only reduce public mass killings but will have the added benefit of reducing suicides.

Part I of the Article examines the typology of a public mass shooter, looking at some of the most notorious rampage gunmen in U.S. history. Part II explains why most current firearm laws do not take into account the unique characteristics of public mass shooters and are, therefore, deficient. Part III proposes state legislation that addresses these deficiencies. Part IV considers whether the legislative proposals in this Article would be constitutional under *District of Columbia v. Heller*¹¹ and its progeny. Finally, Part V concludes that the best approach for disarming mentally unstable persons is a community-policing one that places the onus on those closest to the mentally ill to keep the mentally ill from accessing guns.

Before explaining this novel approach, it is necessary to describe the typical public mass killer.

I. THE TYPOLOGY OF A PUBLIC MASS SHOOTER

“The more indiscriminate the massacre, the more likely it is that mental illness plays a part.”¹²

Although scholars routinely highlight that most mentally ill persons are not typically violent toward others and are more likely to harm themselves than someone else,¹³ one simply cannot ignore the fact that the majority of people committing public mass mur-

11. *District of Columbia v. Heller*, 554 U.S. 570 (2008).

12. Jennifer Welsh, *Scientists Try to Explain What Makes a Mass Murderer*, BUSINESS INSIDER, July 20, 2012, <http://www.businessinsider.com/scientists-explain-what-makes-a-mass-murderer-2012-7> (quoting Northeastern University criminologist Jack Levin).

13. Frederick E. Vars, *Do the Mentally Ill Have a Right to Bear Arms?*, 48 WAKE FOREST L. REV. 1, 2, 4 (2013); Adam Lamparello, *Why Wait Until the Crime Happens? Providing for the Involuntary Commitment of Dangerous Individuals Without Requiring A Showing of Mental Illness*, 41 SETON HALL L. REV. 875, 891–92 (2011) (concluding there is no significant causal link between mental illness and violence based upon a 1990 study by Dr. Jeffrey W. Swanson finding that 90% of persons with mental disorders were not dangerous).

ders have some history of mental illness. An examination of the backgrounds of five public mass shooters proves this point.

A. *Five of the Most Notorious Public Mass Murderers*

1. Charles Whitman

Charles Whitman is arguably the first person who can be credited with introducing our nation to the notion that massive gun violence can erupt unexpectedly anywhere in public, including in our ivory towers.¹⁴ In 1966, Whitman, a twenty-five-year-old former marine, randomly shot and killed those passing by from a tower at the University of Texas, where he was then attending college. Prior to his shooting rampage, Whitman had several personal setbacks. First, Whitman, who was attending the University of Texas on a Marine academic scholarship, lost his scholarship due to his poor academic performance and arrest for poaching a deer.¹⁵ He left school and went back to active duty.¹⁶ A year later, he was honorably discharged from the Marines for threatening a fellow soldier after that soldier failed to repay Whitman a \$30.00 loan with fifty percent interest.¹⁷

After being discharged from the Marines, Whitman returned to the University of Texas and unsuccessfully attempted to regain his scholarship. Apparently feeling inadequate, he began berating himself in his journals for failing to live up to his own expectations.¹⁸ Around the same time, Whitman began suffering

14. Helen Hickey de Haven, *The Academy and the Public Peril: Mental Illness, Student Rampage, and Institutional Duty*, 37 J.C. & U.L. 267, 271–72 (2011) (noting that Whitman’s sniper attack was “the first and, for many years, the worst school shooting in United States history”).

15. A. Jason Huebinger, “Progression” *Since Charles Whitman: Student Mental Health Policies in the 21st Century*, 34 J.C. & U.L. 695, 695–96 (2008).

16. *Id.* at 696.

17. Marlee Macleod, *Charles Whitman: The Texas Bell Tower Sniper*, available at http://www.crimelibrary.com/notorious_murders/mass/whitman/charlie_2.html.

18. *Id.*

from depression and complained of headaches and an “altered mental state.”¹⁹

Whitman voluntarily sought help from a university psychiatrist.²⁰ When Whitman visited the university psychiatrist in April of 1966, he informed the psychiatrist that he was extremely frustrated with his life and “fantasized” about “going up on the Tower with a deer rifle and shooting people.”²¹ Whitman also told others for years that he thought about shooting people from the top of the tower, but unfortunately no one took his comments seriously.²² Although the psychiatrist noted that Whitman “seemed to be oozing with hostility,” the psychiatrist warned no one.²³ Whitman never returned for counseling and the psychiatrist never followed up.²⁴

Three months later, after murdering his wife and mother, Whitman climbed to the observation deck at the top of the University of Texas’s 307-foot tall clock-tower with an arsenal of weapons.²⁵ From his vantage point, he fired gunshots for ninety-six minutes, killing sixteen people and wounding thirty before two police officers shot and killed him.²⁶ Recognizing that he was mentally ill himself, Whitman wrote in his suicide note that he was the “victim of many unusual and irrational thoughts”²⁷ and wanted his brain examined after his death for any physical explanation for his mental illness.²⁸ As it turned out, Whitman had a brain tumor.²⁹

19. Cara Santa Marie, *The Mind of a Mass Murderer: Charles Whitman, Brain Damage, and Violence*, THE HUFFINGTON POST, Mar. 20, 2012, http://www.huffingtonpost.com/2012/03/27/mind-murderer_n_1384102.html.

20. *Id.*

21. Hickey de Haven, *supra* note 14, at 271.

22. Macleod, *supra* note 17.

23. Hickey de Haven, *supra* note 14, at 271.

24. *Id.*

25. Macleod, *supra* note 17.

26. *Id.*

27. Marie, *supra* note 19.

28. Macleod, *supra* note 17.

29. *Id.*

2. Seung-Hui Cho

After Whitman's case, Seung-Hui Cho became the poster child for a mentally ill person shooting up a college campus. Similar to Whitman, Cho also had a history of mental and emotional disorders.³⁰ When Cho was in the third grade, he was "extremely withdrawn and uncommunicative in family and social circles" to the extent that his parents were concerned.³¹ By the seventh grade, Cho was still so abnormally shy that he underwent psychotherapy and was professionally diagnosed with "social anxiety disorder" and "selective mutism."³² In his high school English class, Cho submitted a paper stating that he wanted to repeat the 1999 Columbine High School shootings.³³

Cho was eventually classified as disabled by a mental disorder and given accommodations, which allowed him to excel academically.³⁴ Subsequently, he was accepted into the high-ranking research university, Virginia Polytechnic Institute (Virginia Tech).³⁵

Cho's first two years at Virginia Tech were uneventful; other than being socially withdrawn, he displayed no signs of violence or mental illness during this period.³⁶ His behavior worsened, however, in his junior year when he wrote and shared violent poems with his poetry class, stating "I hope y'all burn in hell for mass murdering and eating all those little animals."³⁷ His writings were so violent and he became so disruptive that students stopped

30. Helen Hickey de Haven, *The Elephant in the Ivory Tower: Rampages in Higher Education and The Case for Institutional Liability*, 35 J.C. & U.L. 503, 555 (2009) [hereinafter Haven, *The Elephant*].

31. *Id.*

32. *Id.*

33. Matthew Alex Ward, *Re-examining Student Privacy Laws In Response to the Virginia Tech Tragedy*, 11 J. HEALTH CARE L. & POL'Y 407, 410 (2008).

34. Haven, *The Elephant*, *supra* note 30, at 555.

35. *Id.*

36. Ward, *supra* note 33, at 410.

37. *Id.*; Haven, *The Elephant*, *supra* note 30, at 557 n.299 (2009) (citing the OFFICE OF THE GOVERNOR OF THE COMMONWEALTH OF VIRGINIA, MASS SHOOTINGS AT VIRGINIA TECH APRIL 16, 2007: REPORT OF THE REVIEW PANEL 71-76 (2007)).

attending his class and his English professor had him permanently removed, fearing he was dangerous.³⁸

After being removed, Cho received private, one-on-one instruction from the English Department Head but continued his violent writings.³⁹ Specifically, he wrote about “shooting and harming people.”⁴⁰ The Department Head expressed concern about Cho to the administrators,⁴¹ and by the Fall of 2006, a classmate told a friend that Cho “was the kind of guy who might go on a rampage killing.”⁴²

Around the same time, outside of class, Cho began sexually harassing a female student who reported Cho to the campus police.⁴³ She complained that Cho would come to her dorm room uninvited in dark mirrored sunglasses and a hat; he also wore dark shades in class.⁴⁴

Cho, described as an angry loner by those who knew him,⁴⁵ also displayed other bizarre behavior. For example, he often signed his name on class attendance rolls with a question mark and was known on campus as “The Question Mark Kid.”⁴⁶ Cho’s menacing behavior also included once taking out a knife at a social gathering in a dorm room and stabbing the carpet with it.⁴⁷ Thereafter, Cho was warned by the police to stop his behavior, after which Cho expressed suicidal ideations to his suitemates.⁴⁸

After his suitemates contacted the police about his intent to commit suicide, the police took Cho to be psychologically evaluated.⁴⁹ A licensed clinical social worker off-campus found Cho to be “mentally ill, imminently dangerous, and resistant to voluntary

38. Haven, *The Elephant*, *supra* note 30, at 557.

39. *Id.*

40. *Id.* at 557–58.

41. Jana R. McCreary, “Mentally Defective” Language in the Gun Control Act, 45 CONN. L. REV. 813, 825 (2013).

42. *Id.* at 829.

43. Ward, *supra* note 33, at 411.

44. Haven, *The Elephant*, *supra* note 30, at 557.

45. John P. Flannery, *Students Died at Virginia Tech Because Our Government Failed to Act!*, 18 GEO. MASON U. C.R. L.J. 285, 287–88 (2008).

46. Haven, *The Elephant*, *supra* note 30, at 557.

47. Flannery, *supra* note 45, at 285, 287–88.

48. Haven, *The Elephant*, *supra* note 30, at 557.

49. *Id.* at 559.

treatment.”⁵⁰ Based on this diagnosis, Cho was involuntarily detained at a mental health facility and given medication.⁵¹ The next day, a psychiatrist found that Cho was mentally ill but not dangerous and recommended that he be treated at Virginia Tech.⁵² During a commitment hearing, the judge ordered Cho to obtain outpatient mental health treatment at Virginia Tech, despite finding that Cho was dangerous.⁵³ Cho never received treatment and his parents were never told of his peculiar behavior leading up to his commitment hearing.⁵⁴

For the next two semesters, Cho kept to himself but continued to sign his name with a question mark and submit violent writings.⁵⁵ In his play writing class, he drafted two plays that were angry and violent, one of which involved murdering a teacher.⁵⁶

Cho then purchased two handguns—a Walther P22 .22 caliber semiautomatic handgun on February 9, 2007, and a Glock 19 9-mm semiautomatic firearm on March 13, 2007.⁵⁷ Although Cho had been temporarily involuntarily committed to a mental institution, the state of Virginia had not reported him to the national database.⁵⁸

On April 16, 2007, at 7:15 a.m., Cho—now aged twenty-three—went to a dormitory where he was rejected by a female student and shot that female student and the dormitory’s resident advisor.⁵⁹ He then marched to the academic building for the College of Engineering where he began shooting people indiscriminately.⁶⁰ At the end of his shooting spree, Cho killed thirty-two people and

50. *Id.* at 560.

51. *Id.*

52. *Id.*

53. Allen Rostron, *Incrementalism, Comprehensive Rationality, and the Future of Gun Control*, 67 MD L. REV. 511, 551 (2008).

54. *Id.*

55. Haven, *The Elephant*, *supra* note 30, at 562.

56. *Id.* at 562–63.

57. McCreary, *supra* note 41, at 829.

58. Rostron, *supra* note 53, at 511, 551–52.

59. Haven, *The Elephant*, *supra* note 30, at 564.

60. *Id.* at 565–66.

wounded seventeen more.⁶¹ Cho subsequently turned the gun on himself.⁶²

3. Jared Loughner

Like Whitman and Cho, Jared Loughner, displayed clear signs of mental illness prior to attempting mass murder at a meet-and-greet event hosted by United States Congresswoman Gabrielle Giffords.⁶³

Loughner dropped out of high school before the twelfth grade and began abusing drugs and alcohol.⁶⁴ Although friends lost touch with him, when they did see him, he appeared “out of it” and “like he was somewhere else.”⁶⁵ People described him as a loner.⁶⁶

Also, acquaintances reported that Loughner occasionally spoke in a random string of words and was paranoid that the government was trying to control him and everyone around him.⁶⁷ Additionally, Loughner could not maintain a steady job because he could not (or would not) follow directions.⁶⁸ Loughner also posted several incoherent and nonsensical videos on the Internet that discussed the gold standard, mind control, and assassination.⁶⁹ In one of his MySpace postings, Loughner depicted a firearm on top of a United States history book.⁷⁰

Meanwhile, Loughner’s parents were becoming more and more concerned about his increasingly bizarre and angry behav-

61. Ward, *supra* note 33, at 410.

62. *Id.*

63. McCreary, *supra* note 41, at 820–21.

64. *Id.*

65. *Id.*

66. See *Suspect Charged in Congresswoman’s Attack*, MSNBC.COM, Jan. 1, 2011, http://www.nbcnews.com/id/40988567/ns/us_news-crime_and_courts/t/suspect-charged-congresswomans-attack/ (where a neighbor reported that Loughner “kept to himself” and friends said he appeared to be “floating through life” and “doing his own thing”).

67. John Cloud, *The Troubled Life of Jared Loughner*, TIME, Jan. 15, 2011, <http://www.time.com/time/magazine/article/0,9171,2042358,00.html>.

68. *Id.*

69. Joseph Hess, *The Death Penalty for Mentally Ill Offenders: Atkins, Roper, and Mitigation Factors Militate Against Categorical Exemption*, 90 U. DET. MERCY L. REV. 93, 94 (2012).

70. *Id.*

ior.⁷¹ Because Loughner had stopped drinking alcohol and abusing drugs, his parents knew his erratic behavior was not attributable to alcohol or substance abuse.⁷²

Loughner's strange behavior became more pronounced while he was attending Pima Community College in Tucson, Arizona.⁷³ Loughner attended the college for five years, but in 2010, he had been contacted by the police five times for disruptive behavior on campus.⁷⁴ For example, Loughner asked a professor during class if he believed in mind control, made outbursts about "blowing up babies," and strolled around the campus with a video camera at night threatening to torture students.⁷⁵ On another occasion, he blurted out in math class "How can you deny math instead of accepting it?"⁷⁶ He also wrote on a math exam "Eat + Sleep + Brush Teeth = Math."⁷⁷ Also, when Loughner was thrown out of class by one of his teachers, he refused to go and his classmates reported being terrified of him.⁷⁸ Finally, Loughner posted a YouTube video accusing Pima of being a "scam" and "illegal according to the U.S. Constitution."⁷⁹ Based upon these incidents, the college gave Loughner an ultimatum—"Get a mental health evalu-

71. Bob Orr, *Newly Released Jared Lee Loughner Files Reveal Chilling Details*, CBS NEWS, Mar. 27, 2013, <http://www.cbsnews.com/news/newly-released-jared-lee-loughner-files-reveal-chilling-details/>.

72. *Id.*

73. McCreary, *supra* note 41, at 821.

74. *Id.*

75. Shaundra Kellam Lewis, *Bullets and Books by Legislative Fiat: Why Academic Freedom and Public Policy Permit Higher Education Institutions to Say No to Guns*, 48 IDAHO L. REV. 1, 2 (2011).

76. McCreary, *supra* note 41, at 821.

77. *Id.* at 822.

78. *Id.* at 821.

79. Gillian Flaccus, *How Jared Loughner Fell Through the Mental Health Cracks*, THE HUFFINGTON POST, http://www.huffingtonpost.com/2011/01/12/jared-loughner-fell-through-mental-_n_808194.html (last visited May 21, 2013).

ation or don't come back."⁸⁰ Loughner decided to leave the institution.⁸¹

A few months later, Loughner went to a grocery store where Congresswoman Giffords was speaking with constituents.⁸² Loughner shot Giffords in the head and then proceeded to shoot nineteen other people who were standing around in the area.⁸³ Six people were killed, including a nine-year-old girl and a federal judge.⁸⁴ It was discovered after the shootings that Loughner's attack on Giffords had been planned for months.⁸⁵ After being arrested and detained for the shootings, Loughner was later diagnosed with schizophrenia, found to be mentally incompetent to stand trial, and determined eligible to be involuntarily medicated.⁸⁶

4. James Eagan Holmes

Just as in the aforementioned cases, James Holmes displayed clear signs of mental illness prior to opening fire inside a movie theater during a showing of *The Dark Knight Rises*.⁸⁷

Before the murders, Holmes was a Ph.D. student at the University of Colorado studying neuroscience.⁸⁸ In June 2011, however, he dropped out and started purchasing guns.⁸⁹

80. James B. Jacobs & Jennifer Jones, *Keeping Firearms Out of the Hands of the Dangerously Mentally Ill*, 47 CRIM. L. BULL. 388, 388 (2011).

81. Gayland O. Hethcoat II, *In the Crosshairs: Legislative Restrictions on Patient-Physician Speech about Firearms*, 14 DePaul J. HEALTH CARE L. 1, 2 (2013).

82. Lewis, *supra* note 75, at 2.

83. *Id.*

84. *Id.*

85. Deborah W. Denno, *Courts' Increasing Consideration of Behavioral Genetics Evidence in Criminal Cases: Results of a Longitudinal Study*, 2011 MICH. ST. L. REV. 967, 968 (2011).

86. Joi T. Montiel, *The Psychotherapist-Patient Privilege as an "Occasional Instrument of Injustice": An Argument for a Criminal Threat Exception*, 36 S. ILL. U. L.J. 445, 448 (2012); Shijie Feng, *Madness and Mayhem: Reforming the Mental Health Care System in Arizona*, 54 ARIZ. L. REV. 541, 543 (2012).

87. See Rick Sallinger, *James Holmes Saw Three Mental Health Professionals Before Shooting*, CBS NEWS (Aug. 21, 2013, 7:38 PM), http://www.cbsnews.com/8301-201_162-57497820/james-holmes-saw-three-mental-health-professionals-before-shooting/.

88. *Id.*

Prior to the shootings, Holmes had seen at least three different mental health professionals at the University of Colorado where he was a student.⁹⁰ One mental health professional warned police that Holmes was dangerous and homicidal a little over a month before the shootings.⁹¹ Holmes had also sent threatening text messages to his psychiatrist.⁹² When the psychiatrist told campus police that Holmes was dangerous, they immediately deactivated his college identification badge, disallowing him access to locked doors around campus.⁹³ Three months prior to the shootings, Holmes told several classmates that he planned to kill people.⁹⁴

Despite Holmes's clear mental illness, he was able to legally purchase firearms, and in July 2012, randomly shot people during the Batman movie as a shooting scene unfolded in the movie.⁹⁵ Fifty-eight people were injured and twelve killed.⁹⁶ As of the date of this Article, Holmes is scheduled to plead not guilty by reason of insanity to the 166-count indictment charging him with murder, attempted murder, and other offenses.⁹⁷

5. Adam Lanza

Similar to Cho, from a very young age — six years old— Adam Lanza's family noticed that Lanza was extremely quiet, so-

89. *Id.*

90. *Id.*

91. Associated Press, *James Holmes's Psychiatrist Warned of Threat Before Attack*, FOXNEWS.COM, Apr. 4, 2013, <http://www.foxnews.com/us/2013/04/04/james-holmes-psychiatrist-warned-threat-before-attack/>.

92. *Id.*

93. Ben Brumfield & Lateef Mungin, *Holmes' Dangerous Mind and Deadly Weapons Revealed in Documents*, CNN (Apr. 5, 2013), <http://www.cnn.com/2013/04/05/justice/colorado-theater-shooting>.

94. McCreary, *supra* note 41, at 823.

95. Brumfield & Mungin, *supra* note 93.

96. Chris Molina, *A Private Sector Solution to a Public Problem*, 41 HASTINGS CONST. L.Q. 421, 433 (2014).

97. John Ingold & Sadie Gurman, *James Holmes' Lawyers say Diagnosis Supports bid to Change Plea to Insanity*, Cops & Courts, THE DENVER POST, (May 13, 2013, 8:39 AM), http://www.denverpost.com/breakingnews/ci_23231454/james-holmes-court-monday-seeking-change-his-plea.

cially withdrawn, and did not like to be touched.⁹⁸ At age six, Lanza was diagnosed with sensory integration disorder (“a not widely accepted diagnosis involving difficulties processing and reacting to stimuli”).⁹⁹

In 1998, the Lanzas moved to Newtown, Connecticut.¹⁰⁰ Lanza, then six years old and in the first grade, started attending Sandy Hook Elementary School.¹⁰¹ Lanza’s mother, however, was still concerned about his shyness and socially withdrawn behavior.¹⁰²

Later, in middle school, Lanza was diagnosed with Asperger’s Syndrome,¹⁰³ “a high-functioning form of autism marked by social awkwardness.”¹⁰⁴ Family members reported that the changing of classes, people being in close proximity to him, and the noise and chaos in middle school was too much for Lanza.¹⁰⁵ Lanza’s mother took him out of the middle school and created a special educational plan for him where he would do some of his school work at home and then be instructed at the school in the evenings after the students had left.¹⁰⁶

In 2006, Lanza attended Newtown High School.¹⁰⁷ In high school, a school club advisor identified Lanza as someone “likely to be bullied and picked on” and asked Lanza’s mother what he

98. *Frontline: Raising Adam Lanza* (PBS television broadcast Feb. 19, 2013, <http://www.pbs.org/wgbh/pages/frontline/social-issues/raising-adamlanza/transcript-39/> [hereinafter *Frontline*]).

99. Cheryl K. Chumley, *Adam Lanza Diagnosed with Sensory Disorder at Age 6*, THE WASHINGTON TIMES (Feb. 20, 2013), <http://www.washingtontimes.com/news/2013feb/20/adam-lanza-diagnosed-sensory-disorder-age-6/>.

100. Michael Daly, *Adam Lanza: Newtown Massacre Suspect a Puzzle to Authorities*, DAILY BEAST (Dec. 17, 2012), <http://www.thedailybeast.com/article/s/2012/12/17/adam-lanza-newtown-massacre-suspect-a-puzzle-to-authorities.html?url=/articles/2012/12/17/adam-lanza-newtown-massacre-suspect-a-puzzle-to-authorities.html>.

101. FRONTLINE, *supra* note 98.

102. *Id.*

103. *Id.*

104. Candiotti et al., *supra* note 2. There is no known link between Asperger’s syndrome and violence. *Id.*

105. FRONTLINE, *supra* note 98.

106. *Id.*

107. *Id.*

could do to help.¹⁰⁸ Lanza would have “episodes” where he would completely shut down and withdraw.¹⁰⁹

In 2008, when Lanza was sixteen-years-old, Lanza’s mother pulled him out of high school.¹¹⁰ Lanza then began taking some classes at Western Connecticut State University,¹¹¹ where he maintained a 3.26 grade point average.¹¹² Soon thereafter, Lanza withdrew from this school.¹¹³

In 2009, Lanza’s parents divorced.¹¹⁴ By 2010, Lanza had stopped communicating with his father and only sibling—a brother.¹¹⁵

By this time, it was well known that Lanza had “significant mental health issues that affected his ability to live a normal life and to interact with others, even those to whom he should have been close.”¹¹⁶ Acquaintances described Lanza as a “shut-in who

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

114. Matt Appuzo & Adam Geller, *Nancy Lanza, Peter Lanza Divorce Documents Reveal Details About Adam Lanza’s Parents*, HUFFINGTONPOST.COM (Dec. 17, 2012, 4:43 PM), http://www.huffingtonpost.com/2012/12/17/nancy-lanza-peter-lanza-divorce_n_2316461.html.

115. FRONTLINE, *supra* note 98.

116. REPORT OF THE STATE’S ATTORNEY, *supra* note 2, at 3. Because of the state of Connecticut’s strict privacy laws, the specific nature of Lanza’s “significant mental health issues” have not been released yet to the public as of the date of this writing. *Id.* at 29; *see also* HUFFINGTON POST CRIME, *Adam Lanza’s Motive: Did Fear of Being Committed Lead to Sandy Hook Elementary Shooting*, THE HUFFINGTON POST.COM (Dec. 19, 2012), http://www.huffingtonpost.com/2012/12/19/adam-lanza-motive_n_2329508.html (commenting court officials said that court records petitioning for conservatorship to enable the involuntary commitment of a mentally ill adult are sealed). Although the specifics of Lanza’s mental illness history were redacted from the State of Connecticut’s official report of the incident released on November 25, 2013, Lanza’s father has subsequently agreed to release Lanza’s medical records to the public. NBC CONNECTICUT, *Father of Sandy Hook Shooter to Turn Over Son’s Medical Records* (Jan. 10, 2014), <http://www.nbcconnecticut.com/news/local/Newtown-Sandy-Hook-Adam-Lanza-Shooter-Shooting-Peter-Father-Mental-Health-Records-239676901.html>.

rarely left home and played military-style video games.”¹¹⁷ In fact, when police searched his home after the Newtown shootings, a search revealed trash bags covering his windows in his room.¹¹⁸

Additionally, Lanza had a strong interest in guns and mass shootings, particularly Columbine.¹¹⁹ A few months before his shooting spree, Lanza’s mother took Lanza to shooting ranges several times.¹²⁰ According to a family friend, at this time, Lanza’s mother was not afraid of him and did not perceive him to be dangerous.¹²¹

However, at some point between this time and the time of the Newtown shootings, Lanza’s mother’s opinion of Lanza’s mental health had changed apparently.¹²² Specifically, according to one newspaper account, Lanza’s mother had planned to have him involuntarily committed to a mental institution around the same time of the Newtown killings.¹²³ Before she could have him committed, however, he brutally murdered her and the elementary school children, as described at the beginning of this article.¹²⁴

Among the electronic evidence seized from Lanza’s house included: (1) a computer game titled “School Shooting,” wherein the object of the game was for the player to enter a school and shoot students; (2) a five-second dramatization of children being shot; (3) videos on suicide by gunshot; and (4) bookmarks on mass

117. Candiotti et al, *supra* note 2.

118. REPORT OF THE STATE’S ATTORNEY, *supra* note 2, at 25.

119. *Id.* at 26. On April 20, 1999, 18-year-old Eric Harris and 17-year-old Dylan Klebold walked into Columbine High School and started shooting; they murdered thirteen people and wounded twenty-one others before turning the guns on themselves. CNN Library, *Columbine High School Shootings Fast Facts*, CNN.COM (Sept. 19, 2013), <http://www.cnn.com/2013/09/18/us/columbine-high-school-shootings-fast-facts/>. Prior to the shootings, they made videos to their parents telling them of their intentions to commit the shootings and apologizing. *Id.*

120. FRONTLINE, *supra* note 98.

121. *Id.*

122. Jana Winter, *Exclusive: Fear of Being Committed May Have Caused Connecticut Gunman to Snap*, FOXNEWS.COM (Dec. 18, 2012), <http://www.foxnews.com/us/2012/12/18/fear-being-committed-may-have-caused-connecticut-madman-to-snap/>.

123. *Id.*

124. FRONTLINE, *supra* note 98.

murders and firearms.¹²⁵ Ironically, the Sandy Hook Elementary School shooting was carried out in a manner consistent with the violent video game found at his house, where the shooter kept changing magazine clips even though they were not empty.¹²⁶ Nevertheless, mental health professionals who treated Lanza claimed that they did not see anything that would have predicted his shooting rampage.¹²⁷ An autopsy revealed no alcohol or drugs (including prescription medications) in Lanza's system.¹²⁸

B. Profiling a Public Mass Murderer

While, according to the Congressional Research Service, there is no official profile of a public mass shooter, several commonalities seem to exist among most public mass shooters, as exemplified by the detailed descriptions above.¹²⁹ First, they are almost exclusively male.¹³⁰ Second, the majority are Caucasian.¹³¹

125. REPORT OF THE STATE'S ATTORNEY, *supra* note 2, at 26.

126. *Id.*

127. *Id.*

128. Dave Collins, *Adam Lanza Toxicology Test Shows no Drugs, Alcohol, Prescription Meds in Shooter's Body: Officials*, HUFFINGTON POST.COM (May 21, 2013, 1:19 PM), http://www.huffingtonpost.com/2013/05/21/adam-lanza-drugs-alcohol_n_3313088.html?view=print&comm_ref=false.

129. Bjelopera et al., *supra* note 7, at 10. The Congressional Research Service's research is based upon a study of 78 public mass shootings that have occurred since 1983. *See also* NEWMAN ET AL., *supra* note 6, at 57. According to Newman, as of 2004, 94.4% of rampage shooters were male and 62.9% were Caucasian. *Id.* Significantly, many serious mental illnesses develop or manifest themselves at the age at which people typically enroll in and attend institutions of higher education." Alberto R. Gonzales, et. al., *Report to the President on Issues Raised by Virginia Tech Tragedy* 5 (June 13, 2007).

130. Bjelopera et al., *supra* note 7, at 10; NEWMAN ET AL., *supra* note 6, at 57; Tia Ghose, *Mass Shooting Psychology: Spree Killers Have Consistent Profile, Research Shows*, HUFFINGTONPOST.COM (Dec. 12, 2012), http://www.huffingtonpost.com/2012/12/19/mass-shooting-psychology-spree-killers_n_2331236.html; Bryann Vossekuil et al., *The Final Report & Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States*, U.S.S.S. & DEP'T EDUC., 15 (May 2002) (finding that out of 37 school shooting incidents, all of the violence was committed by males).

131. While there have been public mass shooters from all ethnic backgrounds (for instance, Seung Hui Cho, who was Asian and Aaron Alexis-- the

Third, they tend to be loners.¹³² Fourth, they have an unusual obsession with guns, violent video games, violent movies, and/or prior mass shootings.¹³³ Fifth, the shooters often feel inadequate, bullied, dejected, marginalized, or grossly mistreated.¹³⁴

Some may say that this “profile” could fit any number of people who are neither mentally ill nor dangerous. However, research shows that this profile, coupled with two other warning signs is indicative that someone is contemplating a mass shooting.

The first warning sign is that the perpetrator communicates to at least one person his intent to kill.¹³⁵ This was certainly the

man who opened fire at the Washington Navy Yard killing thirteen people--was African-American), researchers have observed that most public rampage shooters are Caucasian. Bjelopera et al., *supra* note 7, at 10; NEWMAN ET AL., *supra* note 6, at 57; see also Peter Hermann & Ann E. Marimow, *Navy Yard Shooter Driven by Delusions*, WASH. POST, <http://www.washingtonpost.com/local/crime/fbi-police-detail-shooting-navy-yard-shooting/2013/09/25/ee321abe-2600-11e3-b3e9-d97fb087acd6story.html> (describing Navy Pier shooting).

132. Beth Schuster, *Preventing, Preparing for Critical Incidents in Schools*, 262 *NIJ J.* 43; Jennifer Welsh, *Scientists Try to Explain What Makes a Mass Murderer*, BUSINESS INSIDER, July 20, 2012, <http://www.businessinsider.com/scientists-explain-what-makes-a-mass-murderer-2012-7> (noting that most mass murderers are loners with few friends who are alienated from the rest of the world).

133. Ghose, *supra* note 130.

134. James L. Knoll, IV, MD, *The “Pseudocommando” Mass Murderer: Part I, The Psychology of Revenge and Obliteration*, 38 *J. AM. ACAD. PSYCHIATRY L.* 87, 87–89 (2010) (opining that mass murderers who kill in public during daytime hours, plan their attacks well in advance, and have an arsenal of weapons, often are motivated by “strong feelings of anger and resentment, flowing from beliefs about being persecuted or grossly mistreated.”); Ghose, *supra* note 130; Jennifer Welsh, *Scientists Try to Explain What Makes a Mass Murderer*, BUSINESS INSIDER, July 20, 2012, <http://www.businessinsider.com/scientists-explain-what-makes-a-mass-murderer-2012-7> (observing most mass murderers are “depressed, angry, and humiliated by the world”); Vossekui et al., *supra* note 130, at 21.

135. Katherine S. Newman, *In School Shootings, Patterns and Warning Signs*, CNN.com (Dec. 17, 2012), <http://www.cnn.com/2012/12/17/opinion/newman-school-shooters/> (Dec. 17, 2012) (noting this is true in the rampage school shooting context); Peter Langman, *School Shootings: The Warning Signs*, FORENSIC DIGEST (2012); Schuster, *supra* note 132 (referencing a 2002 U.S. Secret Service and U.S. Department of Education study of 37 targeted school violence incidents where 81% of the perpetrators told a friend, schoolmate, or sibling about their intent to attack). School shooting research is very informative

case with Charles Whitman who, as previously mentioned, confided in his school psychiatrist and friends that he fantasized about going on top of the University of Texas tower and shooting people before he actually did it.¹³⁶ Seung Cho indirectly warned others that he was contemplating committing mass murder by repeatedly writing about doing so in a play he wrote for an English class and other prose.¹³⁷ Finally, James Holmes told friends that he planned on killing people.¹³⁸

The second prominent warning sign is that prior to their killing sprees, the public mass shooters display conduct that is so bizarre that it causes others around them to be concerned.¹³⁹ For example, Jared Loughner spoke in a random string of words and made outrageous outbursts in class, including a ranting about “blowing up babies.”¹⁴⁰ Additionally, Loughner walked around his college at night with a video camera threatening to harm students.¹⁴¹ Officials at his college were so concerned with his behavior that they asked him to get mental health treatment or leave.¹⁴² Finally, months before his shooting spree, Loughner’s parents found his behavior so worrisome that they confiscated his shotgun and disabled his car every night in an effort to keep him home.¹⁴³

Cho also did a number of bizarre things, including stabbing someone’s carpet with a knife at a social event and repeatedly handing in writing assignments discussing murdering his classmates and teachers.¹⁴⁴ His English professor was so unnerved by

in other public mass shooting cases since over half of public mass shootings take place at school or the workplace.

136. See Haven, *supra* note 14, at 271; Macleod, *supra* note 17.

137. See Ward *supra* note 33, at 410; Haven, *The Elephant*, *supra* note 30, at 557 n. 299.

138. See McCreary *supra* note 41, at 821.

139. This is consistent with a study conducted of 37 school shooting incidents, where a research found that 93% of the perpetrators in those cases acted in a way that caused concern to others prior to their attacks. Schuster, *supra* note 132.

140. McCreary, *supra* note 41, at 821; Lewis, *supra* note 75, at 2.

141. Lewis, *supra* note 75, at 1, 2–3.

142. Jacobs & Jones, *supra* note 80.

143. Michael Martinez & Chelsea J. Carter, *New Details: Loughner’s Parents Took Gun, Disabled Car to Keep Him Home*, CNN.COM (Mar. 28, 2013), <http://www.cnn.com/2013/03/27/justice/arizona-loughner-details/>.

144. Flannery, *supra* note 45, at 287–88.

his behavior that she had him removed from her class.¹⁴⁵ James Holmes’s university psychiatrist found his behavior so bizarre she had him kicked out of school.¹⁴⁶ Finally, prior to his murderous rampage, Lanza’s mother was apparently so alarmed by his behavior that she was planning on having him involuntarily committed to a mental institution.¹⁴⁷

If we know that most public mass attackers generally (1) tell someone of their intentions, and (2) display mentally unstable conduct well before their crimes to the extent that it evokes fear and (or) concern from those around them, then should not our legislative efforts to prevent public mass shootings take this information into account? It should, but as explained in the next section, current firearm legislation does not.

II. WHY THE LANGUAGE IN MOST FIREARM LAWS IS “MENTALLY DEFECTIVE”—AN OVERVIEW OF CURRENT LEGISLATION

“[Firearm] Laws are like cobwebs, which may catch small flies, but let wasps and hornets break through.”¹⁴⁸

Both the federal government and most States have legislation specifically prohibiting mentally ill persons from possessing, purchasing, or carrying firearms.¹⁴⁹ The federal and state jurisdictions vary, however, on who falls under the mentally ill umbrella. Most of these federal and state laws are seriously flawed because they continuously allow violent, mentally ill persons to slip through the cracks.

A. Federal Law

The Gun Control Act of 1968, as subsequently amended,¹⁵⁰ tacitly defines a mentally ill person as anyone “who has been adju-

145. Haven, *The Elephant*, *supra* note 30, at 557.

146. Brumfield & Mungin, *supra* note 93.

147. Winter, *supra* note 122.

148. Jonathan Swift, *Quotes About Law*, GOODREADS.COM, <http://www.goodreads.com/quotes/tag/law>.

149. *See infra* notes 151, 157–201.

150. The Gun Control Act has been repeatedly amended over the years by various legislation, including the Firearms Owners’ Protection Act of 1986 which better defined those considered to have a dangerous mental illness—those

dicated as a mental defective or who has been committed to a mental institution” from possessing a firearm.¹⁵¹ Federal regulations define “mentally defective” as someone who has been adjudicated by a court, board, commission or lawful authority (1) as being dangerous to himself or others or lacking the mental capacity to manage or contract his own affairs (2) because of “marked subnormal intelligence, or mental illness, incompetency, condition, or disease.”¹⁵² This definition includes persons found to be not guilty by reason of insanity and those found incompetent to stand trial.¹⁵³ The phrase “committed to a mental institution” requires that a person be formally committed to a mental institution by a court, board, commission or other lawful authority.¹⁵⁴ Excluded from this definition are: (1) persons who are voluntarily committed to a mental institution; and (2) those who are committed to a mental institution for observation purposes only.¹⁵⁵

B. Current State Laws

State laws governing possession of firearms by the mentally ill are varied and, as pertinent to this article, fall into one of five categories: (1) those that are virtually identical to federal law in denying firearm access to persons who have been adjudicated mentally defective or involuntarily committed to a mental institution; (2) those that also restrict firearm access to persons voluntarily committed to a mental institution; (3) those that require a showing of dangerousness; (4) those that preclude firearm possession for persons only *diagnosed* with mental illness; and (5) those that deny

who have been adjudged mentally incompetent and committed to a mental institution), the Brady Handgun Violence Prevention Act of 1993, Pub. L. 103-159, as amended, Pub. L. 103-322, 103 Stat. 2074, that established a national background system check that would provide a list of persons not qualified to purchase a firearm under the Gun Control Act, and the National Instant Check System Improvement Amendments Act of 2007 created to encourage States to report persons disqualified from purchasing firearms with mental illness. *See also* McCreary, *supra* note 41, at 831–38.

151. 18 U.S.C. § 922(g)(4) (2014).

152. 27 C.F.R. § 478.11 (2014).

153. *Id.*

154. *Id.*

155. McCreary, *supra* note 41, at 849.

access to firearms to people who suffer from mentally illness, regardless of whether they have been diagnosed, treated or confined for mental illness.

Most states fall into the first category by either having: (1) specific statutes mirroring federal law requiring a mentally ill adjudication or involuntarily commitment to trigger the gun prohibition; or (2) no specific statute at all and defaulting to the federal standard.¹⁵⁶ The jurisdictions with specific statutes mimicking federal law include the following states: Arkansas;¹⁵⁷ Florida;¹⁵⁸ Iowa;¹⁵⁹ Kansas;¹⁶⁰ Maine;¹⁶¹ Michigan;¹⁶² Mississippi;¹⁶³ Missouri;¹⁶⁴ Nebraska;¹⁶⁵ Nevada;¹⁶⁶ New Mexico;¹⁶⁷ North Carolina;¹⁶⁸ North

156. Frederick E. Vars & Amanda Adcock Young, *Do the Mentally Ill Have A Right to Bear Arms*, 48 WAKE FOREST L. REV. 1, 12 (2013).

157. ARK. CODE ANN. § 5-73-103(a)(2)(3) (2013) (providing “no person shall possess or own any firearm who has been . . . [a]djudicated mentally ill . . . [c]ommitted to a mental institution).

158. FLA. STAT. § 790.065 (2013) (essentially prohibiting licensed firearm dealers from selling firearms to persons who have been “adjudicated mentally defective” or “committed to a mental institution”).

159. IOWA CODE 724.15(1)(c) (West 2013) (disqualifying anyone who is ineligible to possess or have access to firearms under federal law from obtaining a permit to own a gun).

160. KAN. STAT. ANN. § 21-6301(a)(9) (2011) (providing it is unlawful to “sell[], giv[e] or otherwise transfer[] any firearm to any person who is or has been a mentally ill person subject to involuntary commitment for care and treatment).

161. 15 M.R.S.A. § 393(1)(E) (West 2013) (prohibiting a person who has been involuntarily committed to a mental hospital by a court, found not guilty by reason of insanity, or found not mentally competent to stand trial from owning or possessing a firearm).

162. MICH. COMP. LAWS § 28.422 (West 2013) (permitting only those with a license to obtain a pistol and disqualifying those who have been adjudged insane, found legally incapacitated, or involuntarily committed for mental illness from acquiring a license).

163. MISS. CODE ANN. § 45-9-101(2)(H)-(I) (West 2013) (disallowing a person who has been adjudicated mentally ill or hospitalized for mental illness, voluntarily or otherwise, from carrying a concealed pistol or revolver).

164. MO. REV. STAT. § 571.070 (2013) (making it unlawful for a person who has currently been adjudged mentally incompetent from possessing a firearm).

165. NEB. REV. STAT. § 69-2433(2), (6) (West 2013) (prohibiting mentally ill persons ineligible from possessing or purchasing a firearm under federal law

Dakota;¹⁶⁹ Ohio;¹⁷⁰ Oregon;¹⁷¹ Pennsylvania;¹⁷² South Carolina;¹⁷³ Tennessee;¹⁷⁴ Utah;¹⁷⁵ Virginia;¹⁷⁶ Washington;¹⁷⁷ West Virginia;¹⁷⁸ Wisconsin;¹⁷⁹ and Wyoming.¹⁸⁰

and those found to be dangerous under Nebraska's Mental Health Commitment or similar law from obtaining a concealed handgun license).

166. NEV. REV. STAT. § 202.360 (2013) (prohibiting a person who has been adjudicated mentally ill or committed to a mental institution from owning or possessing a firearm).

167. N.M. STAT. ANN. § 29-19-4(A)(8) (West 2013) (disallowing anyone who has been "adjudicated mentally incompetent or committed to a mental institution" from obtaining a license to carry a concealed handgun).

168. N.C. GEN. STAT. §§ 14-403, 14-404 (requiring a permit to purchase or receive a firearm and excluding individuals who have been involuntarily committed to a mental institution or adjudicated by a court to be mentally incompetent from those eligible for permit).

169. N.D. CODE CENT. ANN. §62.1-02-01(1)(c) (prohibiting a person who has been diagnosed *and* confined to a mental hospital or institution by a court or has been adjudicated mentally deficient from possessing a firearm).

170. OHIO REV. CODE ANN. § 2923.13(A)(5) (LexisNexis 2011) (making it illegal for anyone who has been adjudicated mentally incompetent or defective, been committed to a mental institution, been found to be mentally ill by a court and ordered to be hospitalized, or involuntarily hospitalized in a mental institution other than for observation from possessing a firearm).

171. O.R.S. § 166.250(1)(c)(E) (West 2013) (criminalizing the possession of a firearm by a person who has been adjudicated mentally ill by a court and is under court-ordered mental health treatment).

172. 18 PA. C.S.A. § 6105(c)(4) (2014) (prohibiting "[a] person who has been adjudicated as an incompetent or who has been involuntarily committed to a mental institution for inpatient care and treatment" from essentially possessing, using or acquiring a firearm).

173. S.C. CODE 76 ANN. § 16-23-30 (2013) (making it unlawful to sell or transfer a firearm to "a person who by order of a circuit judge or county court judge of this State has been adjudged unfit to carry or possess a firearm, such adjudication to be made upon application by any police officer, or by any prosecuting officer of this State, or sua sponte, by the court, but a person who is the subject of such an application is entitled to reasonable notice and a proper hearing prior to any such adjudication.").

174. TENN. CODE ANN. §39-17-1351 (c)(12) (Westlaw through 2013 Reg. Sess.) (disqualifying anyone adjudicated "mentally defective" or judicially hospitalized for mental illness from obtaining a handgun permit).

175. UTAH CODE ANN. 1953 § 76-10-503(1)(B)(vi)-(vii), (3) (2012) (making it a third-degree felony for anyone who has been found legally incompetent to stand trial for a felony crime, been adjudicated "mentally defective" within

The states that have no state statute specifically denying mentally ill persons access to firearms, and thus, automatically default to federal law are the following: Alabama; Alaska; Colorado; Kentucky; New Hampshire; and Vermont.¹⁸¹ This brings the grand total of states following the federal standard to approximately thirty.

Ten states also preclude persons who have been *voluntarily* committed to a mental institution from possessing a firearm or carrying a concealed firearm. Those jurisdictions include: Connecticut;¹⁸² Delaware;¹⁸³ Georgia;¹⁸⁴ Illinois;¹⁸⁵ Maryland;¹⁸⁶ Massachu-

the meaning of federal law, or committed to a mental institution from possessing a firearm.”).

176. VA. CODE ANN. §§ 18.2-308.1:2, 18.2-308.1:3 (2013) (making it unlawful for any person to purchase or possess a firearm who has been (1) involuntarily committed to a mental institution or court-ordered outpatient services or (2) adjudicated legally incompetent or incapacitated).

177. WASH. REV. CODE § 9.41.040 (2013) (criminalizing the possession of firearms by a mentally ill person involuntarily committed to a mental institution or found not guilty of a crime by reason of insanity).

178. W. VA. CODE § 61-7-7(a)(4) (2012, as amended in 2013 by the 81st Leg. Sess.) (making it unlawful for anyone who has been “adjudicated mentally defective or who has been involuntarily committed to a mental institution” from possessing a firearm, provided they were informed at the time of adjudication to surrender all firearms).

179. WIS. STAT. ANN. § 941.29(1)(c)-(m) (2012) (making it illegal for anyone who has been found not guilty by reason of insanity or involuntarily committed to a mental institution from possessing a firearm).

180. WYO. STAT. § 6-8-404 (2013) (prohibiting a person who has been adjudicated mentally ill or has been committed to a mental institution from possessing a firearm manufactured and remaining solely in Wisconsin).

181. Reid Wilson, *State Rules Vary On Guns for the Mentally Ill*, WASH. POST, Sept. 20, 2013, <http://www.washingtonpost.com/blogs/govbeat/wp2013/09/20/state-rules-vary-on-guns-for-the-mentally-ill/>; Nat’l Conf. of State Legislators, *Possession of a Firearm By People With Mental Illness*, NCLS.ORG (Jan. 2013), <http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx> (listing all the state statutes regulating the possession of firearms by the mentally ill and excluding Alabama, Alaska, Colorado, Kentucky, New Hampshire, and Vermont from the list, indicating they have no specific statutes on the issue). See also Vars, *supra* note 13, at 12 (pointing out that “[w]here there is no state statute . . . the federal standard effectively controls.”).

182. CONN. GEN. STAT. § 53a-217c(a) (2013) (making it unlawful for any person to possess a firearm who has been (1) confined to a mental hospital by

setts;¹⁸⁷ New Jersey;¹⁸⁸ New York;¹⁸⁹ Rhode Island;¹⁹⁰ and Washington, D.C.¹⁹¹

probate court order within the preceding 12 months; (2) released from custody in the past 20 years after being found not guilty by reason of insanity; or (3) voluntarily admitted to a psychiatric hospital after October 1, 2013 not solely for drug or alcohol abuse).

183. DEL. CODE ANN. tit. 11, § 1448(a)(2) (2013) (prohibiting “[a]ny person who has ever been committed for a mental disorder to any hospital, mental institution or sanitarium” from possessing a firearm unless they have a certificate from a Delaware licensed medical doctor or psychiatrist that that they are no longer suffering from a mental illness).

184. GA. CODE § 16-11-129(b)(2)(J) (West 2013) (banning any person who has been hospitalized for mental illness in the five years preceding their application from obtaining a concealed carry license).

185. ILL. REV. STAT. CH. 720, § 5/24–3.1 (West 2013) (making it a crime for anyone to possess a firearm who has been hospitalized, either voluntarily or involuntarily in a mental institution).

186. MD. CODE, PUBLIC SAFETY, § 5–133(b)(6)–(10) (West 2013) (prohibiting anyone from possessing a firearm who has been: (1) voluntarily committed to a mental facility for more than 30 consecutive days, (2) involuntarily committed to a mental institution, (3) suffers from a mental disorder and has a history of violence, (4) found incompetent to stand trial, and (5) found not guilty by reason of insanity).

187. MASS. GEN. LAWS, 140 § 131(d)(ii) (West 2013) (stating anyone who has been “confined” to a mental hospital or institution is ineligible to obtain a concealed carry firearm license, but allowing restoration of gun rights after five years if a physician attests they are no longer suffering from a mental illness that should disqualify them from possessing a firearm).

188. N.J.S.A. 2C:58–3(c)(2) (West 2013) (requiring a permit to purchase a firearm and denying a permit to “any person who is confined for a mental disorder to a hospital, mental institution or sanitarium,” without requiring an involuntary commitment).

189. N.Y. PEN. LAW § 400 (1)(d) (2013) (providing no license to possess or carry a firearm shall be issued to anyone “who has stated whether he or she has ever suffered any mental illness or been confined to any hospital or institution, public or private, for mental illness”).

190. R.I. GEN. LAWS § 11-47-6 (West 2013) (providing “[n]o person who is under guardianship or treatment or confinement by virtue of being a mental incompetent . . . shall purchase, own, carry, transport, or have in his or her possession or under his or her control any firearm,” without requiring the confinement to be involuntary).

191. D.C. CODE § 7-2502.03 (2013) (disqualifying persons who have in the preceding five years either (1) been voluntarily or involuntarily admitted to a

Three states require a showing of dangerousness, in addition to mental illness, before prohibiting a person from possessing a firearm. Those states include: Arizona;¹⁹² California;¹⁹³ and South Dakota.¹⁹⁴

At least one state—Hawaii—precludes persons who have been only diagnosed with mental illness from possessing or purchasing a firearm,¹⁹⁵ and six states restrict firearm access to people merely suffering from mental illness; no prior diagnosis, adjudication of mental defectiveness, or commitment to a mental institution is required. Those states include: Idaho,¹⁹⁶ Indiana,¹⁹⁷ Louisiana,¹⁹⁸ Montana,¹⁹⁹ Oklahoma,²⁰⁰ and Texas.²⁰¹

mental institution or hospital or (2) acquitted of a crime by reason of insanity from possessing a firearm).

192. ARIZ. REV. STAT. ANN. §§ 13-3101(7)(a), 36-540 (2012) (prohibiting firearm possession by a mentally ill person who has been found to pose a danger to himself or others).

193. CAL. WELF. & INST. CODE §§ 8100 (West 2013) (temporarily precluding someone receiving inpatient treatment for a mental disorder from possessing a firearm if the mental health professional treating them believes the mentally ill person poses a danger to himself or others; firearm ban is lifted when person is discharged from facility).

194. S.D. CODIFIED LAWS § 23-7-7.1(5) (2013) (providing that a person who has been found to be a “danger to self” or a “danger to others” or adjudged mentally incompetent shall not be eligible for concealed carry firearm permit).

195. HAW. REV. STAT. § 134-7 (2013) (prohibiting persons who (1) have been diagnosed as having a “significant behavioral, emotional, or mental disorders as defined by the most current diagnostic manual of the American Psychiatric Association or for treatment for organic brain syndrome”; or (2) have been acquitted of a crime by reason of a mental disease).

196. IDAHO CODE ANN. § 18-3302(1) (West 2013) (preventing a person for whom there is “substantial evidence” that they currently are lacking the mental capacity to understand court proceedings or are “mentally ill”); IDAHO CODE ANN. § 66-317(12) (West 2013) (defining “mentally ill” as “a person, who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility or through outpatient treatment.”).

197. IND. CODE § 35-47-2-7(b)(4) (2013) (making it unlawful to transfer a handgun to someone the seller “has reasonable cause to believe” is “mentally incompetent.”).

198. LSA-R.S. § 40:1379.3(C)(5) (Westlaw through 2013 Reg. Sess.) (providing a person who “suffer[s] from a mental or physical infirmity due to

Thus, it is abundantly evident that the overwhelming majority of states follow the federal standard. As explained more fully in the next section, the federal standard and the state statutes modeled after it are woefully deficient when it comes to keeping firearms out of the hands of the mentally ill.

C. Why Public Mass Shooters Keep Slipping Through the Cracks of Most Current Firearm Laws

1. The Problem with “Mental Defectiveness”

The primary reason that the Gun Control Act²⁰² and the state statutes that mirror it are deficient is because those statutes require a formal *adjudication* of “mental defectiveness” or an involuntary commitment to trigger the firearm prohibition on mentally ill persons. As discussed in Part I of this Article, while a significant number of public mass shooters may have been suffering from severe mental illness and even seeing a mental health professional before their murderous rampages, most of them had neither been involuntarily committed to a mental institution nor adjudicated mentally defective by a court. Thus, they did not meet the technical requirements of the aforementioned statutes.²⁰³ This was cer-

disease, illness, or retardation which prevents the safe handling of a gun” is ineligible for a concealed handgun permit).

199. MONT. CODE ANN. § 45-8-321(2) (Westlaw, current through 2013 Sess.) (authorizing the sheriff to deny a concealed handgun license to applicants he “has reasonable cause to believe . . . is mentally ill, mentally defective, or mentally disabled or otherwise may be a threat to the peace and good order of the community to the extent that the applicant should not be allowed to carry a concealed weapon”).

200. OKLA. STAT. tit. 21 § 1289.12 (2013) (prohibiting the transference of a firearm to a person who is “mentally or emotionally unbalanced or disturbed”).

201. TEX. GOV’T CODE § 411.172 (2013) (making persons who merely suffer from, or have been diagnosed with, certain enumerated psychiatric disorders ineligible for obtaining a concealed-weapon-carry license; persons who have been involuntarily hospitalized for psychiatric reasons and entered a plea of not guilty by reason of insanity are also disqualified).

202. 18 U.S.C. §922(g)(4) (2014).

203. The shortcomings of the Gun Control Act’s “mentally defective” and “involuntary commitment” language have been well documented by at least one scholar. See McCreary, *supra* note 41, at 813 (noting “the ease with which per-

tainly the case with Charles Whitman, James Holmes, and Adam Lanza.

Additionally, mentally ill individuals who have never been diagnosed with a mental illness or refuse treatment also would fall outside the purview of these statutes. An example is Jared Loughner, who had declined to get a mental health evaluation despite the urging of his college.²⁰⁴ In sum, the language in question is defective because it ignores the fact that most public mass shooters are not diagnosed with mental illness prior to their crimes and are only found to be mentally ill afterward.²⁰⁵ Therefore, the status quo permits a significant number of public mass shooters to obtain their firearms lawfully.²⁰⁶

2. Involuntary Commitment Requirement is Too Underinclusive

Second, requiring an involuntary commitment before someone can be denied access to firearms permits too many seriously mentally disturbed people to slip through the cracks because it can be extremely arduous to have someone civilly involuntarily committed. For example, while most States require a showing that there is a serious or substantial risk or likelihood that a mentally ill individual poses a danger to himself or others to justify an involuntary commitment, some will not involuntarily commit an individual if better alternative arrangements exist.²⁰⁷ Other states require a showing of “imminent danger.”²⁰⁸ To satisfy the “imminent dan-

sons with dangerous mental illnesses may legally purchase firearms because they do not meet the technical and vague requirements under the Act . . .”).

204. Shijie Feng, *Madness and Mayhem: Reforming the Mental Health Care System in Arizona*, 54 ARIZ. L. REV. 541, 543 (2012) (noting that Loughner never sought assistance from a mental health professional and was only diagnosed as schizophrenic after the shootings).

205. See NEWMAN ET AL., *supra* note 6, at 59 (noting this is true for school shooters).

206. Mark Follman et al., *A Guide to Mass Shootings in America*, MOTHER JONES (Feb. 27, 2013), <http://www.motherjones.com/politics/2012/07/mass-shootings-map>.

207. See, e.g., ME. REV. Stat. TIT. 34-b, § 3864(6).

208. Alison Pfeffer, “Imminent Danger” and Inconsistency: *The Need For National Reform of the “Imminent Danger” Standard for Involuntary Civil*

ger” standard, the mentally ill person must commit some “overt act” during the commitment hearing to meet this requirement.²⁰⁹ Since it is so difficult to have a mentally ill person involuntarily committed, some violent, mentally ill persons are allowed to purchase, possess, and carry guns.

Moreover, laws that require a showing of dangerousness before a mentally ill person is disqualified from possessing a firearm are fraught with difficulties because it is nearly impossible for mental health professionals to predict with any reasonable degree of certainty which mentally ill patients are likely to commit violence against others.²¹⁰ The majority of mentally ill persons are not violent,²¹¹ even though an epidemiological study reveals that persons with a serious mental illness (like schizophrenia, major depression, mania, bipolar disorder, panic disorder) have an increased risk of committing violence than persons without such a mental disorder.²¹²

Commitment In the Wake of the Virginia Tech Tragedy, 30 CARDOZO L. REV. 277, 289–91 (2008).

209. *Id.*

210. See Katherine Newman & Cybelle Fox, *Repeat Tragedy: Rampage Shootings in American High School and College Settings, 2002–2008*, 52 AM. BEHAVIORAL SCIENTIST 9, 9 (2009) (noting that, in her case studies of rampage high school and college shootings from 2002 to 2008, “only rarely” did mental health authorities “imagine that the shooter’s distress would culminate in an attack”).

211. Jane D. Hickey, *Gun Prohibitions For People With Mental Illness—What Should the Policy Be?*, 32 DEV. MENTAL HEALTH L. 1, 2 (2013) (noting the “vast majority of individuals with psychiatric disorders do not commit violent acts.”); Christina Canales, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1738 (2012) (observing that “most of the mentally ill population is not violent.”).

212. Ann Hubbard, *The ADA, The Workplace, and the Myth of the ‘Dangerous Mentally Ill*, 34 U.C. DAVIS L. REV. 849, 870 (2001). Specifically, Professor Jeffrey Swanson and colleagues published a well-received and often cited study, concluding that 6.81% of persons with these diagnoses reported violent behavior in the past year, as opposed to 2.05% of the people without a major mental disorder. Vars, *supra* note 13, at 14–16.

3. Other Loopholes in the Legislation

Another problem with the federal gun control law concerning the mentally ill is that there are too many loopholes. For example, the prohibition on selling or transferring firearms to a person who has been declared “mentally defective” or involuntarily committed to a mental health institution only applies to licensed federal firearms dealers.²¹³ It does not apply to private sellers, who in most jurisdictions have no obligation to run a background check on a potential buyer.²¹⁴ Hence, a private individual can sell or gift a firearm to a person without conducting a background check.

Additionally, the practical reality of current laws is that the laws rely heavily upon the gun applicant to self-report his or her mental illness. Given that an individual arrived at a firearms dealer to purchase a gun, the odds are that he or she will not self-report. Moreover, a mentally ill person purchasing a firearm to commit a public mass shooting will not be deterred by any federal or state penalty for unlawfully possessing a firearm. This rationale turns on the fact that, if the person is not worried about the penalty for murder—the gravest criminal offense, then the person will not be concerned about the lesser penalty for unlawful firearm possession. Moreover, as illustrated by the detailed descriptions of some public mass shooters at the beginning of this article, most public mass shooters commit suicide. This is yet another reason for a potential public mass shooter to be unconcerned with the penalty for misrepresenting his mental health status on a firearm application.

4. Failure to Report

Even if every person who sold or transferred a firearm conducted a background check on an intended recipient, this check would not keep guns out of the hands of the mentally insane be-

213. Andrew Goddard, *A View Through The Gun Show Loophole*, 12 RICH. J.L. & PUB. INT. 357, 357 (2009) (editorial) (noting that federal law exempts private individuals who occasionally sell guns from the mandate that all licensed gun dealers must conduct criminal background checks on potential buyers). This exemption was intended to allow the unregulated transfer of guns to family and friends. *Id.* This loophole allows a large number of guns to be sold without background checks at gun shows. *Id.*

214. *Id.*

cause most States do not provide a full and complete accounting to the federal government's National Instant Check System (NICS) of all persons in their State ineligible to purchase guns because of mental illness. In 2007, only twenty-two states provided information to the NICS system on the mental health records of the persons in its jurisdictions.²¹⁵ As of February 2011, seventeen states sent less than twenty-five names to be added to the NICS database.²¹⁶ Nine states sent no names.²¹⁷

Moreover, in *Printz v. United States*,²¹⁸ the United States Supreme Court held that state executive officers do not have to conduct background checks on behalf of the federal government, even on a temporary basis. In *Printz*, chief law enforcement officers (CLEOs) from two states challenged the constitutionality of the then newly enacted Brady Act establishing the national instant background-check system.²¹⁹ Until the NICS system could be put in place, interim provisions of the Brady Act required CLEOs to: (1) "make a reasonable effort" to conduct a state and federal background check within five days of receiving that person's Brady form to determine whether a prospective gun purchaser was eligible to purchase a firearm; and (2) if a prospective purchaser was ineligible, notify them in writing why he or she is disqualified from purchasing a firearm.²²⁰ The Supreme Court held these provisions were unconstitutional because there was no constitutional or historical basis for permitting the federal government to commandeer state executive officers to administer federal law.²²¹ While state courts are bound to apply federal law under the Supremacy Clause, state executive officers are not required to implement it.²²² Accord-

215. McCreary, *supra* note 41, at 835–36.

216. *Id.* at 821.

217. *Id.*

218. *Printz v. United States*, 521 U.S. 898, 918–22 (1997) (noting "a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front," and permitting federal control of state officers would affect "the separation and equilibration of powers between the three branches of the Federal government itself.").

219. *Printz*, 521 U.S. at 902, 904.

220. *Id.* at 903–04.

221. *See id.* at 905–26.

222. *Id.* at 928–29.

ingly, the provisions in question violated the U.S. Constitution's "incontestable . . . system of dual sovereignty."²²³

In light of *Printz*, it is clear that states only have to provide information to the NICS on a voluntary basis.²²⁴ Not only are some states choosing not to voluntarily report mentally ill citizens to the national database, but States are failing to disclose the names of mentally ill persons to their own state databases as well.²²⁵

In California, for example, thirty-four courts failed 2,300 times to inform the California Department of Justice of mentally ill individuals no longer eligible to possess or purchase firearms between 2010 and 2012.²²⁶ Some reasons for judges' and mental health professionals' recalcitrance could be (1) ignorance of the law, (2) fear of further stigmatizing the mentally ill; (3) failure to recognize a potentially dangerous mentally ill person. Nevertheless, as described *infra* in the next section of this Article, for any legislation prohibiting mentally unstable persons from possessing or purchasing firearms to be successful, the legislation must provide a reliable and comprehensive way of identifying these persons.

Because state executive officers cannot be forced into reporting their state's mentally ill to the NICS, the NICS is virtually useless. Accordingly, the states should take the lead on enacting laws better designed to track and monitor the mentally ill. Indeed, the states are the best places to test new firearm legislation focused primarily on the mentally ill because they always have been great laboratories for testing innovative ideas. Any new legislation designed to prevent future public mass shootings, however, must take into account public mass perpetrators' typical traits and warning signs.

223. *Id.* at 918.

224. Katherine L. Record & Lawrence O. Gostin, *A Robust Individual Right to Bear Arms Versus the Public's Health: The Court's Reliance on Firearm Restrictions on the Mentally Ill*, 6 CHARLESTON L. REV. 371, 375 (2012) (observing that the *Printz* court held that requiring states to report names to the NICS database violated federalism principles).

225. Jessica Calefati, *California No-Gun List: Names of Mentally Ill Often Aren't Reported To Law Enforcement, Auditor Says*, MERCURY NEWS (Oct. 30, 2013), http://www.mercurynews.com/ci_24414672/state-auditor-names-mentally-ill-barred-from-owning.

226. *Id.*

III. LEGISLATIVE PROPOSALS BETTER TAILORED TO DISARM TO THE MENTALLY ILL

To live in freedom is to expose ourselves to the occasional outburst of the insane and the criminal. We cannot stop those who have evil in their hearts, but we can make sure that those who do not — the citizenry and the police — are given a fighting chance to protect us all.²²⁷

A. Proposals

While there is no single piece of legislation that can prevent an individual hell-bent on committing mass murder, the police and the community can make it more difficult. In order to make it more difficult, any legislation designed to disarm the mentally ill should require the following: (1) disqualification of anyone showing signs of mental illness from possessing a firearm, irrespective of a diagnosis; (2) placement of the burden of disarming the mentally ill on those in the community with a special relationship with the mentally ill person; (3) a statewide database listing mentally ill persons ineligible to possess firearms; (4) annual registration of firearms and background checks on all gun purchasers; (5) disallowance of firearms in a household where a mentally ill person resides; and (6) an obligation to report any specific threat of violence made by a mentally ill person to the police.

1. Deny Anyone Displaying Mentally Ill Behavior Access to Guns

First, states should deny access to firearms to any person displaying mentally unstable conduct, regardless of whether they have been diagnosed with a mental illness. This requirement eliminates the problem of seriously mentally ill individuals slipping through the “mentally defective” and involuntary commitment

227. Charles C.W. Cooke, *Norway and Gun Control*, THE NATIONAL REVIEW ONLINE, <http://www.nationalreview.com/articles/272787/norway-and-gun-control-charlie-cooke#!>.

cracks in the federal Gun Control Act and similar statutes. It also takes the guessing work out of determining which mentally ill individuals are dangerous. Finally, it takes into account the research that: (1) most public mass shooters have a history of displaying disturbing behavior for a significant period of time before their killing spree, but are not diagnosed with mental illness until after their dastardly deeds are done; and (2) if they are diagnosed, they have not been adjudicated mentally defective or involuntarily committed as required to trigger the federal and most states gun prohibition mandate. As previously mentioned, at least one state already has such legislation—Oklahoma.²²⁸

2. Place the Onus of Keeping Firearms Out of Mentally Ill's Hands on Those With A Special Relationship With the Mentally Ill Person

Second, to be effective, the proposed legislation must place the burden to keep firearms out of the hands of the mentally ill on family, friends, school officials, mental health professionals, and anyone else who has a “special relationship” with the mentally ill person. This can be accomplished by requiring the persons with a special relationship to report suspected violent, mentally ill individuals to law enforcement.

As used in this Article, “special relationship” has the same connotation that it has under common Tort Law. Under common Tort Law, a “special relationship” can arise when a person knowingly takes charge of a person likely to cause serious bodily harm to another or fails to protect a person under their control.²²⁹ For a “special relationship to be recognized, there must be some degree of dependence on the defendant. As relevant here, courts have

228. OKLA. STAT. tit. 21 § 1289.12 (2013) (prohibiting the transference of a firearm to a person who is “mentally or emotionally unbalanced or disturbed”).

229. Margaret F. Cooper, *A Duty of Care to Protect Persons from the Tortious Acts of Third Parties—Biscan v. Brown: Broadening the Special Relationship Doctrine to Include Adult Hosts of Parties Where Minors Are Consuming Alcohol*, 37 U. MEM. L. REV. 95, 97 (2007) (citing RESTATEMENT OF TORTS (SECOND) §§ 319–20 (1965)).

recognized special relationships between a school and a student;²³⁰ an employer and employee;²³¹ a parent and a minor child;²³² and a mental health professional and an identifiable third-party victim.²³³ To incentivize persons with a special relationship to report a potentially dangerous mentally ill person to law enforcement, any new law would have to make failure to report a crime. Those persons reported to local law enforcement should be placed on a no-firearm list until they can prove their mental fitness. The reason for this measure is because a person with a special relationship with the potentially mentally ill and dangerous person is in the best position to assess the prospective mentally ill person's stability since they see him or her the most.²³⁴

Notably, at least one state—New York—already has legislation requiring mental health professionals to report any person whom they believe “is likely to engage in conduct that would result in serious harm to self or others.”²³⁵ The information conveyed to the division of criminal justice services is confidential and may only be used for determining whether that mentally ill person's firearm rights should be revoked.²³⁶

This legislation was enacted in response to the Newtown tragedy and is a great start. However, the problem with the New York statute is that it is toothless. Specifically, it provides no real consequences for failing to comply with the statute's mandate. Subsection (d) of the New York statute specifically states that a mentally health professional's failure to disclose the name of a person likely to engage in dangerous conduct “shall not be the basis for any civil or criminal liability of such mental health professional” when the decision not to disclose was “made reasonably and in good faith.”²³⁷ Under this language, anybody can avoid lia-

230. *Schieszler v. Ferum College*, 236 F. Supp. 2d 602, 609-10 (W.D. Va. 2002).

231. *A.H. v. Rockingham Pub. Co., Inc.*, 495 S.E.2d 482, 485 (Va. 1998).

232. *Hite v. Brown*, 654 N.E.2d 452 (1995).

233. *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).

234. *But cf. McCreary*, *supra* note 42 at 854–59 (proposing that the burden be shifted to the purchaser by requiring him or her to prove their fitness to purchase a gun in the form of a medical certificate).

235. N.Y. MCKINNEY'S MENTAL HYG. LAW § 9.46(b) (2014).

236. *Id.*

237. *Id.* § 9.46(d)

bility by merely asserting they were acting in good faith, which would be difficult to disprove. One could establish he or she acted “reasonably” equally effortlessly by simply proving that the mentally ill person had never harmed anyone in the past; thus, they had no idea that the person would likely harm someone in the future.

This Article proposes criminal penalties for failing to report someone that a reasonable person would believe is mentally ill and dangerous without leaving any wiggle room to avoid liability. This undoubtedly will encourage those with a special relationship to a mentally ill person to report them to the proper authorities if they believe they are dangerous.

This proposal does not limit the reporting requirement to mental health professionals. As previously mentioned, those closest to mass shooters almost always witnessed menacing and inappropriate behavior well before the rampage shootings were committed. If they tip off the police before the mentally ill person acquires a gun, rampage shootings can be avoided.

Finally, this proposal also deals with the problem of relying upon the mentally ill person to self-report. The latter does not work because, as previously explained, without a complete and accurate national database naming mentally ill persons prohibited from possessing a gun, a firearms dealer has no way of knowing if the person standing before him during a sale transaction is mentally ill, as his interaction with the potential buyer is limited. Likewise, placing the burden on the mentally ill person is problematic because, after all, they are mentally ill. The prospect of going to jail is not much of a deterrent for a mass shooter because most mass shooters end up committing suicide after their rampages. This proposal addresses these concerns by placing the burden on the sane people in the mentally ill person’s life who know or should know whether the mentally ill person is dangerous.

3. Create a Statewide Database of Mentally Unstable Individuals Unable to Possess Guns

Third, the legislation must have a comprehensive reporting and policing component that allows law enforcement to identify and track mentally ill persons similar to a sex offender registry. Those persons listed should be prohibited from possessing or acquiring firearms until they can provide proof from a medical pro-

fessional that they are mentally stable and responsible enough to possess a firearm. If a person is found to be mentally ill and dangerous by the appropriate tribunal (perhaps a mental health court), then they lose their right to own or possess a firearm for five years. The purpose of the five-year waiting period is to make sure that the person's mental health has been restored; a person may be able to fake sanity if the period were shorter.

4. Require Annual Registration of All Firearms and Background Checks for All Gun Sales, Including Private Sales

Fourth, all private sales or transfers of firearms must be finalized by the state, subject to the prospective gun recipient having a clean bill of mental health and a criminal background check. The State can charge a fee for this service, much like the fee associated with registering a car. Indeed, persons should be required to register their firearms and notify the state when ownership of that firearm has been transferred to someone else. This will cover the gifting-of-guns-to-dangerous-mentally-ill-persons loophole, as well as the private sales one. Also, background checks should be performed on all potential buyers, regardless if the sale is by a licensed firearms dealer or a private person.

5. Do Not Permit Mentally Ill Persons To Live in a Household With Firearms

Fifth, mentally ill persons should be prohibited from living in the same household with firearms. This is because there is no safe storage of firearms around a mentally disturbed person bent on committing mass murder—just ask Nancy Lanza. At least one state—Pennsylvania—already has legislation requiring a mentally ill person to transfer or sell any firearms in their possession to an eligible person *outside of their* household within sixty days after being disqualified from possessing a firearm.²³⁸ Such a provision can be enforced the same way the police enforce laws prohibiting convicted felons from possessing a firearm or associating with other known felons; once the police catch a felon with a gun or in the

238. 18 PA. C.S.A. § 6105(a)(2)(1) (2014).

company of another felon, they are arrested and charged with a crime.

6. Require Those To Whom A Specific Threat Has Been
Communicated to Report That Threat to the Police
Immediately

Last but not least, if a mentally ill person communicates to someone an intent to harm others, the recipient of that information is required to report that mentally ill person to the police, regardless of whether they believe the threat is credible or they have a special relationship with the mentally ill person. Just as with any other reported intended crime, it is then the state law enforcement's responsibility to investigate such a report to determine whether it is credible. If it is credible and there is sufficient evidence that the person is about to commit a crime, then the police can arrest the would-be-perpetrator. If the report is unsubstantiated, the police can take no action. This measure takes into account the research that, in most cases, mentally ill persons tell someone of their plans to commit mass murder.

In sum, to effectively disarm the mentally ill, a comprehensive legislative approach at the state level must be adopted. While one state may have one of these measures, no state has all of them.

B. *A Model Statute*

Below is an example of a model statute that embodies the proposals in the previous section:

The Prevention of Mentally Ill Persons' Access to Firearms Act

(a) *Unlawful Acts.*

It shall be unlawful for any person to—

- (1) sell, transfer, provide, or give access to, a firearm to anyone a reasonable person would believe is mentally unstable;
- (2) fail to report to the proper authorities anyone a reasonable person would believe is mentally unstable and dangerous, if the person has a special relationship with the perceived mentally ill individual;

- (3) fail to report to the proper authorities a specific threat of a mass shooting, whether or not they (1) believe the threat is credible or (2) have a special relationship with the person who communicated the threat; or
- (4) store firearms in a house where a person they have reason to believe is mentally ill resides.

(b) *Mental-Health-No-Firearm-Registry.*

- (1) There shall be created a statewide mental-health-no-firearm registry listing the name of every person for which law enforcement has gathered substantial evidence is mentally unstable. This registry shall remain confidential and shall only be used to determine one's eligibility to possess, purchase or otherwise have access to a firearm.
- (2) Any person on the list shall be prohibited from purchasing a firearm until a state mental health profession can attest to their mental fitness to handle a firearm.
- (3) Every person must check with their local police department to see if the potential buyer or gun recipient is qualified to purchase or receive a firearm before selling or transferring a firearm to the prospective purchaser or donee.

(c) *Definitions*

- (1) "Mentally unstable conduct" includes, but is not limited to: (1) repeated irrational or erratic behavior; (2) nonsensical rants; (3) violent writings; (4) obsessive preoccupation with past mass shootings, firearms, or violence; (5) unprovoked acts of violence; (6) unreasonable paranoia; or (7) any other behavior that would cause a reasonable person to be gravely concerned about that person's safety and of those around him. Mere social awkwardness alone does not constitute "mentally unstable conduct."
- (2) As used in this section, "special relationship" has the same meaning as it does under common tort law. Examples of special relationships may include mental health professionals, teachers and other school administrators, and parents. (3) "Substantial evidence" means sufficient evidence that suggests more likely than not a

person is mentally ill, regardless of whether they have been diagnosed, treated, or confined for mental illness.

(3) “Proper authorities” means local law enforcement.

(d) *Penalties.*

(1) A person who violates subsection (1) of this section shall be guilty of a third-degree felony and subject to up to five years imprisonment.

(2) A person who violates subsection (2) of this section shall be guilty of a misdemeanor and subject to up to one year imprisonment and/or a fine of up to \$10,000. If a death results because of a violation of subsection (a)(2), the person shall be guilty of a third-degree felony subject to up to five years imprisonment and a fine of up to \$50,000.

(3) A person who violates subsections (3) or (4) of this section shall be guilty of a third-degree felony and subject to up to five years imprisonment, one year probation, and a maximum \$10,000 fine. If a death results because of a violation of subsection (a)(3), the person may be fined of up to \$ 100,000.²³⁹

C. *Arguments in Favor of Such Legislation*

First, disqualifying those who have displayed signs of mental instability, regardless of whether they have been diagnosed with mental illness, prevents them from slipping through the “mentally defective” cracks, as Charles Whitman, James Holmes, Jared Loughner, and Adam Lanza did. This measure also can reduce the incidence of suicide since most mentally ill persons pose more of a danger to themselves than others and firearms are the most successful way people commit suicide.²⁴⁰

239. The penalty for violating these subsections are greater because failing to report a specific, concrete threat is more egregious than failing to report someone you believe is mentally ill and dangerous but who has made no specific threat to harm anyone.

240. Andrew J. McClurg, *The Public Health Case For the Safe Storage of Firearms: Adolescent Suicides Add One More Smoking Gun*, 51 HASTINGS L.J. 953, 958 (2000) (noting that “firearms are the most lethal method of suicide attempt, succeeding in at least 85% of attempts”).

Second, requiring all sellers or those wishing to transfer a firearm to someone else check with the local police department to see if that person is disqualified from possessing a firearm closes the private sale loophole, making it more difficult for the mentally disturbed persons to circumvent the background check requirement.

Third, it puts the onus on those around the mentally ill person to prevent him from obtaining a gun. This is an effective approach because, as a research study revealed, most foiled elementary school rampage shootings were thwarted because someone notified authorities of the potential shooter's intent to kill.²⁴¹

Fourth, this community policing approach (1) makes everyone more vigilant in paying attention to those around us who may suffer from mental illness, and (2) should encourage loved ones to put pressure on the mentally disturbed individual to seek professional help.

Finally, the finalizing-the-private-sale-of-firearms-through-the-state feature can generate extra revenue for the state and pay for the extra man power it will take to enforce the proposed legislation.

D. Arguments Against Said Legislation

Some individuals may be concerned that the unstable-conduct-provision may be overinclusive and deny access to guns to people with idiosyncrasies or quirky behavior that is misperceived as behavior indicative of mental illness. It is better, however, to be overinclusive than underinclusive. Moreover, this concern should be alleviated by the provision in the proposed statute allowing restoration of gun rights upon proof of mental stability. Also, the statute requires "substantial evidence" of unstable conduct and provides specific, concrete examples of what constitutes such conduct and what does not.

Additionally, some may argue that the above-proposed legislation may further stigmatize the mentally ill and dissuade them

241. Mary Ellen O' Toole, *The School Shooter: A Threat Assessment Perspective*, FED. BUREAU OF INVESTIGATION (1998), available at <http://www.fbi.gov/stats-services/publications/school-shooter>.

from seeking treatment. One can only assume, however, that a person would prefer the stigma of being mentally ill over the stigma of being a mass murderer. Moreover, the provision in the proposed statute providing that the mental-health-no-firearm registry be available only to law enforcement for the purpose of determining whether someone is eligible to purchase or possess a firearm addresses this concern. To further allay any privacy concerns, law enforcement can just inform potential firearm sellers that the person on the list is disqualified from purchasing a firearm without specifying whether it is due to a past felony conviction or mental illness.

Another argument against the proposed legislation could be that family members and other loved ones would be discouraged from housing mentally ill loved ones, as they could be criminally liable for failing to report a mentally ill person deemed dangerous. Research reveals, however, that family members would not abandon their mentally ill loved ones. In fact, as one school shooting expert and her colleagues observed, in more than half the cases of school shootings, friends and family attempted to get help for their loved ones or warn others of the impending violence.²⁴² The proposals in this article should actually encourage loved ones to report suspected violent, mentally ill loved ones, as they could be held criminally responsible for failing to do so. Thus, this is not a legitimate concern.

Some may be concerned with the cost of such a statutory scheme, especially considering our country's struggling economy. A state can cover the cost with the annual-registration-of-a fire-arm-feature and by imposing an excise tax on undesirable firearms like the military-style assault weapons capable of spraying a multitude of bullets in a matter of seconds.²⁴³

A few may be concerned that the proposed reporting mechanism is subject to abuse. For example, a co-worker may falsely report someone in their office whom they do not like as being mentally disturbed and dangerous to authorities. Everything, however,

242. NEWMAN ET AL., *supra* note 6, at 59.

243. The famous comedian Chris Rock once joked that if a bullet cost \$5000.00 a piece, there would be no more innocent-bystanders to shootings. Chris Rock, *Chris Rock Quotes*, DIGITAL DREAM DOOR, http://www.digitaldreamdoor.com/pages/quotes/chris_rock_quotes.html.

is subject to abuse and is not a legitimate justification for not enacting such legislation. For instance, during child custody disputes people have been known to file false child abuse reports; yet, teachers, doctors, and other professionals are still required to report suspected abuse.

Finally, some may argue that if mental health professionals have a difficult time predicting whether a mentally ill person is dangerous, how can we expect others with a special relationship with the mentally ill person to fare any better? The response to this is simple. Parents, teachers, and the like are in no worse position than a mental health professional to predict violence; thus, if mental health professionals are required to report in certain jurisdictions so too should persons with a special relationship with a mentally ill person. Indeed, in most of the real-life examples described earlier in this article, it was the parents, teachers, and classmates who accurately feared violence and not the mental health professionals. Remember, Lanza's mental health professionals claimed they saw nothing that would help them predict Lanza would commit the mass shootings at Sandy Hook; yet, his mother knew he was dangerous, as she had planned to have him involuntarily committed.²⁴⁴ One of Jared Loughner's classmates claimed she sat by the door in their Math class at Pima Community College because she feared Loughner would commit a shooting. Likewise, Cho's classmates and English professor feared impending violence as some students stopped attending class and the professor had him removed. Therefore, common sense dictates this is a reasonable measure.

IV. WHETHER THE PROPOSED LEGISLATION PASSES MUSTER UNDER THE SECOND AMENDMENT, HELLER, AND ITS PROGENY

“A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.”²⁴⁵

244. Winter, *supra* note 122.

245. U.S. CONST. amend. II.

An overview of Second Amendment jurisprudence reveals there is no Second Amendment impediment to the proposed legislative measures. Prior to the United Supreme Court's decision in *District of Columbia v. Heller*,²⁴⁶ it was highly contested whether the Second Amendment protected an individual right to possess and carry firearms unconnected with militia service.²⁴⁷ The prevailing viewpoint, at least in federal courts, was that the Second Amendment only protected a collective right to carry and bear arms in connection with a state organized militia.²⁴⁸ *Heller* unequivocally settled this debate.

A. *Heller* and *McDonald*

In *Heller*, a special police officer challenged District of Columbia statutes that essentially prohibited the possession of a functional, loaded handgun in one's residence, on Second Amendment grounds.²⁴⁹ Recognizing for the first time that individuals have a Second Amendment right to possess and carry firearms irrespective of militia service, the Supreme Court held the statutes in question were unconstitutional.²⁵⁰ In recognizing an individual Second Amendment right to possess and carry firearms in self-defense in the home, the Court stressed that this right, like the First Amend-

246. *D.C. v. Heller*, 554 U.S. 570 (2008).

247. David C. Williams, *Death to Tyrants: Dist. Of Columbia v. Heller and the Uses of Guns*, 69 OHIO ST. L.J. 641, 643 (2008) (explaining the two sides of the debate: one side believed the Second Amendment only protected the right to bear arms in connection with militia service (the collective right) and the other believed the Amendment protects an individual right to bear arms for protection outside of militia service (individual right)); Jason Racine, *What the Hell[er]? The Fine Print Standard of Review Under Heller*, 29 N. ILL. U. L. REV. 605, 613–15 (2009) (noting that, although the Second Amendment was ratified more than 200 years before *Heller*, its meaning had been widely debated); Darrell A.H. Miller, *Guns As Smut: Defending the Home-Bound Second Amendment*, 109 COLUM. L. REV. 1278, 1292–93 (2009) (observing “[f]or decades, individual rights, or ‘Standard Model’ interpretations and collective rights, or ‘State Rights’ interpretations clashed in obscurity.”).

248. *United States v. Tooley II*, 717 F. Supp. 2d 580, 583 (S. D. W. Va. 2010).

249. *Heller*, 554 U.S. at 574–76.

250. *Id.* at 594–95, 635.

ment right to free speech, was not unlimited.²⁵¹ Most notably, the Court emphasized, albeit in *dicta*, that “*nothing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by . . . the mentally ill,*”²⁵² and assuming that *Heller* was not otherwise “disqualified” from the exercise of Second Amendment rights, the District had to issue him a gun license.²⁵³ Thus, from *Heller* it can be assumed that mentally ill individuals are not “qualified” to handling guns, which is why the *Heller* court further made clear that prohibitions on the mentally ill possessing firearms were “presumptively lawful.”²⁵⁴

The Court, however, did not decide what level of scrutiny should apply to future Second Amendment challenges because it found the D.C. statutes prohibiting qualified individuals from possessing a functional handgun in the home would not survive any level of scrutiny.²⁵⁵ It did, however, expressly reject rational-basis review and the “interest-balancing approach” suggested by the dissent, leaving it up to the lower courts to decide the precise level of scrutiny.²⁵⁶

Two years later, in *McDonald v. City of Chicago*,²⁵⁷ the Supreme Court addressed whether the Second Amendment guarantee to possess firearms for protection applied to the States. In *McDonald*, Chicago residents challenged city ordinances that, similar to the statutes in *Heller*, in effect, prohibited them from possessing handguns in their home.²⁵⁸ The City argued the ordinances were constitutional because the Second Amendment only applied to the federal government and not the States.²⁵⁹

251. *Id.* at 595, 626.

252. *Id.* at 626 (emphasis added).

253. *Id.* at 635. Post-*Heller*, courts have interpreted the “disqualified” language to refer to the mentally ill and convicted felons. *See, e.g.*, *United States v. Skoien*, 614 F.3d 638, 639 (7th Cir. 2010).

254. *Heller*, 554 U.S. at 627 n. 26.

255. *Id.* at 628–29.

256. *Id.* at 628–29 n. 27 (stating that “[i]f all that was required to overcome the right to keep and bear arms was a rational basis, the Second Amendment would be redundant with the separate constitutional prohibition on irrational laws, and would have no effect”).

257. *McDonald v. City of Chicago*, 130 S.Ct. 3020 (2010).

258. *Id.* at 3026–27.

259. *Id.* at 3026, 3028.

The Supreme Court reiterated that *Heller* held that “the Second Amendment protects a personal right to keep and bear arms for lawful purposes, most notably for self-defense within the home.”²⁶⁰ The Court then went on to hold this Second Amendment right recognized in *Heller* was incorporated by the Due Process Clause of the Fourteenth Amendment, and thus, applied to the States.²⁶¹ In so holding, the court recognized that the right to keep and bear arms was “fundamental to our scheme of ordered liberty” and “deeply rooted in this Nation’s history and tradition.”²⁶² Even though the court acknowledged that the right to bear arms was a fundamental right, it repeated its assurances that nothing in its holding should “cast doubt on such regulatory measures as ‘prohibitions on the possession of firearms by . . . the mentally ill.’”²⁶³

B. *Post-Heller and McDonald Cases*

Since *Heller* and *McDonald*, lower courts have repeatedly recognized that *Heller* protects only a *qualified*, law-abiding citizen’s right to possess a firearm in the home for self-defense,²⁶⁴ and persons with mental illness are not “qualified” to possess a firearm. Accordingly, the lower courts have routinely rejected Second Amendment challenges to legislation prohibiting a person who has been adjudicated mentally defective or committed to a mental institution from possessing a firearm.²⁶⁵

260. *Id.* at 3044.

261. *Id.* at 3036, 3044.

262. *Id.* at 3036; *see also* United States v. Masciandaro, 638 F.3d 458, 467 (4th Cir. 2011) (observing that the “upshot of the [. . .] [*Heller* and *McDonald*] landmark decisions is that there now exists a clearly-defined fundamental right to possess firearms for self-defense within the home.”).

263. *McDonald*, 130 S.Ct. at 3047.

264. United States v. Reese, 627 F.3d 792, 800 (10th Cir. 2010) (noting *Heller* stated that the core purpose of the Second amendment was to permit “law-abiding, responsible citizens to use arms in defense of hearth and home.”); Tyler v. Holder, No. 1:12-CV-523, 2013 WL 356851 * 2 (W.D. Mich. Jan. 29, 2013).

265. *See, e.g.*, United States v. Roy, 742 F. Supp. 2d 150, 152 (D. Me. 2010) (rejecting the defendant’s argument that his emergency involuntary commitment to a hospital for mental illness did not disqualify him from purchasing a firearm under 18 U.S.C. § 922(g)); Tyler v. Holder, Case No. 1:12-CV-523,

Either the lower courts have: (1) summarily dismissed such claims, relying upon the language in *Heller* recognizing the continued validity of “longstanding prohibitions on the possession of firearms by the mentally ill”;²⁶⁶ or (2) rejected Second Amendment challenges pursuant to the two-prong approach that evolved post-*Heller* for analyzing Second Amendment claims generally. Under the two-step Second Amendment analysis that has been overwhelmingly adopted by most courts,²⁶⁷ the courts first ask whether the conduct the legislation allegedly prohibits or infringes upon is conduct the Second Amendment, as interpreted by *Heller*, was intended to protect.²⁶⁸ That conduct is the right of *qualified* and law-abiding citizens to possess guns for defensive purposes in the home.²⁶⁹ If it is not such conduct, the Second Amendment does not apply, the law in question is valid, and the inquiry stops there. If the conduct falls within the ambit of the Second Amendment, then the courts review the legislation under either intermediate or strict scrutiny, depending upon the severity of the limitation on the right to possess firearms.²⁷⁰ If the law in question severely limits or in-

2013 WL 356851 (W.D. Mich. Jan. 29, 2013); *Redington v. State*, No.53A01-1210-CR-461, 2013 WL 3989296 (Ind. Ct. App. Aug. 6, 2013).

266. *United States v. McRobie*, No. 08-4631, 2012 WL 82715, at * 1 (4th Cir. Jun. 14, 2010); *Petramala v. U. S. Dep’t of Justice*, 481 Fed. Appx. 395, 396 (9th Cir. 2012).

267. *United States v. Marzzarella*, 614 F.3d 85, 89 (3d Cir. 2010); *United States v. Chester*, 628 F.3d 673, 680 (4th Cir. 2013); *National Rifle Ass’n of America, Inc. v. Bureau of Alcohol*, 700 F.3d 185, 194–95 (5th Cir. 2012); *United States v. Greeno*, 679 F.3d 510, 518 (6th Cir. 2012); *United States v. Skoien*, 614 F.3d at 639; *United States v. Chovan*, No.11-50107, 2013 WL 6050914, at *8 (9th Cir. Nov. 18, 2013); *Doe v. Wilmington Hous. Auth.*, 880 F. Supp. 2d 513, 526–27 (D. Del. 2012).

268. *Marzzarella*, 614 F.3d at 89. *See also Ezell v. City of Chicago*, 651 F.3d 684, 701–03 (7th Cir. 2011); *Chovan*, WL 6050914, at *8; *Doe*, 880 F. Supp. 2d 513, 526–27 (D. Del. 2012).

269. *Ezell*, 651 F.3d at 700–01 (recognizing the *Heller* court concluded “the Second Amendment serves a pre-existing natural right to keep and bear arms; that the right is personal and not limited to militia service; and that the ‘central component of the right’ is the right of armed self-defense, most notably in the home.”); *Chovan*, 2013 WL 6050914, *9 (noting “*Heller* tells us that the core of the Second Amendment is “the right of law-abiding, responsible citizens to use arms in defense of hearth and home.”).

270. *See Marzzarella*, 614 F.3d at 96–97 (analogizing Second Amendment challenges to First Amendment Free Speech challenges, where strict scrutiny

fringes upon the right to possess firearms, such as in *Heller* where functional firearms in the home were virtually prohibited, strict scrutiny applies.²⁷¹ If the law in question is less restrictive, such as a law that merely regulates the types of firearms that can be used, intermediate scrutiny applies.²⁷² Most courts addressing Second Amendment challenges have used intermediate scrutiny.²⁷³

In the majority of cases involving Second Amendment challenges to legislation disarming the mentally ill, the courts have found that because a mentally ill person is not “qualified” to possess a firearm, the Second Amendment does not protect their right to possess a gun, and there is no need to go to the second-prong of the two-part test.²⁷⁴ In the cases where the courts have proceeded to the second-part of the analysis, those courts have found that the legislation in question passes the intermediate scrutiny test.²⁷⁵

In *Tyler v. Holder*,²⁷⁶ the plaintiff claimed that his Second Amendment rights were violated when his application to purchase a firearm was denied for being a person who previously had been

does not always apply; rather, level of scrutiny depends upon the type of law challenged and the degree of the infringement on the constitutional right); *Chovan*, 2013 WL 6050914, * 9 (holding “the level of scrutiny should depend on (1) “how close the law comes to the core of the Second Amendment right,” and (2) “the severity of the law’s burden on the right.”); *Doe*, 880 F. Supp. 2d at 527-28 (same).

271. *Marzzarella*, 614 F.3d at 96–98; *Doe*, 880 F. Supp. 2d at 528.

272. *Id.*

273. *United States v. Booker*, 644 F.3d 12, 25 (1st Cir. 2011); *Chovan*, 2013 WL 6050914 at *10; *United States v. Skoien*, 614 F.3d 638, 641–42 (7th Cir. 2010) (en banc); see also Brian Burns, *Holding Fire: Why Long Waiting Periods To Buy a Gun Violate the Second Amendment*, 7 CHS. L. REV. 379, 395 (2013) (noting that “in almost all cases” concerning the constitutionality of firearm provisions post-*Heller* and *McDonald*, the courts have used intermediate scrutiny review). Intermediate scrutiny review requires a showing that the statute in question promotes an “important government interest” and the questionable statute is “substantially related” to that interest. *Skoien*, 614 F.3d at 641–42.

274. See, e.g., *In re Keyes*, 83 A.3d 1016, 1026 (Pa. Super. Ct. 2013) (acknowledging “the mentally ill are disqualified from exercising their Second Amendment rights”); *Tyler v. Holder*, No. 1:12-CV-523, 2013 WL 356851, at * 3 (W.D. Mich. Jan. 29, 2013) (slip op.); *United States v. Murphy*, 681 F. Supp. 2d 95, 103 (D. Me. 2010).

275. See, e.g., *Tyler*, 2013 WL 356851, at *4.

276. *Id.*

“committed to a mental institution.”²⁷⁷ The plaintiff claimed that his involuntary hospitalization should not have disqualified him from purchasing a gun because it occurred twenty-seven years ago and the main reason he was hospitalized was because he was suicidal after a difficult divorce.²⁷⁸ Thus, he argued he was no longer a danger to himself or others.²⁷⁹

The district court disagreed and dismissed his suit. Emphasizing that the longstanding prohibitions on possession of firearms by the mentally ill are “presumptively lawful,” the court held that the Second Amendment did not extend to the plaintiff.²⁸⁰ The court reasoned that even if it did, the denial of the plaintiff’s firearm application was still constitutional because it would pass intermediate scrutiny.²⁸¹ The court concluded that relying upon a prior commitment, as an indicator of future dangerousness was a classification that was substantially and reasonably related to the important government objective of preventing firearm violence.²⁸² The court also pointed out how the First Circuit Court of Appeals had observed how difficult it would be to administer a prohibition of firearms on only those mentally ill persons who are currently dangerous.²⁸³ The First Circuit noted “to require a full-scale adversarial proceeding and finding that a person is mentally ill and ‘poses a likelihood of harm to himself or others before giving effect to § 922’s prohibitions’ would undermine Congress’s judgment that the *risk or potential*, not likelihood, probability, or certainty, of violence is all that is required.”²⁸⁴

Likewise, in *Redington v. State*,²⁸⁵ the Indiana Court of Appeals upheld the warrantless search and seizure of firearms pursuant to a state statute permitting the retention of firearms belonging to a mentally ill person deemed “dangerous” under the statute. In that case, the police seized a total of forty-eight firearms from a

277. *Id.* at *1.

278. *Id.* at *3.

279. *Id.*

280. *Id.*

281. *Id.* at *4.

282. *Id.* at *5.

283. *Id.*

284. *Id.* (emphasis supplied).

285. *Redington v. State*, No.53A01-1210-CR-461, 2013 WL 3989296 (Ind. Ct. App. Aug. 6, 2013).

man a police officer encountered in a public parking garage acting strange and irrational.²⁸⁶ The man had volunteered to the officer that he was looking for a missing college student, saw spirits, and believed he had killed someone behind a gun range but later learned the person had killed himself.²⁸⁷ The court upheld the seizure of the weapons, concluding that the state statute in question advanced the legitimate governmental interest of proscribing the possession of firearms by the mentally ill and did not materially burden the mentally unstable man's right to bear arms under the state or federal constitution.²⁸⁸

Indeed, the author has found no case where a court has found that a statute prohibiting a mentally ill person from possessing, purchasing, or carrying a firearm is unconstitutional under *Heller*. To the contrary, courts universally agree that keeping firearms away from mentally unstable persons is either an important governmental interest (in federal cases) or a reasonable exercise of police power (in state cases) because it is reasonable to conclude that a mentally unstable person with a gun poses a danger to himself and others.²⁸⁹ In light of these cases, there appears to be no present Second Amendment impediment to proscribing firearm possession to those solely displaying signs of mental illness. A court facing a challenge to this measure will likely uphold it based upon the rationale that (1) the Second Amendment is inapplicable because it was not intended to protect the conduct of an unqualified, mentally ill person possessing a gun; or (2) the measure is substantially related to the important government interest of disarming the mentally ill in order to reduce gun violence.

286. *Id.* at *1–2. The police retrieved two guns on the man's person, one in his vehicle in the parking garage, and forty-five guns in his bedroom. *Id.* at *1, *3.

287. *Id.* at *1–3. It is significant to note that prior to confiscating the firearms, the police had the firearm owner evaluated by a mental health professional who concluded the man appeared “religiously preoccupied, “delusional,” and “grandiose.” *Id.* at *3. A licensed psychiatrist also found that the gun owner suffered from “schizotypal”—a “flavor of schizophrenia. *Id.* at *3–4.

288. *Id.* at 8–9.

289. *Id.* at 8–9.

CONCLUSION

Shooting persons randomly for no apparent reason is a radical crime that calls for radical measures. Arguably, there is nothing extreme about preventing mentally ill persons from accessing a firearm since it is reasonable to conclude they are not responsible enough to handle a firearm. The United States Supreme court has made clear that the Second Amendment right to possess firearms in self-defense is not absolute; as stressed in *Heller*, the longstanding prohibition on mentally ill persons possessing firearms is still a valid restriction on the right to bear arms so long as the restriction is reasonable.

This Article is not about further ostracizing or stigmatizing the mentally ill; rather, it is about ensuring that mentally ill persons who are potentially dangerous do not have access to firearms and receive the necessary medical treatment they need in order to keep themselves and society safe. Therefore, state courts should adopt the proposed measures in this article.

Granted there is no single piece of legislation that can stop a crazed gunman intent on killing many, but this does not mean that legislators, and the community at large, should not try. It takes a village to disarm a mentally ill person planning a public mass murder, and legislation should reflect that reality.

Psychological Injury and Law I: Causality, Malingering, and PTSD

BY GERALD YOUNG* & ERIC Y. DROGIN**

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SUMMARY

Psychological injury and law is an emerging field in mental health law and policy. Legally, psychological injury refers to a mental harm (damages or dysfunction in thinking, emotions, or actions) at a level significant enough to lead to a claim of liability and damages due to the event at issue.¹ The area of psychological

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injury and law deals with tort, workers compensation, disability insurance, and related cases that lead to psychological impairment and disability, for issues such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and chronic pain. Although psychological injury is a relevant factor in criminal matters as well – and we will undertake to describe salient differences for the sake of readers more familiar with practicing in that arena – the primary focus of this Article will be civil matters.

This Article, and its companion Article, describe a new area of scholarship in terms of scope, rules of evidence, tort, causality, malingering and related negative response biases, assessment and testing, stress at work, and two recent cases: one American and one Canadian. The companion Article includes discussion of the

Association for Scientific Advancement in Psychological Injury and Law. Dr. Young recently published a book that covers all areas of psychological injury and law, focusing on malingering, *see* GERALD YOUNG, MALINGERING, FEIGNING, AND RESPONSE BIAS IN PSYCHIATRIC/ PSYCHOLOGICAL INJURY - IMPLICATIONS FOR PRACTICE AND COURT 925 (2014). Dr. Young has published other works in the area, *see* GERALD YOUNG, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT (2007). For Dr. Young's research in child development, *see* DEVELOPMENT AND CAUSALITY: NEO-PIAGETIAN PERSPECTIVES 850 (2011); *see also* Dr. Young's most recent trade book is YOU CAN REJOIN JOY: BLOGGING FOR TODAY'S PSYCHOLOGY (2012). Dr. Young has published multiple journal articles, specifically on psychological injury, law, causality, PTSD, and pain. Dr. Young may be reached at gyoung@glendon.yorku.ca.

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1. GERALD YOUNG & ANDREW W. KANE, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT 13 (Gerald Young, Andrew W. Kane & Keith Nicholson eds., 2007).

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)² and the Research Domain Criteria project (RDoC),³ emphasizing the necessity in both cases of adopting a biopsychosocial perspective. The author of the companion Article provides a novel ethical framework of ten principles, five adopted from the APA “Ethics Code,”⁴ and five new ones, e.g., on ethics and science, that apply to and could help in the field of mental of health policy and law. In general, these two Articles adopt a systems perspective and show the value of the area of psychological injury and law for the area of mental health law, policy, and disability. For mental health practitioners seeking to work in this area, the Article emphasizes throughout the need for a scientifically-informed, comprehensive, and impartial approach.

I. INTRODUCTION

A. *Psychological Injury*

This Article reviews the major areas of psychological injury and law, and their relation to mental health law and policy. The major areas in the field of psychological injury and law⁵ include: law, forensics, assessment, malingering and symptom validity tests (SVTs), disability and return to work, practice affairs, post traumatic stress disorder (PTSD), chronic pain, traumatic brain injury (TBI), rehabilitation, discrimination and harassment, ethics, and general interest and controversies. Malingering is an essential axis for all these topics, as are response biases and other threats to validity.

2. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTIC MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

3. Thomas Insel et al., *Research Domain Criteria (RDoC): Toward a New Classification Framework for Research on Mental Disorders*, 167 AM. J. PSYCHIATRY 748, 748 (2010).

4. American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCHOL. ASSOCIATION (2010), available at <http://www.apa.org/ethics/code/index.aspx> [hereinafter EPPCC].

5. As described in the masthead of the journal, *Psychological Injury and Law*.

The area of psychological injury and law coalesced in 2006-2007 with seminal books on the topic.⁶ Also see Parry and Drogin on mental disability and law,⁷ in addition to seminal books addressing personal injury.⁸ The field took a major turn with publication of the *Psychological Injury and Law* (PIL) journal beginning in 2008. PIL does not shy away from tackling major issues and controversies in the field, for example, on the FBS (Symptom Validity Scale of the Minnesota Multiphasic Personality Inventory, Second Edition),⁹ and on the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5).¹⁰ In this Article, the new direction we take is to extend work in the area of PIL to mental health policy and law.

In his Article on psychological injury and the law, Young noted that the literature has explored in depth mental disability

6. See WILLIAM J. KOCH ET AL., *PSYCHOLOGICAL INJURIES: FORENSIC ASSESSMENT, TREATMENT AND LAW* (2006); GERALD YOUNG, ANDREW W. KANE & KEITH NICHOLSON, *PSYCHOLOGICAL KNOWLEDGE IN COURT: PTSD, PAIN, AND TBI* (2006); GERALD YOUNG, ANDREW W. KANE & KEITH NICHOLSON, *CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT* (2007).

7. JOHN PARRY & ERIC Y. DROGIN, *MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY: A COMPREHENSIVE REFERENCE MANUAL FOR LAWYERS, JUDGES, AND MENTAL DISABILITY PROFESSIONALS* (2007).

8. See, e.g., MARC J. ACKERMAN & ANDREW W. KANE, *PSYCHOLOGICAL EXPERTS IN PERSONAL INJURY ACTIONS* (3rd ed. 1998); IZABELA Z. SCHULTZ & DOUGLAS O. BRADY, *PSYCHOLOGICAL INJURIES AT TRIAL* (2003).

9. See JAMES N. BUTCHER ET AL., *MANUAL FOR THE RESTANDARDIZED MINNESOTA MULTIPHASIC PERSONALITY INVENTORY: MMPI-2, AN INTERPRETIVE GUIDE* (1989); James N. Butcher et al., *Potential for Bias in MMPI-2 Assessments Using the Fake Bad Scale (FBS)*, 1 *PSYCHOL. INJ. & L.* 191 (2008); Yossef S. Ben-Porath et al., *The MMPI-2 Symptom Validity Scale (FBS) Is an Empirically Validated Measure of Overreporting in Personal Injury Litigants and Claimants: Reply to Butcher et al.* (2008), 2 *PSYCHOL. INJ. & L.* 62, 62 (2009).

10. DSM-5, *supra* note 2. See *Psychological Injury and Law* special issues, e.g. Gerald Young & Michael B. First, *Special Issue: The DSM-5 Draft: Implications for Psychological Injury and Law*, 3 *PSYCHOL. INJ. & L.* 255-55 (2010); Gerald Young, *Special Issue: DSM-5*, 6 *PSYCHOL. INJ. & L.* 277-48 (2013).

definitions and their applications, especially in Parry and Drogin.¹¹ In this regard, Parry and Drogin indicated that the term mental or psychic “harm” applies to personal injury and worker compensation claims.¹² However, in venues in which disability is treated, such as Veteran Administration (VA) disability benefit programs, and in referrals for private disability insurance benefit policies, mental “impairment” is the preferred term.

B. *Impairment and Disability*

In this section of the Article, we first describe impairment and disability, and then address claims in the venue of workers compensation, in particular. Mental disability is defined in terms of one or more mental impairments that “substantially” limit one or more major life activities, such as vocationally, socially, or cognitively.¹³ Specifically, mental impairment refers to a mental condition that might be diagnosable as a disorder according to the DSM (presently, the DSM-5). However, the attribution of a mental diagnosis alone ordinarily is not sufficient to establish the presence of substantial limitation. Rather, the evaluator should consider the pattern of symptom expression, and more objective criteria or other aspects, depending on the legal context. Factors involved in establishing psychological limitations include the impairment’s nature, severity, projected duration, continuity, and long term, perhaps permanent effects. Other factors to consider in this regard include whether the evaluation is oriented to the examinee’s current state, the role of mitigating interventions, (e.g., medication, treatment), whether the impairment is open to further improvement, and whether the examinee is open to getting help from treatment. The evaluator must consider the critical issue of whether the impairment “significantly” or “severely” restricts the major life activities in question, assuming it is not preventing them from occurring. Another key issue is whether there are residual functional capacities, especially related to work options. For

11. Gerald Young, *Psychological Injury and Law: Defining a Field*, 1 PSYCHOL. INJ. & L. 78, 79 (2008). See also PARRY & DROGIN, *supra* note 7.

12. PARRY & DROGIN, *supra* note 7.

13. *Id.*

example, can the evaluator establish that no work of any kind can be undertaken?

The Social Security Disability Program¹⁴ specifies that a disability involves an inability to engage in a “gainful” activity that has lasted or is expected to last on a continuous basis for twelve months or more.¹⁵ In order to better assess whether a substantial limitation is present, the evaluator should break down the claimed impaired activity into its discrete behavioral, cognitive, and emotional demands and, in so doing, qualify, define, and list its components in sufficient detail. An impairment (or an impairment combination) is considered “severe” when the examinee is limited by the impairment(s) in the ability to undertake *most* work activities. There are four essential spheres or functional areas for working effectively, and each is rated for degree of impairment: activities of daily living [e.g., grooming (for work)], social functioning, concentration/ persistence/ pace (e.g., work errors), and deterioration or decompensation, that is, an inability to adapt (e.g., cope with stress) at work. The first three areas are evaluated on a five-point scale of functional impairment: none, mild, moderate, marked, extreme; the last area is rated on a four-point scale of frequency (0, 1-2, 3, 4+). Based on these impairment ratings, the SSA determines the degree of overall functional mental limitation.¹⁶ Further, in a combined evaluation, it couples the latter with estimates of physical limitations. The mental impairment must correspond to a list of categories as well (their list of disorders resembles those in the DSM), or the impairment must be below the residual functional capacity that is necessary for a return to prior work, or to any work.¹⁷ Those used to practicing primarily or exclusively in criminal as opposed to civil contexts may be surprised to see how institutional rather than DSM-5 diagnostic entities are likely to hold sway in these cases.¹⁸

14. Social Security Administration, *Disability Evaluation Under Social Security*, SOC. SECURITY ADMINISTRATION (2006), <http://www.ssa.gov/disability/professionals/bluebooks> [hereinafter SSA].

15. PARRY & DROGIN, *supra* note 7.

16. SSA, *supra* note 14.

17. PARRY & DROGIN, *supra* note 7.

18. Michael D. Chafetz, *The Psychological Consultative Examination for Social Security Disability*, 4 PSYCHOL. INJ. & L. 235, 237–38 (2011).

Other regimes might involve disability assessments.¹⁹ Private disability policies function according to the test that an impairing mental condition must, at a minimum, prevent or limit work for a specified term. A major difference among various policies relates to the degree of inclusiveness of what constitutes a claimable mental condition. Moreover, private insurance policies specify that access to mental health treatment depends on evaluation of the presence of a mental disability.

C. Workers Compensation

Workers compensation (WC) provides benefits for losses sustained due to injuries or to death at work.²⁰ Benefits within the WC system are based on no-fault compensation. Generally, the presumption is that any doubt about the application of statutes should be resolved in favor of the beneficiary.

Workers compensation for mental impairments constitutes the most controversial type of claim. Often, benefits are less for a mental injury when compared to those for other types of injury (e.g., having a physical component). Moreover, there is more controversy regarding the validity of mental impairments resulting from a psychological injury at work. That is, disagreements over WC claims arise more often in cases in which the mental impairment originates from a putative work-related emotional stimulus. The traditional approach had been that no compensation was awarded without a physical injury or physical trauma, but this is changing to some degree. Nevertheless, Parry and Drogin noted that “although it is increasingly apparent that science is blurring the distinction between mental and physical health, third-party providers continue to resist the expansion of coverage to illnesses that are seen – among other considerations – as easy to malingering.”²¹ In criminal matters, of course, the notion of a “mental health defense” is well-entrenched, such that the system has long been accustomed to counsel’s attempts to mitigate or obviate charges on the basis of a lack of trial competency, a lack of

19. PARRY & DROGIN, *supra* note 7.

20. *Id.*

21. PARRY & DROGIN, *supra* note 7, at 412.

criminal responsibility, or mitigating factors that may fall short of a defense *per se*.²²

Mental harm or injury in the WC system typically requires that the harm had taken place when the worker had been on the job and also had been due to something more than “everyday” work stressors that are experienced by most workers.²³ Workers will be denied benefits for the effects of lesser stressors that prevent them from working.

Depending on the WC system, compensable mental injuries could be either entirely mental, or could be mental but akin to physically-based injuries. Melton, Petrila, Poythress, and Slobogin added that pre-existing psychological disturbances that are “aggravated” or “accelerated” at work could be compensable.²⁴ However, these authors considered these latter terms somewhat ephemeral, and ones that complicate causation attribution as lying at least partly in the work incident at issue.²⁵

Concerning evaluations in the WC system, these are substantially based on the *Guides to the Evaluation of Permanent Impairment* promulgated by the American Medical Association (AMA), which established impairment ratings analogous to those used in SSA disability evaluations.²⁶ The AMA Guides allow for the use of DSM diagnostic categories in helping determine permanent mental or behavioral impairment – again, in contrast to criminal cases, in which the editions of the Diagnostic and

22. PAUL M. KAUFMANN, CLINICAL NEUROPSYCHOLOGY IN THE CRIMINAL FORENSIC SETTING 55 (Robert L. Denney & James P. Sullivan eds., 2011).

23. PARRY & DROGIN, *supra* note 7.

24. GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATION FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS (3rd ed. 2007).

25. *Id.*

26. PARRY & DROGIN, *supra* note 7; *see also* LINDA COCCHIARELLA & GUNNAR B. J. ANDERSSON, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (5th ed. 2001); ROBERT D. RONDINELLI ET AL., GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (6th ed. 2008).

Statistical Manuals (e.g. the DSM-IV-TR)²⁷ have typically stood alone as a definitional source with respect to diagnosis.²⁸

D. Court

In personal injury litigation, recovery for damages due to mental harm or emotional distress is difficult to accomplish, because (1) the legal definitions involved are rigorous; and (2) it is problematic to translate diagnoses into legal standards.²⁹ Moreover, the legal term “psychic [or mental] harm” does not have an equivalent definition or diagnosis in psychiatry [or psychology].³⁰ In tort cases, for example, the harm might be a product of either negligent or intentional action. Hagan and also Ziskin and Faust argued that both psychiatry and psychology have been criticized for being “soft” and even “pseudo” sciences, which would disqualify them for admissibility in court in both civil and criminal cases alike.³¹ However, the current view is that mental health professionals possess an expertise that is generally reliable for court purposes and, moreover, that his or her testimony is prevalent in expert testimony proffered to the court.³² Also noted that while judges function as gatekeepers of admissibility, they might lack sufficient scientific [psychological] literacy to discharge their function adequately. Their knowledge of science might be inadequate to arrive at valid decisions about the science

27. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

28. Jessica R. Gurley, *A History of Changes to the Criminal Personality in the DSM*, 12 HIST. PSYCHOL. 285, 300 (2009).

29. PARRY & DROGIN, *supra* note 7; Allen P. Wilkinson, *Forensic Psychiatry: The Making – And Breaking – Of Expert Opinion Testimony*, 25 J. PSYCHIATRY & L. 51, 55–58 (1997).

30. PARRY & DROGIN, *supra* note 7.

31. MARGARET A. HAGEN, *WHORES OF THE COURT: THE FRAUD OF PSYCHIATRIC TESTIMONY AND THE RAPE OF AMERICAN JUSTICE* (1997); JAY ZISKIN & DAVID FAUST, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE* (4th ed. 1988).

32. PARRY & DROGIN, *supra* note 7.

involved in testimony, although training judges on science could help in this regard.³³

That having been said, the courts are ambivalent about having to deal with mental health testimony.³⁴ The Supreme Court of the United States has taken issue with the inherent limits of mental disorder diagnosis. Specifically, in the case of *Clark v. Arizona*,³⁵ the Court considered diagnoses of mental illness as potentially misleading and subject to conclusions that were fraught with many perils. Although the *Clark* case resides within a criminal law context, its comments are highly applicable to the civil context as well. The implication here is that mental health professionals need to tread carefully in their assessments and need to keep legally informed about matters related to them.³⁶ Dvoskin and Heilbrun further pointed out that the actuarial method – in which predictions about the case at hand are made using data and statistics from population level science – might not yet be “reliable” enough to be more probative than prejudicial in the task of making legal judgments reach sufficient standards of proof.³⁷ The next section of this Article explores legal standards of proof and the legal decisions underlying them, and then continues with the theme of psychological injuries in court. After examining rules of evidence that apply to psychological injury litigation, the authors then examine the area of torts.

E. Rules of Evidence

In their Article about presenting evidence of psychological injury in court, Young and Kane explained that the ruling of the Supreme Court of the United States in *Daubert v. Merrell Dow Pharmaceuticals Incorporated*³⁸ served as a landmark of present-

33. DEMOSTHENES LORANDOS & TERENCE W. CAMPBELL, BENCHBOOK IN THE BEHAVIORAL SCIENCES: PSYCHIATRY-PSYCHOLOGY-SOCIAL WORK (2005).

34. PARRY & DROGIN, *supra* note 7.

35. *Clark v. Arizona*, 548 U. S. 735 (2006).

36. Joel A. Dvoskin & Kirk Heilbrun, *Risk Assessment and Release Decision-Making: Toward Resolving the Great Debate*, 29 J. AM. ACAD. PSYCHIATRY 6, 7 (2001).

37. PARRY & DROGIN, *supra* note 7.

38. *Daubert v. Merrell Dow Pharm. Inc.*, 509 U.S. 579 (1993).

day contemporary requirement for admitting expert evidence in to court, supplanting existing federal caselaw and, in many states, the general acceptance standard of *Frye v. United States*³⁹ – a criminal case with enduring relevance to the full spectrum of legal proceedings.⁴⁰ *Daubert* led to subsequent Court rulings in *General Electric Company v. Joiner*⁴¹ and in *Kumho Tire Company v. Carmichael*⁴² such that this case and its progeny are commonly called “the *Daubert* trilogy.” *Joiner* added that the standard for appellate review is abuse of discretion, and *Kumho* expanded its application to non-scientific but nevertheless, technical and specialized knowledge.

Note that, in the Canadian context, *Daubert* has been cited in a Supreme Court of Canada case, *R. v. J-L.J.*, SCC 51,⁴³ and also in some provincial matters as well. *Daubert*’s standards for evidence admissibility, as well as the gatekeeping function of judges, have been matched in the Canadian context by similar requirements in *R. v. Mohan*.⁴⁴

Daubert emphasized that scientific testimony must meet accepted standards of legal reliability—that is, it must be trustworthy, sound, and grounded in appropriate scientific methods and standards.⁴⁵ *Daubert* also specified that scientific testimony must be legally relevant, that is, applicable to the particular case at hand, or of aid to the trier of fact in evaluating the case.⁴⁶ Specifically, *Daubert* acknowledged that any science used in court must meet standards related to falsifiability (being empirically testable), error rate (false positives and false negatives), and follow standardized procedures.⁴⁷ However, there is no general standard on how to apply *Daubert* criteria. For example, different social sciences vary in how to define the concepts of scientific reliability

39. *Frye v. United States*, 293 F. 1013 (D.C.Cir. 1923).

40. YOUNG & KANE, *supra* note 1, at 14.

41. *Gen. Elec. Co. v. Joiner*, 522 U.S. 136 (1997).

42. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

43. *R. v. J-L.J.* [2000] 2 S.C.R. 51, 600 (Can.).

44. *R. v. Mohan* [1994] 2 S.C.R. 9, 80 (Can.). *See also* ALAN D. GOLD, EXPERT EVIDENCE IN CRIMINAL LAW: THE SCIENTIFIC APPROACH (2003).

45. *Daubert v. Merrell Dow Pharm. Inc.*, 509 U.S. 579, 579 (1993).

46. *Id.*

47. *Id.*

and validity, which complicates the confusion between the different uses of the terms in legal and scientific arenas.⁴⁸

Also, Young described how Welch maintained that *Daubert* has not succeeded in tightening admissibility standards and that all but the most obvious junk science is admitted in judges' gatekeeping function regarding evidence in court.⁴⁹ However, others have maintained that *Daubert* has tightened the judicial gate and has served its function of excluding from court poor or junk science.⁵⁰ Although *Daubert* arose in the civil context, the notion of the "*Daubert* hearing" has been very much a part of criminal admissibility proceedings as well.⁵¹

Dobbin, Gatowski, Eyre, Dahir, Merlino, and Richardson presented data relating to surveys of judges about admissibility issues in court.⁵² Both federal and state judges perceived that most problems related to proffered evidence concern disagreement among experts and also the experts' lack of objectivity. Other problems found included the costs involved in hiring experts and the quality (legal reliability) of the evidence presented to court.

48. Leonard Saxe & Gershon Ben-Shakhar, *Admissibility of Polygraph Tests: The Application of Scientific Standards Post-Daubert*, 5 PSYCHOL. PUB. POL'Y & L. 203, 217 (1999).

49. Gerald Young, *Causality and Causation in Law, Medicine, Psychiatry, and Psychology: Progression or regression?* PSYCHO. INJ. & L. 161, 179 (2008) (citing Cassandra H. Welch, *Flexible Standard, Differential Review: Daubert's Legacy of Confusion*, 29 HARV. J. L. & PUB. POL'Y 1085, 1091–93 (2005–06)).

50. E.g., M. Finch & P. M. Burlington, Amended Brief of Amicus Curiae, Academy of Florida Trial Lawyers, on Behalf of Petitioner, Jill March. Circuit Court Case No. CIO-99-6377; *Marsh v. Valyou*, 979 So.2d 389 (Fla.Ct. App. 2008).

51. Jennifer L. Groscup et al., *The Effects of Daubert on the Admissibility of Expert Testimony in State and Federal Criminal Cases*, 8 PSYCHOL. PUB. POL. & L. 339, 340–42 (2002); Daniel Krauss, *Evaluating Science Outside the Trial box: Applying Daubert to the Federal Sentencing Guidelines' Criminal History Score*, 29 INT. J. L. & PSYCHIATRY 289, 295–96 (2006); EARL F. MARTIN, HANDBOOK OF FORENSIC PSYCHOLOGY: RESOURCE FOR MENTAL HEALTH AND LEGAL PROFESSIONALS 579 (William O'Donohe & Eric R. Levensky eds., 2004); CHRISTOPHER SLOBOGIN, PSYCHOLOGICAL EVALUATION FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS (3rd ed. 2007).

52. Shirley A. Dobbin et al., *Federal and State Trial Judges on the Proffer and Presentation of Expert Evidence*, 28 JUST. SYS. J. 1, 3–6 (2007).

Young noted that the summary of the results provided by Dobbin, Gatowski, Eyre, Dahir, Merlino, and Richardson does not reflect the actual items and results of their surveys.⁵³ For example, the results included: (a) extensive disagreement among experts (conflicts among experts that defy reasoned assessment); (b) experts abandoning objectivity and becoming advocates for the side that retained them; (c) excessive expense of party-hired experts; and (d) expert testimony of apparent questionable validity (legal reliability).⁵⁴ Clearly, the status of the effectiveness of *Daubert* in court has not been established sufficiently, nor has the evidence allowed by the gatekeeping function in *Daubert* always deemed clearly good as opposed to bad or “junk” science.

F. Torts

A tort is a civil wrong that can include both acts of commission and omission.⁵⁵ The primary aim of a tort action is to make plaintiffs “whole” as they had been prior to the incident at issue, with “punitive damages” as a secondary consideration – in contrast to criminal matters, which in modern times have come to serve a primary aim of deterrence.⁵⁶

Young and Kane noted that, according to McLearn, Pietz, and Denney, a tort is a private or civil wrong or injury, such as in negligent or intentionally tortious conduct, which a fact finder might conclude merits an award of damages.⁵⁷ The process of proving a tort in court depends on meeting four criteria, which have been referred to as the “4 Ds”: duty, dereliction, direct causation, and damages.⁵⁸

53. Young, *supra* note 49, at 179.

54. *Id.*

55. See AMERICAN LAW INSTITUTE, A CONCISE RESTATEMENT OF TORTS (2000); LISA DRAGO PIECHOWSKI, THE HANDBOOK OF FORENSIC PSYCHOLOGY 171 (Irving B. Weiner & Randy K. Otto eds., 4th ed. 2014).

56. Robert Apel, *Sanctions Perceptions, and Crime: Implications for Criminal Deterrence*, 29 J. QUANT. CRIM. 67, 71 (2013).

57. YOUNG & KANE, *supra* note 1, at 16–18. See also ALIX M. MCLEAREN, CHRISTINA A. PIETZ & ROBERT L. DENNEY, HANDBOOK OF FORENSIC PSYCHOLOGY: RESOURCE FOR MENTAL HEALTH AND LEGAL PROFESSIONALS 267 (William O’Donohue & Eric R. Levensky eds., 2004).

58. See also PIECHOWSKI, *supra* note 55.

In order for a plaintiff to receive damages in a tort case, the defendant must have committed a “derelict” act or omission, in which a “duty” was owed to the plaintiff. For example, in negligence, the standard involved is generally the “reasonable-person test”; normally, in the event at issue, would a reasonable person have engaged in the same behavior (or its lack thereof) as the defendant? If dereliction of duty is established in the case at issue, then the causal question must be satisfied – is the dereliction of duty, or the lack thereof, the “proximate cause” of the injury at issue? That is, did it factually and logically precede the harm incurred by the event? For this question, as well, the reasonable person test is applied – normally, would another person in the same situation as the defendant have reasonably predicted that the act (or its omission) would have caused the harm at issue?

“[P]roximate” cause is not defined the same way in different jurisdictions.⁵⁹ Legal standards vary by case law in indicating which of the harms incurred involve a legally protected right or interest that can be pursued for legal damages.

Another important legal test to consider in tort cases involving psychological harm concerns “foreseeability.” In this test, one establishes whether, given the negligent conduct of the defendant, the psychological harm that had been purportedly caused by the conduct (or its omission) at issue had been reasonably foreseeable. Could the harm at issue have been readily anticipated? For example, had the negligent person foreseen or been able to predict any possible psychological harm deriving from the negligent conduct at issue? The foreseeability test facilitates viewing each case on its facts and merits, thereby permitting laypersons serving as jurors to better evaluate them.⁶⁰ The foreseeability test, however, has been criticized for being not stringent enough and for being open to subjective influence.⁶¹

Traditionally, case law had not considered strictly psychological damages as an adequate basis for successful tort

59. See MCLEAREN, PIETZ & DENNEY, *supra* note 57 *citing* TORT LAW DESK REFERENCE: A FIFTY STATE COMPENDIUM (Morton F. Daller ed., 2000).

60. MCLEAREN, PIETZ & DENNEY, *supra* note 57.

61. D. S. CAMPBELL & C. MONTIGNY, ANNUAL REVIEW OF CIVIL LITIGATION: 2003, 133 (Todd Archibald & Michael Cochrane eds., 2004).

claims.⁶² The physical “contact or impact” rule excluded cases of such psychological harm occurring alone. However, development of the “zone of danger” and “bystander” or “physical proximity” rules broadened the range of claimable tort cases. In particular, Shuman and Hardy⁶³ noted that the seminal California Supreme Court case of *Dillon v. Legg*⁶⁴ allowed for consideration of all the relevant causal circumstances in a claim for psychological harm.⁶⁵ Nevertheless, cases involving strict psychological damages, generally, are “much more difficult” to prove⁶⁶, and courts are still considering such cases more stringently than those involving physical harm.⁶⁷ This is especially true for cases in which there are pre-existing mental conditions that are involved or are exacerbated.

Foote and Lareau noted that, in court, the plaintiff must establish that the defendant breached a duty sufficiently to cause a harm, which for psychiatric/psychological harm, involves “negligent infliction of emotional distress,” or NIED.⁶⁸ In emotional claims, the zone-of-danger rule has broadened such that bystanders can claim damages just by witnessing a horrific trauma to a family member, although limits are imposed on the rule.⁶⁹

This concludes a presentation of the basics of what constitutes psychological injury and the thresholds or tests needed in court to establish actionable claims. The next part of this Article examines the concept of causality and causation from a legal perspective. Causality represents a difficult axis among the four

62. See, e.g., VILMA GABBAY & CARMEN M. ALONSO, POSTTRAUMATIC STRESS DISORDER IN CHILDREN AND ADOLESCENTS: HANDBOOK 60 (Raul R. Silva ed., 2004); MCLEAREN, PIETZ & DENNEY, *supra* note 57; DANIEL W. SHUMAN & JENNIFER L. HARDY, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT 517 (Gerald Young, Andrew W. Kane & Keith Nicholson eds., 2007); ANDREW W. KANE ET AL., FORENSIC ASSESSMENTS IN CRIMINAL AND CIVIL LAW 148 (Ronald Roesch & Patricia A. Zapf eds., 2013).

63. SHUMAN & HARDY, *supra* note 62.

64. *Dillon v. Legg*, 68 Cal.2d 728 (Cal. 1968).

65. SHUMAN & HARDY, *supra* note 62.

66. MCLEAREN, PIETZ & DENNEY, *supra* note 57.

67. GABBAY & ALONSO, *supra* note 62.

68. WILLIAM E. FOOTE & CRAIG R. LAREAU, HANDBOOK OF PSYCHOLOGY: VOL. 11. FORENSIC PSYCHOLOGY 172 (Randy K. Otto & Irving B. Weiner eds., 2nd ed. 2013).

69. See, e.g., *Thing v. La Chusa*, 771 P.2d 814 (Cal.1989).

D's, even though it is pertinent to every tort and related forensic disability case. The definitional distinction between causation and causality is ambiguous so we use the terms interchangeably.⁷⁰ Piechowski reminded us that, in the forensic context, psychological damages are impairment- rather than diagnosis-related.⁷¹ For the tort or related case to have any weight, the impairments in any case at hand need to be shown to derive from the event at issue in a causal analysis.

II. CAUSALITY AND CAUSATION

Young noted that the definition of causality varies across disciplines and that even within law there is no clear consensus on what it constitutes.⁷² Russell represents those philosophers who have also denied that causality can be ascertained, deeming it a confused and confusing concept.⁷³

For example, in civil law, the “but-for” test is the test traditionally used to establish causation (“but for the event at issue, the survivor would have been able to continue life as before”).⁷⁴ However, this test cannot cover all contingencies, such as when two events at issue combine to cause the losses and liabilities found. Lucy referred to these complex situations as involving “preemptive” or “duplicative” cause.⁷⁵

In general, situations involving joint, serial, or severing causality are not easily apportioned by using a “but-for” argument. Therefore, other causality tests are applicable to these cases, e.g.,

70. GERALD YOUNG & RONNIE SHORE, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT 87 (Gerald Young, Andrew W. Kane & Keith Nicholson eds., 2007).

71. PIECHOWSKI, *supra* note 55. *See also* Stuart A. Greenberg, Randy K. Otto & Anna C. Long, *The Utility of Psychological Testing in Assessing Emotional Damages in Personal Injury Litigation*, 10 ASSESSMENT 411, 416 (2003).

72. Young, *supra* note 49; *see also* YOUNG & SHORE, *supra* note 70.

73. As cited in Young, *supra* note 49. *See* BERTRAND RUSSELL, PHILOSOPHICAL ESSAYS (3rd Imp. 1910); BERTRAND RUSSELL, MYSTICISM AND LOGIC (Allen & Unwin 1918); BERTRAND RUSSELL, MYSTICISM AND LOGIC: AND OTHER ESSAYS (9th Imp. 1950); WILLIAM LUCY, PHILOSOPHY OF PRIVATE LAW (2007).

74. Young, *supra* note 49.

75. LUCY, *supra* note 73.

the material contributions test: as long as the event at issue has contributed more than a minor degree to the liability at issue, it is considered responsible at least in part.

Young also noted that Wright has argued that it is still possible to develop an integrated model of causality that subsumes the various and complex examples and tests.⁷⁶ For example, his NESS (Necessary Element of a Sufficient Set) test of causality has gained some currency.⁷⁷ However, Lucy maintained that the NESS test has its own limits, such as difficulty in differentiating primacy in circumstances with multiple causes.⁷⁸

Building on the work of Young and Shore,⁷⁹ Young⁸⁰ noted that, for law causation refers to all the factors that contribute to an effect but that, for the civil law, liability is what matters.⁸¹ The legal test is whether an individual's negligent actions helped elicit an actionable outcome. Legally, the causative event needs to be the proximate or dominant one, or at least function as contributory, substantive, or material, and not just tangentially or "de minimus."⁸²

If proximate causation refers to the "essential" or "dominant and responsible" cause and "but-for" cause refers to a necessary cause, an actual cause, a cause in fact, or a factual cause,⁸³ material cause refers either to the sole legal or legitimate cause of an event at claim or a factor that is part of it (a contribution that is necessary and sufficient). The "substantial"

76. Young, *supra* note 49, at 162; *see also* RICHARD W. WRIGHT, EMERGING ISSUES IN TORT LAW 287 (Jason W. Neyers, Erika Chamberlain & Stephen G. A. Pitel eds., 2007).

77. WRIGHT, *supra* note 76. ("a particular condition is a cause of or contributes to a specific consequence if and only if it is a necessary element of a set of antecedent actual conditions that had been sufficient for the occurrence of the consequence").

78. LUCY, *supra* note 73.

79. YOUNG & SHORE, *supra* note 70.

80. GERALD YOUNG, MALINGERING, FEIGNING, AND RESPONSE BIAS IN PSYCHIATRIC/PSYCHOLOGICAL INJURY: IMPLICATIONS FOR PRACTICE AND COURT (2014).

81. BLACK'S LAW DICTIONARY 249 (9th ed. 2009).

82. YOUNG, *supra* note 80.

83. BLACK'S LAW DICTIONARY 228 (9th ed. 2009).

contributions test in causality is recognized in the ALI tort statement.⁸⁴

In *Burrage v. United States*,⁸⁵ the issue of causation was discussed in the context of a criminal case, although consideration of the civil context also was undertaken. The Court granted certiorari on two questions involving causality regarding a death due to alcohol and heroin use as contributing cause and foreseeable result.⁸⁶ The court noted that causation has been long considered a “hybrid concept.”⁸⁷ In the criminal context, the crime has to constitute both the “actual” cause and the “legal” or “proximate” cause. The court’s decision related only to the actual cause in the particular case.

The court referred to the classic “but-for” test of causality – the harm at issue would not have occurred absent the defendant’s conduct.⁸⁸ In the “but-for” test, the event at issue constitutes the “minimum” requirement for effective causation.⁸⁹ Typically, courts consider phraseology such as “results from,” “because of,” “based on,” and “by reason of” as consistent with the “but-for” model.⁹⁰

There are less demanding standards of causality, such as when an act or omission is considered a “cause in fact” if it is simply a “substantial” or “contributing” factor. However, the court in *Burrage* rejected this more “permissive” interpretation of causality. It argued that, if taken literally, this standard of causality allows any act or omission, no matter how “small,” to serve as a contributing factor in causality determination in any case. The court could not determine any way of differentiating “too insubstantial” and “substantial” causation, which is important in criminal cases, for which the standard of proof is “beyond a reasonable doubt.”⁹¹

84. AMERICAN LAW INSTITUTE, *supra* note 55. See also PIECHOWSKI, *supra* note 55.

85. *Burrage v. United States*, 134 S. Ct. 881 (2014).

86. *Id.*

87. *Id.*; see also H. L. A. HART & TONY HONORÉ, CAUSATION IN THE LAW (2nd ed. 1959).

88. *Univ. of Tex. Sw. Med. Ctr. v. Nassar*, 133 S.Ct. 2517 (2013).

89. See, e.g., *United States v. Hatfield*, 59 F.3d 945, 948 (7th Cir. 2010).

90. *Burrage*, 134 S.Ct. at 881.

91. *Id.*

However, the court also noted that in tort law “material” or “substantial” elements or factors can constitute “a cause” of an event at issue.⁹² However, Keeton, Dobbs, Keeton, and Owen added the proviso that a material contributor still must meet the “but-for” test. The court held in *Burrage* a different conclusion – that without meeting the “but-for” test, the act of the defendant cannot be considered liable.⁹³ However, in the tort context, the standard of proof is “more likely that not,” and in this sense we concur with the court that in the civil context it is acceptable to have a more lax burden of proof that makes a material contribution to an event at issue sufficient to render the party allegedly at fault liable.

The conclusion that applies best to the question of causality in the civil arena, generally, and the one of psychological injury, particularly, is that the material or substantial contribution test of causality dictates the minimal threshold for apportioning causality in the typical multifactorial case that constitutes tortious and related events at issue. The legal “but-for” test of causality is consonant with the material contributions test. However, in tort actions, such as those related to motor vehicle accidents, events at claim are embedded in broad multifactorial causal arrays that include multiple factors beyond the particular event. The latter include pre-event psychological vulnerabilities if not psychopathologies, complexities in the event at claim itself, including the perceived, subjective individualized evaluation of its severity and trauma, and extraneous factors, such as unanticipated job loss or the death of a family member incidentally to the event at issue. The next part of this Article considers forensic psychology in relation to the law, of which the question of causality is but one matter.

92. W. PAGE KEETON, DAN B. DOBBS, ROBERT E. KEETON & DAVID G. OWEN, PROSSER AND KEETON ON TORTS 263 (William Prosser & W. Page Keeton eds., 5th ed. 1984).

93. *Burrage*, 134 S.Ct. at 881.

III. LAW AND PSYCHOLOGY

Otto and Ogloff confirmed that there is no consensual definition of “forensic psychology.”⁹⁴ Broadly speaking, the term refers to the application of psychology to legal matters. The APA’s “Forensic Specialty Guidelines” refer to forensic psychology as the application of psychological knowledge to the law in order to assist in legal-related matters – both civil and criminal.⁹⁵ The journal *Psychological Injury and Law* (PIL) promotes the reciprocal nature in the interaction of law and psychology. The mission statement for the society housing the journal (www.ASAPIL.net) notes that it hopes to facilitate communication between psychology and law, and also to encourage the legal community to appreciate the role that psychologists can provide to litigants and the court.

Otto, Kay, and Hess traced the Federal Rules of Evidence (FRE) as they relate to testifying as an expert in forensic, e.g., psychological injury cases.⁹⁶ FRE 702 notes that experts need to demonstrate their expertise, provide adequate factual bases for proffered “opinions,” use “valid” techniques, and apply them “validly” to the case at hand.⁹⁷ The research on a judge’s gatekeeping functions in this regard indicates that testimony is deemed inadmissible especially when it is considered neither assistive to the trier of fact nor relevant to the case. Also, inadmissible evidence might be more prejudicial than probative, and proffered by a worker without the necessary adequate

94. RANDY K. OTTO & JAMES, R. P. OGLOFF, *THE HANDBOOK OF FORENSIC PSYCHOLOGY* 35 (Irving B. Weiner & Randy K. Otto eds., 4th ed. 2014).

95. American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCHOL. 7, 7 (2013).

96. OTTO, KAY & HESS, *supra* note 94, at 733.

97. FED. R. EVID. 702.

qualifications.⁹⁸ Criminal arena practitioners will find themselves already well versed in these concepts.⁹⁹

Examination of the contents of the *Mental Health Law and Policy Journal* indicates that mental health law is a specialization of law that involves persons with a diagnosis—or possible diagnosis—of mental illness and the intersection of mental health with the court and legal venues. This category of legal practice also addresses persons managing or treating those with (possible) diagnoses of mental illness and their function within parameters of relevant law.¹⁰⁰ Mental health law and public policy include a range of applications of law, and have expanded to areas involving psychological injury. For example, Wandler queried the extent to which the Veterans Administration Compensation and Pension examination is culturally sensitive.¹⁰¹ Although, according to Wandler, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR),¹⁰² included an appendix for cultural formulation, which is important for addressing the diagnosis of PTSD in military veterans, the “quasi-gatekeeping” psychiatrists and the gatekeeping rating specialists in the VA system appear to use a one-size-fits-all format.¹⁰³ Wandler recommended a move to more culturally sensitive policies for the VA.¹⁰⁴

98. See, e.g., Groscup et al., *supra* note 51, at 353–70.; Margaret Bull Kovera et al., *Assessment of the Commonsense Psychology Underlying Daubert: Legal Decision Makers’ Abilities to Evaluate Expert Evidence in Hostile Work Environment Cases*, 8 PSYCHOL. PUB. POL’Y & L. 180, 180 (2002); Carol Krafka et al., *Judge and Attorney Experiences, Practices, and Concerns Regarding Expert Testimony in Federal Civil Trials*, 8 PSYCHOL. PUB. POL’Y & L. 309 (2002).

99. Groscup et al., *supra* note 51, at 353–70.

100. See volumes 1, 2, and 3 of the MENTAL HEALTH L. & POL’Y J., available at <http://www.memphis.edu/law/mhlpjournal.php>.

101. Hillary A. Wandler, *The Role of Culture in Advocating for Accurate Diagnosis and Rating of Veterans’ Psychological Disabilities*, 2 MENTAL HEALTH L. POL’Y J. 1, 2–42 (2013).

102. DSM-IV-TR, *supra* note 27.

103. Wandler, *supra* note 101, at 41–42; see also Mark D. Worthen & Robert G. Moering, *A Practical Guide to Conducting VA Compensation and Pension Exams for PTSD and Other Mental Disorders*, 4 PSYCHOL. INJ. & L. 187 (2011).

104. Wandler, *supra* note 101, at 33–42.

Other research in mental health law and policy includes criticisms of the DSM-5. Van Rensburg discussed its changes from the DSM-IV-TR in capital punishment cases involving intellectual disability/ disorder.¹⁰⁵ The changes in the DSM-5 affect other disorders, such as PTSD.

Young noted difficulties in translating terms from law into psychology, and vice versa.¹⁰⁶ Reliability in law can mean something more akin to validity in science, which is a source of much confusion for workers not entirely familiar with the field, and especially for novices. Damages are losses in psychology but the term refers to restorative compensation in law. As for the standard of proof or the burden of proof, in civil matters it refers to the preponderance of the evidence, or a probability of above 50% degree of certainty. In psychology, the level of support of a scientific finding is established by research results that are considered significant, or reside at the alpha level of 5% or 1%, a level of certainty that is quite different from the preponderance of evidence standard in court. Cut scores in some tests might be at this low level, but are generally higher and not necessarily statistically derived, further complicating the issue of probability as used for evaluation and court purposes. These examples illustrate that possessing a solid grounding both in science and in law is essential for work in this field, and also that education, training, and licensing criteria should entail regulations assuring that the full knowledge needed for practice in the area is acquired.

Young, Greiffenstein and Kaufmann discussed the differences between law and science, or psychology, and referred to the two as having different epistemologies.¹⁰⁷ In particular, they noted that psychologists are educated and trained to be objective and to at least “partially” ground their assessments in science. In contrast, because legal proceedings take place in adversarial settings, attorneys are supposed to be “zealous” advocates.

105. Kate Janse van Rensburg, *The DSM-5 and Its Potential Effects on Atkins v. Virginia*, 3 MENTAL HEALTH L. POL’Y J. 61, 61 (2013); see generally *Atkins v. Virginia*, 536 U.S. 204 (2002).

106. YOUNG, *supra* note 80, at 795.

107. MANFRED F. GREIFFENSTEIN & PAUL M. KAUFMANN, FORENSIC NEUROPSYCHOLOGY: A SCIENTIFIC APPROACH 23 (Glenn J. Larrabee ed., 2012); MANFRED F. GREIFFENSTEIN, TEXTBOOK OF CLINICAL NEUROPSYCHOLOGY 905 (Joel E. Morgan & Joseph Richter eds., 2008).

Greiffenstein and Kaufmann asserted that, for attorneys, the goal of “winning” cases is more important than any accuracy or objectivity.¹⁰⁸ Moreover, the outcome of the judicial process is considered more important than any truth itself. This does not mean that attorneys are permitted to lie to court; nevertheless, they are allowed to exclude testimony that is not helpful to their cases. “An accurate, comprehensive, and balanced report may be harmful to an attorney’s case.”

Young concluded that, despite having adopted distinct perspectives on impartiality, science, and truth in the legal and psychological arenas, psychologists need to understand and know how to navigate the legal adversarial divide.¹⁰⁹ Although the collective ethics and obligations in presenting and defending evidence in court are strikingly different between legal and mental health professionals, these persons need to work together in cases for which mental health evidence, reports, and testimony are required. In terms of attributions of malingering, or its absence, the importance of this clash in epistemology and practice over legal and mental health workers is even more striking. That is, psychologists are educated and trained to present evidence impartially about any allegations with respect to malingering but, in contrast, attorneys are understandably loath to proffer any evidence to the court that does not meet their advocacy objectives in the case at hand.

The next portion of the Article addresses the critical issue of malingering. We maintain that having an unbiased perspective optimally and equally serves the mental health professional, the evaluatee, and the court. First, we explore court cases related to malingering. Then, we examine the term itself of malingering, e.g., conceptually, definition. Next, we list the multiple terms related to malingering, such as feigning. These terms are best used when the evaluator does not find irrefutable evidence of malingering or when the interview data suggest other possible explanations for exaggerations, such as being overwhelmed and crying out for help. In conclusion, we explore the research on the prevalence of base rate of malingering—estimates of which vary widely.

108. GREIFFENSTEIN & KAUFMANN, *supra* note 107, at 27.

109. YOUNG, *supra* note 80, at 268.

IV. MALINGERING

A. Court

In the area of psychological injury and law, the assessment of malingering and related response styles and biases in presentation and performance constitutes a critical component in evaluations, testimony, and other court-related work. Young argued that unless malingering per se is demonstrated incontrovertibly, mental health professionals should use other, more accurate ways of characterizing problematic presentations and performances.¹¹⁰ The latter behavior by examinees might reflect non-conscious intent rather than conscious intent to fabricate or grossly exaggerate symptoms, disorders, impairments, and functionality for monetary or other material gain. For example, examinees might be careless in responding to tests, be interfered with by comorbid pain or poor sleep, express a cry for help, and/or experience distress at the litigation process. Evaluations conducted by practitioners in the area should necessarily involve tests, measures, scales, or indicators that can potentially detect malingering and related response biases. However, problematic negative response biases can be detected in an additional way. That is, compelling, marked, or substantial discrepancies or inconsistencies in the file of a case at hand could be quite revealing of malingering and other negative response biases. The same is true with respect to the exploration and explanation of these concepts in criminal matters.¹¹¹

Young noted that Taylor addressed the issue of malingering in court by depicting malingering as an “octopus” with tentacles that reach into every aspect of personal injury cases.¹¹² The decision whether malingering is involved in a civil

110. YOUNG, *supra* note 80, at 813.

111. See ROBERT L. DENNEY, ASSESSMENT OF FEIGNED COGNITIVE IMPAIRMENT: A NEUROPSYCHOLOGICAL PERSPECTIVE 428 (Kyle Brauer Boone ed., 2007); Peter A. Weiss, Katherine J. Bell & William U. Weiss, *Use of the MMPI-2 Restructured Clinical (RC) Scales in Detecting Criminal Malingering*, 25 J. POLICE CRIM. PSYCHOL. 49, 49 (2010).

112. J. SHERROD TAYLOR, NEUROPSYCHOLOGY OF MALINGERING CASEBOOK 494 (Joel E. Morgan & Jerry J. Sweet eds., 2009).

trial has long been considered an issue “during every moment.”¹¹³ Juries are typically cautious with respect to this issue, in that they worry that malingerers might be compensated if they are not detected.¹¹⁴ However, Taylor noted that trial lawyers for plaintiffs have a “keen interest” in demonstrating that malingering is *not* an issue.¹¹⁵ Young noted that the converse argument would be that defense lawyers have a “keen interest” in “proving” that plaintiffs are malingering.¹¹⁶

Taylor continued that when the courts accept that a plaintiff is not a malingerer, it facilitates compensation from the court action.¹¹⁷ However, trial courts have been known to refuse evidence about the plaintiff not being a malingerer, although, the courts might be taken by an appeal in such actions. In *Means v. Gates*¹¹⁸ such a scenario led to a new trial.

Taylor continued and noted that experts need to be impartial in court about malingering.¹¹⁹ However, she cited the remarkable testimony found in *Ladner v. Higgins*¹²⁰ in which the defense expert stated the following about whether the examinee was malingering: “I wouldn’t be testifying if I didn’t think so, unless I was on the other side, then it would be a posttraumatic condition.” Taylor noted that the court in the *Ladner* case rightfully rejected the admissibility of the defense expert’s testimony.¹²¹ Only positive and convincing evidence should lead to a conclusion of the presence of malingering.¹²² Finally, unlike for the ultimate issue in criminal cases, experts are allowed to testify

113. United States Fid. & Guar. Co. v. McCarthy, 50 F.2d 2 (8th Cir. 1931).

114. Southwire Co. v. George, 470 S.E.2d 865 (Ga. 1996).

115. Salas v. United States, 974 F.Supp. 202 (W.D.N.Y. 1997).

116. YOUNG, *supra* note 80, at 270.

117. TAYLOR, *supra* note 112, at 494 (*citing* Macsenti v. Becker, 237 F.3d 1223 (10th Cir. 2001)).

118. Means v. Gates, 558 S.E.2d 921 (S.C. Ct. App. 2001).

119. TAYLOR, *supra* note 112.

120. Ladner v. Higgins, Inc., 71 So.2d 242 (La.Ct. App. 1954).

121. TAYLOR, *supra* note 112, at 494 (*citing* Ladner v. Higgins, Inc., 71 So.2d 242 (La.Ct. App. 1954)).

122. Williams v. Bituminous Cas. Corp., 131 So.2d 844 (La.Ct. App. 2d Cir. 1961).

about malingering because it is not “a direct opinion on the issue of lying.”¹²³

Another matter related to malingering that has been addressed in court concerns the use of dedicated scales for its detection. Young described that Kaufmann addressed the symptom validity test (SVT) wars,¹²⁴ for example, of the admissibility of the MMPI-2 (Minnesota Multiphasic Personality Inventory, Second Edition),¹²⁵ Symptom Validity Scale (FBS)¹²⁶ to the court. Kaufmann noted that the courts have been addressing the role of SVTs in malingering detection for the past decade.¹²⁷ In general, for Kaufmann, the arguments against the use of SVTs in assessments include: (a) results of SVTs are more prejudicial than probative or helpful; (b) they are confusing to triers of fact; (c) they relate more to the examinee’s character; (d) they are akin to hearsay evidence; (e) they intrude into the role of the trier of fact in court; and (f) they do not meet the general acceptance standard for admissibility.¹²⁸

After reviewing twelve cases challenging its admissibility in court, Kaufmann noted that apparently the FBS is “here to stay” with respect to its use in court cases about malingering.¹²⁹ Moreover, the evidence provided on the basis of SVTs generally goes unchallenged in court,¹³⁰ and is typically admitted when it is challenged.¹³¹ Young reviewed the research of Lilienfeld, Thames, and Watts, who confirmed that failing to meet the threshold on SVTs does not automatically imply that malingering has taken

123. *Rose v. Figgie Int’l, Inc.*, 495 S.E.2d 77, 502 (Ga.Ct.App. 1997).

124. KAUFMANN, *supra* note 22.

125. *See* BUTCHER ET AL., *supra* note 9; JAMES N. BUTCHER ET AL., MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2: MANUAL FOR ADMINISTRATION AND SCORING (2d ed. 2001).

126. *See* YOSSEF S. BEN-PORATH & AUKE TELLEGEN, MMPI-2-RF: MANUAL FOR ADMINISTRATION, SCORING, AND INTERPRETATION (2008/2011); Paul R. Lees-Haley, Lue Thorn English, & Walter J. Glenn, *A Fake Bad Scale on the MMPI-2 for Personal Injury Claimants*, 68 PSYCHOL. REP. 203, 203 (1991).

127. *See, e.g.*, *Batzel v. Gault*, No. 195596 (Va.Cir. Apr. 12, 2002).

128. KAUFMANN, *supra* note 22.

129. *Id.* *See also* R. D. Hoyt, *Is the Fake Bad Scale Test Here to Stay?*, 8 MASS. TORTS 14, 23 (2009).

130. Ben-Porath et al., *supra* note 9.

131. *See, e.g.*, *Jackson v. Mason*, Case No. 5:08-cv-5267-JLH (2009).

place and that SVTs assess examinee variability related not only to response bias but also to “genuine psychopathology”; therefore, they argued, such results do not have a “precise meaning” and scores obtained on many SVTs need “clarification.”¹³²

The adversarial divide in the area of psychological injury and law leads to opposing opinions and interpretations of multiple topics on the science in the area, including on malingering and negative response bias. Part of the difficulty in these regards relates to the lack of clarity in the various concepts, research, and findings in the field. Also, examinees’ presentations and performances often are difficult to disambiguate, such that examinees may reside in a “gray zone” with respect to credibility and diagnostic clarity. Finally, workers in the field should develop and use the most appropriate and scientifically and legally accepted methods, procedures, and instruments, while being able to defend their choices for court and related purposes. Young noted that Redding and Murrie remarked that, generally, psychological evidence is not held in high regard in court.¹³³ Therefore, those authors advised that psychological experts should carefully convey the scientific foundations of their testimony and opinions and/or the lack of such found in opposing testimony and opinions.¹³⁴

Vore¹³⁵ described case law emphasizing the need to maintain assessor independence in order to avoid potential liability, including *Hangarter v. The Paul Revere Insurance Company*¹³⁶ and *Hangarter v. Provident Life and Accident Insurance Company*.¹³⁷ Vore concluded that psychological

132. Scott O. Lilienfeld, April D. Thames & Ashley L. Watts, *Symptom Validity Testing: Unresolved Questions, Future Directions*, 4 J. EXP. PSYCHOPATH 78, 78 (2013).

133. Young, *supra* note 11, at 85; *see also* RICHARD E. REDDING & DANIEL C. MURRIE, FORENSIC PSYCHOLOGY: EMERGING TOPICS AND EXPANDING ROLES 683 (Alan M. Goldstein ed., 2007).

134. *Id.*

135. DAVID A. VORE, FORENSIC PSYCHOLOGY: EMERGING TOPICS AND EXPANDING ROLES 489 (Alan M. Goldstein ed., 2007).

136. *Hangarter v. Paul Revere Life Ins. Co.*, 236 F. Supp. 2d 1069 (N.D. Cal. 2002).

137. *Hangarter v. Provident Life & Accident Ins. Co.*, 373 F.3d 998 (9th Cir. 2004).

evaluators should adhere scrupulously to the highest practice standards in conducting their examinations.¹³⁸

An appropriate conclusion concerning the evaluation of possible malingering in the psychology injury and law context is that it is necessary to proceed with a science-first, ethical, and prudent fashion. Evaluator bias, in particular, needs to be addressed and countered. In this regard, Kassin, Dror, and Kukucka referred to a forensic “confirmation bias,”¹³⁹ Murrie, Boccaccini, Guarnera, and Rufino to an “allegiance” effect,¹⁴⁰ and Stanovich, West, and Toplak to “myside” bias.¹⁴¹ Science must constitute the best source of evidence for courts in order to dispel any hint of bias emanating from any side of the court process. The same is certainly true in criminal matters, as well.¹⁴²

B. Terms

1. Malingering

Review of definitions of malingering across different fields reveals a readily apparent lack of consensus.¹⁴³

- For the primary psychiatric nosological manual, malingering involves the “intentional production of false or grossly exaggerated physical and psychological symptoms” that derives from “motivation by external incentives,” for example, for obtaining financial compensation, as described in both the DSM-IV-TR¹⁴⁴ and the DSM-5;¹⁴⁵

138. VORE, *supra* note 135.

139. Saul M. Kassin, Itiel E. Dror & Jeff Kukucka, *The Forensic Confirmation Bias: Problems, Perspectives, and Proposed Solutions*, 2 J. APPLIED RES. MEMORY & COGNITION 42, 42 (2013).

140. Daniel C. Murrie et al., *Are Forensic Experts Biased By the Side That Retained Them?* 24 PSYCHOL. SCI. 1889, 1890–96 (2013).

141. Keith E. Stanovich, Richard F. West & Maggie E. Toplak, *Myside Bias, Rational Thinking, and Intelligence*, 22 CURRENT DIRECTION PSYCHOL. SCI. 259, 259 (2013).

142. Michael L. Commons, Patrice M. Miller & Thomas G. Gutheil, *Expert Witness Perceptions of Bias in Experts*, 32 J. AM. ACAD. PSYCHIATRY L. 70, 73 (2004).

143. YOUNG, *supra* note 80, at 28.

144. DSM-IV-TR, *supra* note 27.

145. DSM-5, *supra* note 2.

- The American Psychological Association's *Dictionary of Psychology* does not reference exaggeration in its definition of malingering. According to this resource, malingering is the deliberate feigning of an illness or disability that is motivated to achieve a particular specific external factor or outcome, e.g., financial gain obtained by faking physical illness;¹⁴⁶
- As for a legal definition, *Black's Law Dictionary* provides a definition that includes feigning for external incentives, such as disability benefits, but does not include an exaggeration component ("to feign illness or disability" [for example, to initiate receiving or] "to continue receiving disability benefits");¹⁴⁷
- In terms of a layperson definition of malingering, *Merriam-Webster's Collegiate Dictionary* includes an exaggeration component but without specifying degree, such as is the case for the DSM's adjective of gross exaggeration (definition: to pretend or exaggerate incapacity or illness, e.g., to avoid work).¹⁴⁸

Young noted that the DSM-IV-TR and DSM-5 approaches to the definition of malingering can be qualified by the separation of its two major components.¹⁴⁹ That is, the definition implies the presence of either: (a) overt, outright, frank, and conscious, intentional fabrication, feigning, or dissimulation of symptoms, disorders, disabilities, or functional impairments for external incentives, such as financial gain, and for which there is incontrovertible, indisputable, or compelling evidence; or (b) conscious, intentional gross exaggerations of symptoms, disorders, disabilities, or functional impairments that clearly are greater than the moderate level, for the same external incentives, and for which there is incontrovertible, or compelling evidence.¹⁵⁰

146. AMERICAN PSYCHOLOGICAL ASSOCIATION, *APA DICTIONARY OF PSYCHOLOGY* (Gary R. Vandenbos ed., 2007).

147. *BLACK'S LAW DICTIONARY* 1044 (9th ed. 2009).

148. FREDERICK C. MISH, *MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY* (11th ed. 2003).

149. YOUNG, *supra* note 80, at 29.

150. *Id.*

Young further qualified that in malingering, unlike what is specified in the DSM definition, the intention is not to *produce* false or exaggerated symptoms but clinically to *present* with them.¹⁵¹ For example, symptoms that are self-reported are not “produced” per se; rather, they are merely “presented” in a description to the evaluator as being part of the presenting problem. There might be no actual “symptoms” produced at all. Second, even if there were symptoms produced, the process of somatization could be in play. Moreover, even in the case of somatization, identified symptoms might be intentional for financial gain, which is to say malingered rather than being unconscious. For example, one could firmly wish that one had been injured (although one has not), with the associated stress, lack of sleep, anger against the insurance process, and so on, all conspiring to produce pain and related claimable symptoms. Thus, a conscious process of presenting with symptoms may serve to actually produce them and the origin of the symptoms no longer can be recalled. In short, an improved definition of malingering might reflect:

The intentional *presentation* with false or grossly exaggerated symptom [physical, mental health, or both; full or partial; mild, moderate, or severe], for purposes of obtaining an external incentive, such as monetary compensation for an injury and/or avoiding/evading work, military duty, or criminal prosecution

Other advantages of the new definition is that the use of the word “presentation” instead of “production” more clearly covers negative symptoms as well as positive ones, such as failing to present capable of work when that is not the case. Moreover, the changes made to the definition allow more clearly combined physical and psychological symptoms.

2. Terms Other Than Malingering

Assessors in the area of psychological injury and law need to differentiate malingering from similar terminology. Accurate

151. *Id.*

terms should be used in lieu of the establishment of malingering per se. For example:

- Deception. Attempt to distort or misrepresent in self-reporting, e.g., acts of deceit, often accompanied by nondisclosure;¹⁵²
- Defensiveness. Deliberate denial/ gross minimization of physical/ psychological symptoms;¹⁵³
- Disengagement. Minimally engaged in the assessment process;¹⁵⁴
- Dissimulation. The deliberate distortion of or misrepresentation of psychological symptoms. Not necessarily malingering, defensiveness, or any specific response style;¹⁵⁵
- Extension. Another type of fraudulent claim: symptoms or impairments caused by an injury had resolved or improved, but they are claimed to continue at the level of initial injury or even have worsened over time;¹⁵⁶
- Exaggeration. The evaluatee represents true symptoms or impairments caused by an injury as worse relative to his/her actual condition.¹⁵⁷ For Kane and Dvoskin, exaggeration concerns a “relatively mild overstatement” of injury sequelae and, furthermore, it might be either within or outside of conscious awareness;¹⁵⁸
- Fabrication. Refers to fraudulently presenting in a wholesale invention symptoms or impairments that are present as being the result of an injury;¹⁵⁹

152. RICHARD ROGERS, CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION 3 (Richard Rogers ed., 3rd ed. 2008).

153. *Id.*

154. RICHARD ROGERS, KENNETH W. SEWELL & NATHAN D. GILLARD, STRUCTURED INTERVIEW OF REPORTED SYMPTOMS, SECOND EDITION: PROFESSIONAL MANUAL (2d ed. 2010).

155. ROGERS, *supra* note 152.

156. LAURENCE MILLER, ROBERT L. SADOFF & FRANK M. DATTILIO, HANDBOOK OF FORENSIC ASSESSMENT: PSYCHOLOGICAL AND PSYCHIATRIC PERSPECTIVES 277 (Eric Y. Drogin et al., eds., 2011).

157. *Id.*

158. ANDREW KANE & JOEL DVOSKIN, EVALUATION FOR PERSONAL INJURY CLAIMS (2011).

159. MILLER, SADOFF & DATTILIO, *supra* note 156.

- Factitious presentation. An intentional production/ feigning of symptom(s) in order to assume a sick role (DSM-IV-TR).¹⁶⁰ Pursuant to the DSM-5,¹⁶¹ the symptomatology could be physical and not only psychological, the presentation could be as impairment or injury, and not only illness, and the motivation could be for falsification, deception, and external reward in addition to adopting the sick/ injured/ impaired role;
- Faking bad. Any attempt, conscious or not, to represent a more exaggerated symptomatology, for example, on test item endorsements, than is actually experienced by the respondent; suggestive of feigning and negative impression management. Could be confused with malingering, so over-reporting is the preferred term,¹⁶²
- Feigning. The deliberate fabrication/ gross exaggeration of psychological/physical symptoms without assuming its goal;¹⁶³
- Hybrid responding. Use of more than one response style in particular context,¹⁶⁴
- Irrelevant responding. Evaluatee does not become psychologically engaged in the evaluation;¹⁶⁵
- Misattribution. Symptoms that preceded, postdated, or are otherwise unrelated to an injury are fraudulently attributed to it;¹⁶⁶
- Negative impression management. Impression management refers to deliberate effort to control others' perceptions of oneself.¹⁶⁷ Negative impression management refers to test item endorsement or other behavior that suggests an

160. DSM-IV-TR, *supra* note 27.

161. DSM-5, *supra* note 2.

162. BEN-PORATH & TELLEGEN, *supra* note 126.

163. RICHARD ROGERS & SCOTT D. BENDER, 11 COMPREHENSIVE HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 109 (Alan M. Goldstein ed., 2003).

164. ROGERS, *supra* note 152.

165. See Richard Rogers, *Towards An Empirical Model of Malingering and Deception*, 2 BEHAV. SCI. L. 93, 94 (1984); ROGERS, *supra* note 152.

166. MILLER, SADOFF & DATTILIO, *supra* note 156.

167. ROGERS, *supra* note 152.

exaggerated, unfavorable impression, including of possible malingering;¹⁶⁸

- Noncredible. Of insufficient grounds to foster belief; unlikely, implausible¹⁶⁹
- Nondisclosure. Withholding of information (i.e., omission), without assumptions about intentionality;¹⁷⁰
- Overreporting. A statistically high level of item endorsement, especially on multiscale inventories. Should not be equated with feigning;¹⁷¹
- Primary gain. In primary gain, which is an internalized motivation, symptoms create relief and help avoid an unconscious, internal conflict, for example, by providing an acceptable excuse to avoid a situation. Primary gain is different from secondary gain, for which the motivation is conscious and externally-based and is related to obtaining or to avoiding something knowingly and willingly;¹⁷²
- Random responding. Responding based entirely on chance factors;¹⁷³
- Secondary gain. Rogers noted that from a forensic perspective, individuals might deliberately feign an illness to gain special attention/ material gains.¹⁷⁴ The term “secondary gain” can be used in an assessment but should be limited to the context of the assessment and should never be used as a synonym for malingering;¹⁷⁵

168. LESLIE C. MOREY, *PERSONALITY ASSESSMENT INVENTORY* (2d ed. 2007).

169. MISH, *supra* note 148.

170. ROGERS, *supra* note 152.

171. BEN-PORATH & TELLEGEN, *supra* note 126.

172. PAMELA A. WARREN, *BEHAVIORAL HEALTH DISABILITY: INNOVATIONS IN PRESENTATION AND MANAGEMENT* 9 (Pamela A. Warren ed., 2011).

173. ROGERS, *supra* note 152.

174. *Id.*

175. Robert Heilbronner et al., *American Academy of Clinical Neuropsychology Consensus Conference Statement on Neuropsychological Assessment of Effort, Response Bias, and Malingering*, 23 *CLINICAL NEUROPSYCHOLOGY* 1093, 1098 (2009).

- Social desirability. “Presenting oneself in the most favorable way compared to relevant social norms/mores”,¹⁷⁶
- Suboptimal effort. The subtext sometimes used is that these terms represent a proxy for malingering;¹⁷⁷
- Symptom magnification. Some exaggeration of symptom(s) that is likely intentional;¹⁷⁸
- Unreliability. Questions about the accuracy of reported information; without making assumptions about intent/reasons for inaccurate information;¹⁷⁹

3. Malingering Base Rate

The bewildering array of conceptual and definitional issues concerning malingering is paralleled by a corresponding confusion about its base rate or prevalence in civil forensic disability and related populations for which psychological injuries are a focus. The debate about the base rate of malingering especially began with publication of a survey in 2002.

Mittenberg, Patton, Canyock, and Condit surveyed practitioners about base rates of malingering and probable symptom exaggeration in over 30,000 cases of neuropsychological assessment that took place during the preceding year, about one third of which were for personal injury or disability cases.¹⁸⁰ For these two types of examination, the base rate was 29% and 30%, respectively. For mild TBI, the rate was 39%; and for pain conditions it was 31% - 35%. Frederick added that the prevalence rate of malingering based on the literature review is “probably not more than 50% - 60%.”¹⁸¹ A study conducted by Ardolf, Denney,

176. Maryon F. King & Gordon C. Bruner, *Social Desirability Bias: A Neglected Aspect of Validity Testing*, 17 *PSYCHOL. MARKETING* 79, 80 (2000).

177. See ROGERS, *supra* note 152; RICHARD ROGERS & CRAIG S. NEUMANN, *MALINGERING AND ILLNESS DECEPTION* 71 (Peter Halligan, Christopher Bass & David Oakley eds., 2003).

178. ROGERS ET AL., *supra* note 154.

179. ROGERS, *supra* note 152.

180. Wiley Mittenberg et al., *Base Rates of Malingering and Symptom Exaggeration*, *J. CLINICAL EXPERIENCE NEUROPSYCHOLOGY* 1094, 1097 (2002).

181. RICHARD I. FREDERICK, *COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY* 229, 231 (David Faust ed., 6th ed. 2012).

and Houston suggested the presence of comparably high base rates in criminal matters as well.¹⁸²

However, not all empirical research supports this high percentage of malingering in forensic disability and related assessments. Young reviewed some contradictory literature, or research for which careful analysis provided a different perspective on the malingering base rate in such cases.¹⁸³ He found that, for Sollman and Berry, the evidence of base rates for “suboptimal effort” in clinical practice is equal to or greater than 40% in some settings.¹⁸⁴ By using a more generic or global term than of malingering (suboptimal effort), Sollman and Berry afforded the possibility that such terms might involve even mild exaggeration.¹⁸⁵ Their estimate that the percentage might be even higher than 40% for the base rate of suboptimal effort makes sense if one includes all types of suboptimal effort and reasons for them.¹⁸⁶

Young also described how Greve, Bianchini, Etherton, Ord, and Curtis conducted a study in which the prevalence of malingered disability in compensation-seeking chronic pain patients was presented as follows: of 508 patients, up to 36% were classified as probable or definite malingerers, with 10.4% as definite malingerers.¹⁸⁷ Greve gave the results for the prevalence of malingering as between 20 and 50%, depending on the type of analysis undertaken.¹⁸⁸ However, according to that author’s own data, the estimate was closer to 10%.¹⁸⁹

182. Barry R. Ardolf, Robert L. Denney & Christi M. Houston, *Base Rates of Negative Response Bias and Malingered Neurocognitive Dysfunction Among Criminal Defendants Referred for Neuropsychological Evaluation*, 21 CLINICAL NEUROPSYCHOLOGY 899, 913 (2007).

183. YOUNG, *supra* note 80, at 38.

184. Myriam J. Sollman & David T. R. Berry, *Detection of Inadequate Effort on Neuropsychological Testing: A Meta-Analytic Update and Extension*, ARCHIVES CLINICAL PSYCHOL. 774, 775 (2011).

185. *Id.*

186. *Id.*

187. YOUNG, *supra* note 80, at 43 *citing* Kevin W. Greve et al., *Detecting Malingered Pain-Related Disability: Classification Accuracy of the Portland Digit Recognition Test*, 23 CLINICAL NEUROPSYCHOLOGY 850, 862 (2009).

188. *Id.*

189. *Id.*

As reported in Young, Wygant, Anderson, Sellbom, Rapier, Allgeier, and Granacher identified a percentage of definite malingering that was only 8%.¹⁹⁰ Also, Young found that Lee, Graham, Sellbom, and Gervais had administered the FBS (Fake Bad Scale) to claimants who had undergone non-neurological medico-legal disability assessments: according to those authors, only 19 claimants met the criteria for definite malingering – a percentage of about 1.5%.¹⁹¹

Young concluded that clearly establishing the actual base rate or prevalence of malingering and related response biases in psychiatric/psychological injury population remains an outstanding issue in the field.¹⁹² Moreover, Young¹⁹³ noted that estimates in the literature on the malingering base rate applicable to forensic disability and related contexts are much less than the 40-50% level (or more),¹⁹⁴ which is often touted as the appropriate level in the applicable literature. That having been acknowledged, the estimates of problematic presentation and performances to lesser degrees than outright malingering might be this high, and malingering itself might be as high as 10-15%,¹⁹⁵ although other researchers might dispute this figure, with estimates as low as 1-2%.¹⁹⁶

The section of this Article that addresses malingering covers a fundamental and controversial area in the field of

190. YOUNG, *supra* note 80, at 44–45 *citing* Dustin B. Wygant et al., *Association of the MMPI-2 Restructured Form (MMPI-2-RF) Validity Scales with Structured Malingering Criteria*, 4 PSYCHOL. INJ. & L. 13, 18 (2011).

191. YOUNG, *supra* note 80, at 45 *citing* Tayla T. C. Lee et al., *Examining the Potential for Gender Bias in the Prediction of Symptom Validity Test Failure by MMPI-2 Symptom Validity Scale Scores*, 24 PSYCHOL. ASSESSEMENT 618, 621 (2012).

192. YOUNG, *supra* note 80, at 46.

193. *Id.*

194. *E.g.*, Gleen J. Larrabee, Scott R. Millis & John E. Meyers, *40 Plus or Minus 10, A New Magical Number: Reply to Russell*, 23 CLINICAL NEUROPSYCHOLOGY 841, 843 (2009); GLEEN J. LARRABEE, *FORENSIC NEUROPSYCHOLOGY: A SCIENTIFIC APPROACH* (2nd ed. 2012).

195. *E.g.*, Richard Rogers, Scott D. Bender & Stephanie F. Johnson, *A Critical Analysis of the MND Criteria for Feigned Cognitive Impairment: Implications for Forensic Practice and Research*, 4 PSYCHOL. INJ. & L. 147, 149–50 (2011).

196. *E.g.*, Lee et al., *supra* note 191.

psychological injury and law – similar to its clear salience in criminal matters as well. There is no accepted consensus definition of malingering, with base rate or prevalence estimates varying from 1% to over 50%. Moreover, workers in the area are subject to the pulls and pushes of the plaintiff-defense or adversarial divide. Controversies arise for other areas of psychological injury and law, including for the most prominent disorders, diagnoses, or conditions attributed to survivors of events at claim. These include the core psychological injuries of PTSD, mild TBI, and chronic pain. All three conditions are highly contested and contribute to the epidemic of invalid claims in court. It is true that after verification and rule out of possible malingering, evaluators do determine that individuals do suffer legitimate traumatic reactions to events at issue, including polytraumatic, comorbid ones. The following section of the Article discusses the contentious diagnosis of PTSD, including the limits of the DSM-5 approach to this disorder. This leads to a discussion of the DSM-5 in relation to the RDoC project to begin the companion Article.¹⁹⁷

In the final section of this Article, we explore one of the most contentious diagnoses in psychological injury cases: that of PTSD. First, we discuss its controversies, including about its validity. Then, we show that its symptom clusters, as presented in the DSM-5, do not necessarily reflect extant research. To conclude, we describe difficulties presented by its extensive symptom combinations and its extensive comorbidities.

V. POSTTRAUMATIC STRESS DISORDER

A. *Controversies*

Kane noted that PTSD constitutes the most common diagnosis in personal injury cases.¹⁹⁸ Young and Yehuda had argued that each case of PTSD should be considered at the individual level and not as representative of a category.¹⁹⁹

197. Insel et al., *supra* note 3.

198. KANE ET AL., *supra* note 62.

199. GERALD YOUNG & RACHEL YEHUDA, PSYCHOLOGICAL KNOWLEDGE IN COURT: PTSD, PAIN, AND TBI 55 (Gerald Young, Andrew W. Kane & Keith Nicholson eds., 2006).

However, PTSD has presented the court many sticky issues. Overall, Young²⁰⁰ noted that this diagnostic category is (a) open to “bracket creep” in its eliciting stressors;²⁰¹ (b) has led to an explosion of tort actions,²⁰² and; (c) is a disorder with facility in malingering.²⁰³

Rosen and Grunert²⁰⁴ noted that Breslau and Kessler showed that the definition of the PTSD entry criterion A allows for an increase of over 50% in the types of events that are considered sufficiently traumatic to reach the PTSD diagnostic threshold.²⁰⁵ The creep has extended to include “vicarious traumatization,”²⁰⁶ to the apparent extent that even “crude jokes” could elicit it.²⁰⁷

Lareau indicated that the PTSD diagnosis remains very much in vogue.²⁰⁸ This has led, perhaps inevitably, to it being given pejorative labels such as “compensationitis” and “accident victim syndrome.”²⁰⁹ Therefore, in forensic cases, it is all the more important that clearly adequate psychometric testing should be

200. Gerald Young, *PTSD, Endophenotypes, the RDoC, and the DSM-5*, 7 PSYCHOL. INJ. & L. 75, 75 (2014).

201. Richard J. McNally, *Progress and Controversy in the Study of Posttraumatic Stress Disorder*, 54 ANN. REV. PSYCHOL. 229, 231–32 (2003).

202. KANE & DVOSKIN, *supra* note 158.

203. GERALD M. ROSEN & BRAD K. GRUNERT, NEUROPSYCHOLOGICAL ASSESSMENT OF WORK RELATED INJURIES 163 (Shane Bush & Grant L. Iverson eds., 2012).

204. *Id.*

205. Naomi Breslau & Ronald C. Kessler, *The Stressor Criterion in DSM-IV Posttraumatic Stress Disorder: An Empirical Investigation*, 50 BIOLOGICAL PSYCHIATRY 699, 701–02 (2001).

206. *See, e.g.*, Jennifer Ahern et al., *Television Images and Probable Posttraumatic Stress Disorder After September 11: The Role of Background Characteristics, Event Exposures, and Perievent Panic*, 192 J. NERVOUS & MENTAL DISEASE 217, 224–25 (2004); Rachel Sabin-Farrell & Graham Turpin, *Vicarious Traumatization: Implications For the Mental Health of Health Workers?* 23 CLINICAL PSYCHOL. REV. 449, 450–80 (2003).

207. Claudia Avina & William O’Donohue, *Sexual Harassment and PTSD: Is Sexual Harassment Diagnosable Trauma?* 15 J. TRAUMA STRESS 69, 70–72 (2002).

208. CRAIG R. LAREAU, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 610 (David Faust ed., 6th ed. 2011).

209. Ralph Slovenko, *The Watering Down of PTSD in Criminal Law*, 32 J. PSYCHIATRIC L. 411, 411 (2004).

employed,²¹⁰ including measures with negative response bias detection scales, e.g., MMPI-2-RF, Minnesota Multiphasic Personality Inventory-2 Restructured Form.²¹¹ Nevertheless, in every research study, psychometric tests have imperfect sensitivity and specificity,²¹² and the search for markers of PTSD that can reliably help differentiate valid from invalid cases constitutes an important avenue.²¹³

Young described how Andrikopoulos and Greiffenstein examined research on the prevalence of PTSD in motor vehicle accidents (MVAs).²¹⁴ They focused on prospective studies that assessed consecutive admissions to hospitals.²¹⁵ Identified prevalence rates were 1.9% (at 1 year) and 2.5%, respectively. These estimates of PTSD due to MVAs contrast to claims made by other researchers of a higher prevalence rate.²¹⁶ However, the latter study did not check for possible malingering. According to Lareau,²¹⁷ most individuals exposed to serious or traumatic events do not develop PTSD. Moreover, of those who do, only 9-15% develop chronic PTSD.²¹⁸

Table 1 presents the symptom clustering approaches in the DSM-IV-TR and the DSM-5. The former divides the seventeen symptoms of PTSD into three clusters—Re-experiencing/Intrusion, Avoidance/ Numbing, and Hypervigilance. The DSM-5 added

210. LARRABEE, *supra*, note 194.

211. BEN-PORATH & TELLEGEN, *supra* note 126.

212. YOUNG, *supra* note 80.

213. LAREAU, *supra* note 208.

214. YOUNG, *supra* note 80, at 239 *citing* JIM ANDRIKOPOULOS AND MANFRED F. GRIFFENSTEIN, *FORENSIC NEUROPSYCHOLOGY: A SCIENTIFIC APPROACH* 365 (Glenn J. Larrabee ed., 2nd ed. 2012).

215. *See generally* Ulrich Schnyder et al., *Prediction of Psychiatric Morbidity in Severely Injured Accident Victims at One-Year Follow-Up*, 164 *AM. J. RESPIRATORY & CRITICAL CARE MEDICINE* 653, 653 (2001); Marco Wrenger et al., *Psychiatric Disorders After An Accident: Predictors and the Influence of the Psychiatric Condition Prior to An Accident*, 23 *EUROPEAN PSYCHIATRY* 434, 434 (2008).

216. *E.g.*, EDWARD B. BLANCHARD AND EDWARD J. HICKLING, *AFTER THE CRASH: ASSESSMENT AND TREATMENT OF MOTOR VEHICLE ACCIDENT SURVIVORS* (2d ed. 2004).

217. LAREAU, *supra* note 208.

218. WILLIAM J. KOCH ET AL., *PSYCHOLOGICAL INJURIES: FORENSIC ASSESSMENT, TREATMENT, AND LAW* (2006).

three more symptoms, modified some of the extant seventeen ones, and divided the symptoms into four clusters. Elhai, Biehn, Armour, Klopper, Frueh, and Palmieri have proposed a five-factor approach.²¹⁹ Pietrzak, Galea, Southwick, and Gelernter²²⁰ and Pietrzak, Henry, Southwick, Krystal, and Neumeister²²¹ have found data consistent with Elhai's approach. Young, Lareau, and Pierre have pointed to the limits of the DSM-5 approach to PTSD symptoms and their clustering, and recommended a biopsychosocial approach that focused on primary, core symptoms, in particular.²²²

B. Posttraumatic Stress Disorder Combinations and Comorbidity

1. Posttraumatic Stress Disorder in the DSM-5

Young and Haynes indicated that criteria in the DSM-5 2010 draft proposal for PTSD (field tested in 2010–11) were altered in the DSM-5's final version.²²³ Given these extensive changes, the reliability reported for PTSD in the field trials do not pertain to the final version for PTSD published in the DSM-5.²²⁴ Moreover, Zoellner, Bedard-Gilligan, Jun, Marks, and Garcia

219. Jon D. Elhai et al., *Evidence for a Unique PTSD Construct Represented by PTSD's D1-D3 Symptoms*, 25 J. ANXIETY DISORDERS 340, 342–44 (2011).

220. Robert H. Pietrzak et al., *Examining the Relation Between the Serotonin Transporter 5-HTTLPR Genotype x Trauma Exposure Interaction on a Contemporary Phenotypic Model of Posttraumatic Stress Symptomatology: A Pilot Study*, 148 J. AFFECT DISORDER 123, 123 (2013).

221. Robert H. Pietrzak et al., *Linking In Vivo Brain Serotonin Type 1B Receptor Density to Phenotypic Heterogeneity of Posttraumatic Stress Symptomatology*, 18 MOLECULAR PSYCHIATRY 399, 399 (2013).

222. Gerald Young, Craig Lareau & Brandon Pierre, *One Quintillion Ways to have PTSD Comorbidity: Recommendations for the Disordered DSM-5*, 7 PSYCHOL. INJ. & L. 61, 61 (2014).

223. GERALD YOUNG & STEPHEN HAYNES, CAUSALITY IN NORMAL AND ABNORMAL BEHAVIOR: EMERGENCE IN DEVELOPMENT, BIOLOGY, BRAIN, MIND, AND FREE WILL (forthcoming 2014).

224. Darrel A. Regier et al., *DSM-5 Field Trials in the United States and Canada, Part II: Test-Retest Reliability of Selected Categorical Diagnosis*, 170 AM. J. PSYCHIATRY 59, 59 (2013).

noted that by adding three new symptoms to PTSD, the DSM-5 increased the heterogeneity of symptom expression in an already diversely presented disorder, so that increased comorbidity in diagnosis is promoted.²²⁵ All this adds to the clinical and forensic complications presented by the DSM-5 approach to PTSD.

The high degree of overlap of PTSD symptoms with those of other disorders has led to proposals that it should be reduced to core symptoms. Consistent with Young's recommendations, Brewin, Lanius, Novac, Schnyder, and Galea have proposed that a minimum of three symptoms should be sufficient to diagnose PTSD.²²⁶

2. Combinations and Comorbidities

Young, Lareau, and Pierre reviewed how Galatzer-Levy and Bryant calculated the symptom combinations possible among the twenty PTSD symptoms in the DSM-5.²²⁷ The amount of combinations that those authors found arrived at the astounding amount of 636,120, leading them to assert that this amount illustrates the amorphous nature of the PTSD category and more generally, the limits of the categorical approach in the DSM.²²⁸

Lockwood and Forbes noted that Kessler, Sonnega, Bromet, Hughes, and Nelson found in the National Comorbidity Study (NCS) that 88% of men and 79% of women with PTSD were comorbid for another diagnosis.²²⁹ Similarly, Brown, Campbell, Lehman, Grisham, and Mancill reported that 92% of individuals with a principal current diagnosis of PTSD were

225. Lori A. Zoellner et al., *The Evolving Construct of Posttraumatic Stress Disorder (PTSD): DSM-5 Criteria Changes and Legal Implications*, 6 PSYCHOL. INJ. & L. 277, 278–86 (2013).

226. Young, Lareau & Pierre, *supra* note 222, at 65; Chris R. Brewin et al., *Reformulating PTSD for DSM-V: Life After Criterion A*, 22 J. TRAUMA STRESS. 366, 366 (2009).

227. Young, Lareau & Pierre, *supra* note 222, at 70 citing Isaac R. Galatzer-Levy & Richard A. Bryant, *120 Ways to Have Posttraumatic Stress Disorder*, 8 PERSPECT PSYCHOL. SCI. 651, 651 (2013).

228. *Id.*

229. Emma Lockwood & David Forbes, *Posttraumatic Stress Disorder and Comorbidity: Untangling the Gordian Knot*, PSYCHOL. INJ. & L. (2014) citing Ronald C. Kessler et al., *Posttraumatic Stress Disorder in the National Comorbidity Survey*, 52 ARCHIVES GEN. PSYCHIATRY 1048, 1055 (1995).

comorbid for another disorder.²³⁰ For those expressing PTSD currently, whether or not as a principal diagnosis, 100% of the participants were comorbid for a disorder at one point in their lives.

Young calculated the symptom combinations involving not just PTSD but comorbid PTSD presentations, as in cases of polytrauma.²³¹ For example, PTSD and major depressive disorder (MDD) could be expressed in as many as 270,351,000 ways. When pain is involved, the symptom combination amount extends to 1.89 billion. If one includes MTBI, the amount of symptom combinations reaches to 1.79 trillion. By adding in alcohol use disorder, the combinations total escalates to 3.64 quadrillion. Finally, when borderline personality disorder is added (it could be a precursor exacerbated by an MVA, for example), the total of possible symptom combinations reaches 1.39 quintillion.²³²

Young, Lareau, and Pierre added that, this total in symptom heterogeneity in PTSD comorbidity symptom expression could be highly confusing and at time virtually unmanageable.²³³ Young, Lareau, and Pierre noted that the amount of comorbid PTSD symptom combinations that is possible reveals the potential problems not only for PTSD specifically but also for the DSM-5 generally.²³⁴

One way of reducing PTSD complexity involves defining classes in its expression with comorbid disorders. In this regard, using Latent Class Analysis (LCA), Galatzer-Levy, Nickerson, Litz, and Marmar found three lifetime PTSD comorbidity patterns.²³⁵ Notable none were a “pure” type.²³⁶ The accompanying Article considers whether one solution to the DSM-

230. Timothy A. Brown et al., *Current and Lifetime Comorbidity of the DSM-IV Anxiety and Mood Disorders in a Large Clinical Sample*, 110 J. ABNORMAL PSYCHOL. 585, 595 (2001).

231. Young, Lareau & Pierre, *supra* note 222, at 70.

232. *Id.*

233. *Id.*

234. *Id.*

235. Isaac R. Galatzer-Levy et al., *Patterns of Lifetime PTSD Comorbidity: A Latent Class Analysis*, 30 DEPRESSION ANXIETY 489, 489 (2013).

236. *Id.*

5 difficulties lies in the RDoC project.²³⁷ The RDoC also aims to simplify psychiatric disorder, especially to basic neural circuits.

VI. CONCLUSIONS

The first of these two companion Articles considered core areas in psychological injury and law, from forensics, to evidence law and tort, to malingering and PTSD. The companion Article expands this focus to consider the DSM-5, the RDoC project, tests, a recent Supreme Court of Canada case, theory, and ethics. Psychological injury and law is an area needing an extended and diverse knowledge base. Moreover, its work in these extended, diverse areas can help other areas in their psychological conceptualizations and practice, as shall be shown.

Table 1
**DSM-IV-TR/ DSM-5 PTSD Symptoms and Their Cluster/
Factor Structure**

DSM-IV-TR		DSM-5	
PTSD Symptom	Cluster Model/ Elhai (Five-factor Model) ²³⁸	PTSD Symptom	Four Cluster Model
B1. Intrusive trauma thoughts	R (I)/ R	B1. Recurrent/ involuntary/ intrusive distressing memories	I
B2. Recurrent trauma dreams	R (I)/ R	B2. Recurrent distressing dreams in their content/ affect	I
B3. Flashbacks	R (I)/ R	B3. Dissociative reactions (e.g., flashbacks); the person feels/ acts as if recurring (at worst, a complete loss of present awareness)	I

237. Insel et al., *supra* note 3.

238. Elhai et al., *supra* note 219, at 342–44.

B4. Trauma-cue emotional reactivity	R (I)/ R	B4. Intense/ prolonged psychological distress at exposure to internal/ external signals	I
B5. Trauma-cue physiological reactivity	R (I)/ R	B5. Marked physiological reactions to reminders (internal/ external signals)	I
C1. Avoiding trauma thoughts	A/ A	C1. (Tries to) avoid distressing internal reminders (thoughts/ feelings/ memories)	A
C2. Avoiding trauma reminders	A/ A	C2. (Tries to) avoid external reminders (e.g., people, places, conversations, activities, objects, situations)	A
C3. Inability to recall trauma aspects	A/ N	D1. Inability to remember important aspect	N'
C4. Loss of interest	A/ N	D2. Persistent/ exaggerated negative beliefs/ expectations about one's self, others/ world (e.g., "I'm bad," "Trust no one now," "The world is totally dangerous")	N'
C5. Detachment	A/ N	D3. Persistent, distorted thoughts about the cause/ consequences, leading to self/ other blame	N'
C6. Restricted affect	A/ N	D4. Persistent negative emotional state	N'

C7. Sense of foreshortened future	A/ N	D5. Markedly diminished interest/ participation in important life activities	N'
D1. Sleep disturbance	H/ DA	D6. Feeling of detachment/ estrangement	N'
D2. Irritability	H/ DA	D7. Persistent inability to experience positive emotions	N'
D3. Difficulty concentrating	H/ DA	E1. Irritability/ angry behavior (to little or to no provocation), shown as verbal/ physical aggression to people/ objects	H
D4. Hyper vigilance	H/ AA	E2. Recklessness/ self-destructiveness	H
D5. Exaggerated startle response	H/ AA	E3. Hyper vigilance	H
		E4. Exaggerated startling response	H
		E5. Concentration problems	H
		E6. Sleep disturbance	H

Abbreviations. Re-experiencing (R); Avoidance (A); Hyper arousal (H); Dysphoria, (D); Numbing (N); Dysphoric Arousal (DA); Anxious Arousal (AA); Negative Alterations (N').

Psychological Injury and Law II: Implications for Mental Health Policy and Ethics

BY GERALD YOUNG*

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I. SUMMARY

This second Article in the series on psychological injury and law in relation to mental health law and policy tackles broader

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issues, such as the role of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) in the field, what the Research Domain Criteria (RDoC)¹ project will bring to the area, ethics, and theory. The first Article, a companion piece to this Article, described the nature of the area of psychological injury and law, its premiere journal of the same name, and multiple practice and research issues. These included forensic psychology, evidence law, torts, worker compensation, malingering, posttraumatic stress disorder, and causality. Much of the present Article concerns the issue of claimed psychological impairment and disability due to work stress and whether the causality in such types of stress can be reliably apportioned, including to any material contribution from the work environment itself. This Article offers a literature review on the topic and also consideration of another literature review executed by an expert whose report was filed in a workers compensation case before the Supreme Court of Canada. The author served as an expert witness in the case, and this Article presents the author's rebuttal of the expert's literature review and conclusions. Further, the author provides policy recommendations related to mental health and work stress for the worker compensation system.

The Article moves to discuss the DSM-5² and the RDoC project. It presents a new ethical framework consisting of ten principles, five adopted from the American Psychological Association ethics code,³ and five new ones. The Article includes presentation of a new definition of mental disorder, a section on tests, and it concludes with the need for a systems approach to the field.

1. Thomas Insel et al., *Research Domain Criteria (RDoC): Toward a New Classification Framework for Research on Mental Disorders*, 167 AM. J. PSYCHIATRY 748 (2010).

2. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-5 (5th ed. 2013) [hereinafter DSM-5].

3. American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCH. ASS'N (2010), <http://www.apa.org/ethics/code/index.aspx> [hereinafter EPPCC].

II. DSM-5 AND THE RESEARCH DOMAIN CRITERIA

A. DSM-5

Dr. Gerald Young⁴ reviewed the special issue on the psychiatric diagnostic manual, the DSM-5⁵ that appeared in the journal *Psychological Injury and Law* (PIL). The special issue considered changes in the DSM-5 relative to the DSM-IV-TR⁶ from both a clinical utility and scientific point of view. Although the DSM-5 manual did not undergo wholesale change, the changes to diagnostic categories for psychological injuries—especially posttraumatic stress disorder (PTSD), mild traumatic brain injury (TBI), and chronic pain—present both practical and forensic conundrums that complicate clinical and legal work in the area.

Thomas⁷ pointed out the forensic pitfalls in using the DSM-5. Gordon and Cosgrove⁸ noted that ethical use of a psychiatric diagnostic manual, such as the DSM-5, should assure its acceptable reliability and validity. The authors concluded with the standards in the psychologists' principles in its ethical code⁹ that drive DSM-5 working group conduct. Zoellner, Bedard-Gilligan, Jun, Marks, and Garcia¹⁰ addressed the confusion of what constitutes a traumatic stressor in the A criterion of PTSD. They analyzed the potential legal implications of all aspects of the PTSD criteria. Biehn, Elhai, Seligman, Tamburrino, Armour, and

4. Gerald Young, *Breaking Bad: DSM-5 Description, Criticism, and Recommendations*, 6 PSYCHOL. INJ. & L. 345, 346–47 (2013).

5. DSM-5, *supra* note 2.

6. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

7. Lori C. Thomas, *The DSM-5 and Forensic Relationship Status: It's Complicated*, 6 PSYCHOL. INJ. & L. 324, 325 (2013).

8. Robert M. Gordon & Lisa Cosgrove, *Ethical Considerations in the Development and Application of Mental and Behavioral Nosologies: Lessons From DSM-5*, 6 PSYCHOL. INJ. & L. 330, 331–35 (2013).

9. EPPCC, *supra* note 3.

10. Lori A. Zoellner et al., *The Evolving Construct of Posttraumatic Stress Disorder (PTSD): DSM-5 Criteria Changes and Legal Implications*, 6 PSYCHOL. INJ. & L. 277, 278–80 (2013).

Forbes¹¹ examined the factor structure of the DSM-5 PTSD symptoms in relation to depressive symptoms. Schultz¹² questioned the validity of omitting a diagnostic category for moderate neurocognitive disorder (NCD) in the DSM-5 and having only mild and severe NCD. Young¹³ argued that the removal of pain disorder from the DSM-5, by placing pain as a predominant complaint in the new generic category of somatic symptom disorder (SSD) complicates forensic applications. Young¹⁴ proposed that Chronic Pain Complication Disorder be included to replace SSD in the DSM-5. Hopwood and Sellbom¹⁵ described research on the Personality Inventory of DSM-5 (PID-5) and the validity of the trait approach, in general, in understanding psychopathology. Frances and Halon¹⁶ described the poor state of affairs of forensic psychiatry and its use of the DSM.

Young¹⁷ concluded that the articles in this special issue on the DSM-5 in the *Psychological Injury and Law* journal have examined multiple relevant issues related to the DSM-5. Moreover, the articles collectively point to what is needed for the DSM-5 to reach acceptable admissibility standards to court. He added that it does not consider the available research to a sufficient degree. Therefore, for forensic purposes, despite its cautions about its use in court, in many ways, it fails to meet the bar in terms of the requisite standards of reliability and validity.

11. Tracey L. Biehn et al., *Underlying Dimensions of DSM-5 Posttraumatic Stress Disorder and Major Depressive Disorder Symptoms*, 6 PSYCHOL. INJ. & L. 290, 295–97 (2013).

12. Izabela Z. Schultz, *DSM-5 Neurocognitive Disorders: Validity Reliability, Fairness, and Utility in Forensic Applications*, 6 PSYCHOL. INJ. & L. 299, 300–02 (2013).

13. Young, *supra* note 4, at 346.

14. *Id.*

15. Christopher J. Hopwood & Martin Sellbom, *Implications of DSM-5 Personality Traits for Forensic Psychology*, 6 PSYCHOL. INJ. & L. 314, 318–20 (2013).

16. Allen Frances & Robert Halon, *The Uses and Misuses of the DSM in Forensic Settings*, 6 PSYCHOL. INJ. & L. 336, 337–39 (2013).

17. Young, *supra* note 4, at 347.

B. Research Domain Criteria

Young¹⁸ described that Insel and Lieberman¹⁹ noted that the Research Domain Criteria (RDoC)²⁰ is oriented to the assumption that mental illness should be understood best as disorders of “brain function and structure,” which affect domains of cognition, emotion, and behavior. The goal of the RDoC project is to organize psychiatric nosology according to genetics, neuroscience, and behavioral science. The RDoC is an emerging critical framework in mental health research and it will inform and channel conceptualization and empirical investigation in the field, including for the DSM-5, generally, and on specific disorders, such as PTSD. However, its neuroscientific focus should not preclude a wider model of psychopathology and its development in context.

Young²¹ argued that advances are being made in understanding the pathway to disorder in PTSD in terms of brain regions, neuronal networks, stress-related systems (e.g., hypothalamic pituitary adrenal (HPA) axis), and their underlying genetic and neurogenetic bases. Nevertheless, it would be premature to embrace the RDoC project as the major direction needed in revising the DSM. For example, psychiatric illness is affected by Genetic x Environment interactions with brain circuits, as well. Therefore, a primary focus on pathophysiological intermediates in any disease pathway, as appears emphasized in the RDoC approach to etiology of psychiatric disorder, puts aside a more inclusive biopsychosocial approach.

The authors conclude that whether for PTSD or any disorder in the DSM-5, multiple pathways toward better classification should be undertaken, without a premature primary focus on neurosignatures. Young²² had noted that the term biopsychosocial had

18. Gerald Young, *PTSD, Endophenotypes, the RDoC, and the DSM-5*, 7 *PSYCHOL. INJ. & L.* 75, 84–87 (2014) [hereinafter *PTSD*].

19. Thomas Insel & Jeffrey A. Liberman, *DSM-5 and RDoC: Shared Interests*, NIMH (2013), available at www.nimh.nih.gov.

20. Insel et al., *supra* note 1, at 749.

21. *PTSD*, *supra* note 18, at 77–84.

22. Gerald Young, Ph.D., Address at the Canadian Academy of Psychologists in Disability Assessment: DSM-5: Overview, Critique, Recommendations (Jun. 21, 2013); GERALD YOUNG & STEPHEN HAYNES, CAUSALITY IN

been included in the DSM-5 draft version but had been removed from the final published version. It is time to adopt a wider focus not only for diagnostic and classification purposes but also because of the impact a more inclusive psychological and psychiatric focus will have on mental health policy and global mental health issues.²³

III. PSYCHOLOGICAL TESTS, COMBINATIONS, AND A NEW MALINGERING DETECTION SYSTEM

A. Tests

In order to detect malingering and other negative response biases, psychologists trained in the use of psychometric tests who work in the forensic disability and related civil areas can choose from among five types of instruments, depending on the nature of the case.

First, there are structured interviews aimed at detecting feigned psychopathology. These interviews include the Miller Forensic Assessment of Symptoms Test (M-FAST),²⁴ which includes the following scales: Reported versus Observed (RO), Extreme Symptomatology (ES), Rare Combinations (RC), Unusual Hallucination (UH), and Total (Tot). More extensive tests of this nature include the Structured Interview of Reported Symptoms (SIRS)²⁵ and the Structured Interview of Reported Symptoms, Second Edition (SIRS-2).²⁶ The scales in the latter include: Rare Symptoms (RS), Symptom Combinations (SC), Improbable or Absurd Symp-

NORMAL AND ABNORMAL BEHAVIOR: EMERGENCE IN DEVELOPMENT, BIOLOGY, BRAIN, MIND, AND FREE WILL (forthcoming 2014).

23. Dan J. Stein, Crick Lund, & Randolph M. Nesse, *Classification Systems in Psychiatry: Diagnosis and Global Mental Health in the Era of DSM-5 and ICD-11*, 26 CURRENT OP. PSYCHIATRY 493 (2013).

24. HOLLY A. MILLER, M-FAST: MILLER FORENSIC ASSESSMENT OF SYMPTOMS TEST (Psychol. Assessment Res. 2001).

25. RICHARD ROGERS, MICHAEL BAGBY, & SUSAN E. DICKENS, STRUCTURED INTERVIEW OF REPORTED SYMPTOMS (Psychol. Assessment Res. 1992).

26. RICHARD ROGERS, KENNETH W. SEWELL & NATHAN D. GILLARD, STRUCTURED INTERVIEW OF REPORTED SYMPTOMS: PROFESSIONAL MANUAL (Psychol. Assessment Res. 2nd ed. 2010).

toms (IA), Blatant Symptoms (BL), Subtle Symptoms (SU), Selectivity of Symptoms (SEL), Severity of Symptoms (SEV), and Reported versus Observed Symptoms (RO).

Another major type of test to detect malingering involves personality and related inventories. These include the MCMI-III (Millon Clinical Multiaxial Inventory, Third Edition)²⁷ and the MMPI (Minnesota Multiphasic Personality Inventory, Second Edition),²⁸ as well as the Personality Assessment Inventory (PAI).²⁹

The Minnesota Multiphasic Personality Inventory, Second Edition Restructured (MMPI-2-RF),³⁰ includes the following response validity indicators: Infrequent Response (F-r), Infrequent Psychopathology Response (Fp-r), Infrequent Somatic Responses (Fs), and Symptom Validity (FBS-r). Also, other scales can be scored with it in this regard, such as the RBS (Response Bias Scale),³¹ and the Henry-Heilbronner Index (HHI).³²

The third class of malingering detection instrumentation involves two-alternative, or forced-choice instruments. These tests

27. THEODORE MILLON, MANUAL FOR THE MCMI-III (Nat'l Computer Sys. 1994); THEODORE MILLON, ROGER DAVIS & CARRIE MILLON, MILLON CLINICAL MULTIAXIAL INVENTORY III: MANUAL (Nat'l Computer Sys. 2nd ed. 1997).

28. JAMES N. BUTCHER ET AL., MANUAL FOR THE RESTANDARDIZED MINNESOTA MULTIPHASIC PERSONALITY INVENTORY: MMPI-2, AN INTERPRETIVE GUIDE (Univ. Minn. Press 1989); JAMES N. BUTCHER ET AL., MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2: MANUAL FOR ADMINISTRATION AND SCORING (Univ. Minn. Press 2nd ed. 2001).

29. LESLIE C. MOREY, PERSONALITY ASSESSMENT INVENTORY: PROFESSIONAL MANUAL (Psychol. Assessment Res. 1991); LESLIE C. MOREY, PERSONALITY ASSESSMENT INVENTORY: PROFESSIONAL MANUAL (Psychol. Assessment Res. 2nd ed. 2007).

30. YOSSEF S. BEN-PORATH & AUKE TELLEGEN, MMPI-2-RF: MANUAL FOR ADMINISTRATION, SCORING, AND INTERPRETATION (Univ. Minn. Press 2011).

31. Roger O. Gervais, Yossef S. Ben-Porath, Dustin B. Wygant & Paul Green, *Development and Validation of a Response Bias Scale (RBS) for the MMPI-2*, 14 ASSESSMENT 196, 196 (2007).

32. George K. Henry et al., *The Henry-Heilbronner Index: A 15-Item Empirically Derived MMPI-2 Subscale for Identifying Probable Malingering in Personal Injury Litigants and Disability Claimants*, 20 CLINICAL NEUROPSYCHOLOGY 786, 786 (2006).

include the Medical Symptom Validity Test (MSVT),³³ Nonverbal Medical Symptom Validity Test (NV-MSVT),³⁴ Test of Memory Malingered (TOMM),³⁵ Victoria Symptom Validity Test (VSVT),³⁶ and Word Memory Test (WMT).³⁷ These tests are effective in detecting negative response bias because they appear difficult on the surface, but even brain-damaged individuals might do sufficiently well on them compared to norms.

In the field, there are also dedicated tests to detect malingering. Common among the embedded neuropsychological tests are the California Verbal Learning Test (CVLT),³⁸ and the Reliable Digit Span (RDS).³⁹

For PTSD, dedicated tests with validity indicators include the Clinician-Administered PTSD Scale (CAPS),⁴⁰ the Detailed Assessment of Posttraumatic Stress (DAPS),⁴¹ the Morel Emotional Numbing Test (MENT),⁴² the Morel Emotional Numbing Test –

33. PAUL GREEN, GREEN'S MEMORY COMPLAINTS INVENTORY (Green's 2004) [hereinafter MCI].

34. PAUL GREEN, MANUAL FOR NONVERBAL MEDICAL SYMPTOM VALIDITY TEST (Green's 2008).

35. TOM N. TOMBAUGH, TOMM: THE TEST OF MEMORY MALINGERING MANUAL (Multi-Health Sys. 1996).

36. DANIEL SLICK ET AL., VICTORIA SYMPTOM VALIDITY TEST: PROFESSIONAL MANUAL (Psychol. Assessment Res. 1997/2005).

37. PAUL GREEN, GREEN'S WORD MEMORY TEST FOR WINDOW'S USER'S MANUAL (Green's 2005).

38. DEAN C. DELIS ET AL., CALIFORNIA VERBAL LEARNING TEST: MANUAL (Psychol. Corp. 1987).

39. Manfred F. Greiffenstein, John W. Baker & Thomas Gola, *Validation of Malingered Amnesia Measures with a Large Clinical Sample*, 6 PSYCHOL. ASSESSMENT 218, 219–20 (1994).

40. Dudley David Blake et al., *The Development of a Clinician-Administered PTSD Scale*, 8 J. TRAUMATIC STRESS 75, 75 (1995).

41. JOHN BRIERE, DETAILED ASSESSMENT OF POSTTRAUMATIC STRESS PROFESSIONAL MANUAL (Psychol. Assessment Res. 2001).

42. Kenneth R. Morel, *Use of the Binomial Theorem in Detecting Fictitious Posttraumatic Stress Disorder*, 2 ANXIETY DISORDER PRAC. J. 55, 55 (1995); see also Kenneth R. Morel, *Development and Preliminary Validation of Forced-Choice Test of Response Bias for Posttraumatic Stress Disorder*, 70 J. PERSONALITY ASSESSMENT 299, 299 (1998).

Revised (MENT-R),⁴³ the Trauma Symptom Inventory (TSI),⁴⁴ and the Trauma Symptom Inventory (TSI-2).⁴⁵

As for other tests useful for adults, the Brief Battery for Health Improvement, Second Edition (BBHI-2),⁴⁶ and the Ruff Neurobehavioral Inventory (RNBI)⁴⁷ have relevant negative response bias scales. For children, the Behavior Assessment System for Children, Second Edition (BASC-2)⁴⁸ does as well.

B. Comments

Note that in listing these instruments, the authors are not recommending them, per se. Each assessor in the field is responsible for selecting the most psychometrically sound and best-fitting tests for the case at hand. Further, some of the mentioned tests will need alteration to better fit the DSM-5 (e.g., those applied to PTSD). Finally, the use of these tests needs careful application in cases of psychological injury because they have not necessarily been the standardized norm for populations expressing these disorders in forensic disability and related contexts. For example, Young⁴⁹ and also Young and Wang⁵⁰ have shown the data on cut

43. Julia M. Messer & William J. Fremouw, *Detecting Malingered Post-traumatic Stress Disorder Using the Morel Emotional Numbing Test-Revised (MENT-R) and the Miller Forensic Assessment of Symptoms Test (M-FAST)*, 7 J. FORENSIC PSYCHOL. PRAC. 33, 33 (2007).

44. JOHN BRIERE, TRAUMA SYMPTOMS INVENTORY PROFESSIONAL MANUAL (Psychological Assessment Res. 1995).

45. JOHN BRIERE, TRAUMA SYMPTOMS INVENTORY (TSI-2) PROFESSIONAL MANUAL (Psychological Assessment Res. 2nd ed. 2011).

46. JOHN MARK DISORBIO & DANIEL BRUNS, BRIEF BATTERY FOR HEALTH IMPROVEMENT 2 MANUAL (Pearson Assessment Sys. 2002).

47. RONALD M. RUFF & KRISTIN M. HILBBARD, RNBI: RUFF NEUROBEHAVIORAL INVENTORY PROFESSIONAL MANUAL (Psychol. Assessment Res. 2003).

48. CECIL R. REYNOLDS & RANDY W. KAMPHAUS, BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN (Am. Guidance Serv. 2nd ed. 2004).

49. GERALD YOUNG, MALINGERING, FEIGNING, AND RESPONSE BIAS IN PSYCHIATRIC/ PSYCHOLOGICAL INJURY: IMPLICATIONS FOR PRACTICE AND COURT (Springer Sci. + Bus. Media 2014).

50. Gerald Young, Ph.D., C. Psych. & Jenny X. T. Wang, B. Sci., Address at the 121th Annual Convention of the American Psychological Association: Detecting Malingered PTSD After Trauma: Implications for Practice and Court (Aug. 2, 2013).

scores for psychological instruments having validity indicators that are applicable to PTSD cases, and they concluded that much further work in these regards is needed on these tests in relation to cut scores.

Aside from issues on the use of individual tests in assessments related to psychological injury, the manner in which test results are combined toward conclusions about malingering attribution is subject to controversy and change in their algorithms. It is beyond the scope of the present Article to discuss these procedures in depth.⁵¹ However, comprehensive review can be found in books by Carone and Bush,⁵² Larrabee,⁵³ and Young,⁵⁴ in particular.

Moreover, Young⁵⁵ presented a new malingering detection system that builds on the others and is applicable to the three core psychological injuries: PTSD, mild TBI, and chronic pain. He emphasized that data from tests can be combined with information on compelling inconsistencies in a patient's file to arrive at conclusions on the degree of feigning evident in an evaluation, if any, and that malingering can be attributed in cases where the evidence is clear that it has taken place. Finally, the malingering detection system developed by Young⁵⁶ is flexible enough to allow for use not only by psychologists and psychiatrists but also by other mental health professionals who seek out inconsistencies and discrepancies in their cases.

Aside from these latter aspects, it is notable that the system that Young⁵⁷ developed took a whole chapter to present in tabular form compared to the others systems that are presented in short tables. Also, it included sixty rules for how to combine tests to arrive at conclusions. Notably, it considered malingering as the ex-

51. See, e.g., SLICK ET AL., *supra* note 36; Kevin J. Bianchini, Kevin W. Greve & Gary Glynn, *On the Diagnosis of Malingered Pain-Related Disability: Lessons from Cognitive Malingering Research*, 5 SPINE J. 404, 404 (2005).

52. DOMINIC CARONE & SHANE S. BUSH, *MILD TRAUMATIC BRAIN INJURY: SYSTEM VALIDITY ASSESSMENT AND MALINGERING* (Springer 2013).

53. GLENN J. LARRABEE, *FORENSIC NEUROPSYCHOLOGY: A SCIENTIFIC APPROACH* (Oxford Univ. Press 2012).

54. YOUNG, *supra* note 49.

55. *Id.*

56. *Id.*

57. *Id.*

treme end of a continuum of negative response bias that included different degrees of exaggeration and absent bias. Finally, it cautioned that malingering should be attributed only when the evidence is incontrovertible, but that many cases involve problematic presentations and performances and the astute assessor will find ways to convey their impressions of feigning and negative response bias without using the “M” word. Young⁵⁸ called for more research on the various systems to detect malingering, including his own, before they can be used in reliable and valid methods for a court.

The next portion of the Article concerns a Canadian Supreme Court case involving an extensive literature review and also a critique of a literature review presented by another expert on the case. The contrast in our expert approaches is instructive for workers who proffer evidence in court. After discussion related to the case, the Article discusses the broader issue of modeling in the area of psychological injury and law, and considers ethics.

IV. REBUTTAL OF EXPERT REPORT PROFFERED TO THE SUPREME COURT OF CANADA

A. Introduction

The case at issue is a workers compensation case that was heard by the Supreme Court of Canada. The author was asked to submit a rebuttal report to an expert report indicating how difficult it is to determine causality in worker stress and to apportion at least part of it to work factors. The following presents the major sections of the report proffered to the court that would be of interest to the readership. The literature review is presented first, followed by an edited excerpt of the rebuttal report and a brief review of policy implications.

58. *Id.*

B. Work Stress

1. Primary Research Cited

Stansfeld and Candy⁵⁹ conducted a meta-analytic review of longitudinal studies on the topic of the relations between psychosocial work environment or stress and ill mental health (common mental disorders). The review began in 1994 and continued until 2005. Eleven studies met its inclusion criteria.

The construct of psychosocial work stress used in the review was based on combination of predominant models in the field.⁶⁰ Some of these work stressor variables included: decision authority, decision latitude, psychological demands, work social support, job strain, and effort-reward imbalance.

Prior research did not sufficiently account for social disadvantage (social class), and worker self-report has been used to measure both work and mental health variables, so that there might be “response bias.”⁶¹ For example, pre-existing personality traits, low self-esteem, negative affectivity, or poor worker mental health could influence the self-report of work variables. In addition, there might be “reverse causation,” such that these latter variables could induce poorer perception of work. Therefore, in their paper, Stansfeld and Candy reviewed only high quality longitudinal studies of worker perception of work characteristics and mental health. This enabled them to resolve the inconsistencies in the literature. Also, their careful analysis helped clarify the causal direction involved across work stress and related variables.

59. Stephen Stansfeld & Bridget Candy, *Psychosocial Work Environment and Mental Health – A Meta-Analytic Review*, 32 SCANDINAVIAN J. WORK 443, 446 (2006).

60. E.g., Robert A. Karasek, Jr., *Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign*, 24 ADMIN. SCI. Q. 285, 287–89 (1979); ROBERT KARASEK & TORES THEORELL, *HEALTH WORK: STRESS PRODUCTIVITY AND THE RECONSTRUCTION OF WORKING LIFE* (Basic Books 1990); ROBERT KARASEK ET AL., *JOB CONTENT INSTRUMENT: QUESTIONNAIRE AND USER’S GUIDE* (Univ. S. Cal. 1985); Johannes Siegrist, *Adverse Health Effects of High-Effort/ Low-Reward Conditions*, 1 J. OCCUPATIONAL HEALTH PSYCHOL. 27, 29–31 (1996).

61. Stansfeld & Candy, *supra* note 59.

In the eleven studies included in the meta-analysis, the mental health outcome measures were established using the International Classification of Disease and Related Health Problems, the 10th Revision (ICD-10).⁶² The ICD-10 codes that were chosen covered the disorders of phobia, anxiety, obsession-compulsion, depression, and mood in the last twelve months.⁶³ In order to accommodate the confounder of bias, the analyses in the selected articles had to account for the presence of any earlier mental disorder. Study sample size had to be less than 200. Populations were from established industrial countries. Odds ratios were extracted for each relevant variable in each study.

The results of the meta-analysis, in particular, showed that high job strain and effort-reward imbalance for men expressed causal associations with the common mental disorders measured.⁶⁴ For women, the results showed smaller effects.

As for mechanisms of the effects of work characteristics on mental health, the authors referred to stress, arousal, and neuroendocrine and metabolic changes, with the psychological pathways including self-esteem and a sense of mastery (internal locus of control). The authors noted, however, that these latter variables might involve pre-existing influences and not only mechanistic ones. In this regard, other pre-existing or confounding factors might be certain personalities and also poor childhood mental health.

The abstract of the article concluded that the evidence is robust that certain psychosocial work characteristics are predictive risk factors for common mental disorders and that the associations involved are not simply reflections of response bias.

Stansfeld, Clark, Caldwell, Rodgers, and Power⁶⁵ further investigated the relationship between psychosocial work characteristics and midlife anxiety and depressive disorder diagnoses for possible effects of prior psychological distress. They examined

62. International diagnostic and coding manual of all disease, medical, and psychiatric.

63. World Health Organization, *International Statistical Classification of Diseases and Related Health Problems 10th Revision*, WHO (2010), <http://apps.who.int/classifications/icd10/browse/2010/en#V>.

64. Stansfeld & Candy, *supra* note 59.

65. Stephen Stansfeld et al., *Psychosocial Work Characteristics and Anxiety and Depressive Disorders in Midlife: The Effects of Prior Psychological Distress*, 65 OCCUPATIONAL & ENVTL. MEDICINE 634, 636 (2008).

mental disorder in workers at forty-five years of age (N = 8,243) with a Revised Clinical Interview Schedule⁶⁶ keyed to the ICD-10. Work characteristic measurement, in particular, was based on Karasek's⁶⁷ method. As for prior psychological distress, this longitudinal study examined childhood problems at seven, eleven, and sixteen years of age and then, psychological malaise at twenty-three and thirty-three years of age using reliable and valid measures.

The results showed that childhood mental health did predict adult variables but only for work characteristics and not ill mental health. Moreover, the former were associated with ill mental health (depression, anxiety, in particular). Finally, the association between work characteristics and any mental health diagnosis remained significant even after accounting ("adjusting") for childhood problems (internalizing) and adult problems (malaise, age twenty-three).

The authors concluded that, for the measures used, early psychological distress is not a "vulnerability to the effects of work on mental health in midlife." They highlighted their main message that the association of work characteristics and disorders of depression and anxiety at age forty-five was only reduced "minimally" by adjusting for prior childhood and young adult psychological distress.

The research by Stansfeld and colleagues⁶⁸ is clearly supportive of a causal association of work stress and workplace depression and other disorders (and therefore potential disability), with response bias controlled as a confounding factor. Moreover, pre-existing variables stretching into childhood were controlled in the analyses.

66. Glyn Lewis et al., *Measuring Psychiatric Disorder in the Community: A Standardized Assessment for Use by Lay Interviewers*, 22 *PSYCHOL. MED.* 465, 468–71 (1992).

67. Karasek, Jr., *supra* note 60, at 287–89.

68. Stansfeld & Candy, *supra* note 59, at 454; Stansfeld et al., *supra* note 65, at 641.

2. Other Research Cited

Recent Canadian research points to the role of work characteristics in eliciting health-related outcomes. White, Wagner, Schultz, Murray, Bradley, Hsu, McGuire, and Schultz⁶⁹ conducted a review of both meta-analyses and systematic reviews of modifiable workplace risk factors affecting workplace absence due to physical and/or psychological factors (excluding severe conditions). They found twenty-seven reviews in the literature to consider.

The results showed that across two or more health conditions the following work conditions were pertinent: lack of social support, increased physical work demands, job strain, lack of supervisor support, increased psychological demands, low job satisfaction, low job control, and poor leadership quality. Job strain was found to predict strongly psychosocial and stress issues as well as cardiovascular ones. The authors concluded that an integrative frame for understanding risk factors for work disability relates to “occupational stress.”⁷⁰ Other modifiable work factors for which some evidence was found for health effects included: non-fulltime work, lack of workplace fairness, and lack of managerial involvement. Other factors for which insufficient evidence was found need more research. The review by White⁷¹ stands out because it was conducted in conjunction with input from multiple stakeholders in the province of British Columbia work-related community.

Szeto and Dobson⁷² examined the Canadian Community Health Survey by Statistics Canada (CCHS)⁷³ for cross-sectional

69. Marc White et al., *Modifiable Workplace Risk Factors Contributing to Workplace Absence Across Health Conditions: A Stakeholder-Centered Best-Evidence Synthesis of Systematic Reviews*, 8 WORK 1, 9 (2013).

70. Karasek, Jr., *supra* note 60, at 287–89; E.g., Robert Karasek et al., *The Job Content Questionnaire (JCQ): An Instrument for Intentionally Comparative Assessments of Psychosocial Job Characteristics*, 3 J. OCCUPATIONAL HEALTH PSYCHOL. 322, 322 (1998).

71. White et al., *supra* note 69, at 9.

72. Andrew C. H. Szeto & Keith S. Dobson, *Mental Disorders and Their Association with Perceived Work Stress: An Investigation of the 2010 Canadian Community Health Survey*, 18 J. OCCUPATIONAL HEALTH PSYCHOL. 191, 192 (2013).

associations between work-related stress and mental disorder. In their literature review, they cited Stansfeld and Candy's⁷⁴ meta-analysis that demonstrated that the variable of negative psychosocial job characteristics was associated with common mental disorders. In addition, they described the study by Wang,⁷⁵ which found a relationship between work stress and one-month prevalence of any mood or anxiety disorder. Specifically, for a short work stress questionnaire, those scoring in the top 25% had a prevalence rate of 6.8%, compared to 1.8% for those who scored in the bottom 25% in work stress.

In the CCHS 2010 survey, work-related stress was assessed with one question. Another question asked about mood and anxiety disorder. The treatment question concerned any disorder. The time frame involved was at least one year. The specific results showed that those with "extremely stressful" jobs had an association with diagnosis and treatment of mental health condition/disorder two to three times higher than those with nonstressful jobs.

Szeto and Dobson⁷⁶ concluded that in the last ten years in Canada there has been a trend to increase "legal recognition" of mental/ psychological injury in the workplace for the broader focus of "negligent and chronic" excessive work demands.⁷⁷ They advocated for recognizing ("enhance the emphasis") work stress in relation to mental disorder as an important issue in employment and in public health.

The recent Canadian research clearly reveals the role that work stress can play in mental conditions. In this regard, the

73. Statistic Canada, *Canadian Community Health Survey (CCHS): 2010 Questionnaire*, STAT. CANADA (2010), available at http://www23.statcan.gc.ca/imdb-bmdi/instrument/3226_Q1_V7-eng.pdf.

74. Stansfeld & Candy, *supra* note 59.

75. Jian L. Wang, *Perceived Work Stress, Imbalance Between Work and Family/Personal Lives, and Mental Disorders*, 41 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 541, 543–45 (2006).

76. Szeto & Dobson, *supra* note 72.

77. Martin Shain, *Tracking the Perfect Legal Storm: Converging Systems Create Mounting Pressure to Create the Psychologically Safe Workplace*, MENTAL HEALTH COMM'N OF CANADA (2010), available at http://www.mentalhealthcommission.ca/English/node/506/Workforce_Tracking_the_Perfect_Legal_Storm_ENG_0.pdf.

White⁷⁸ review highlighted occupational stress and the Szeto and Dobson⁷⁹ one work-related stress. In the former study, the province of BC was seen as taking a proactive approach and, in the latter study, the need to consider work stress in relation to mental disorder was highlighted.

Several recent articles have supported that stressful work conditions “cause” depression.⁸⁰ This mental condition is one that could be disabling. Kivimäki, Hotopf, and Henderson⁸¹ referred to the methodological challenges in establishing the link, such as the presence of undiagnosed pre-existing depression or its incipient (prodromal) phase. Nevertheless, quasi-experimental and longitudinal research is confirming that stressful work conditions can lead to depression, and “reverse causality,” or a role for earlier depressive symptoms in the link, is “excluded.”⁸² The authors concluded that multiple factors are involved in clinical disease expression, so that any one “exposure” as in work stress is difficult to ascertain as an independent cause.

In a Dutch sample, Verboom, Sentse, Sijtsema, Nolen, Ormel, and Penninx⁸³ found that “high levels” of work stress were among the strongest predictors of disability in cases of Major Depression, although personal characteristics were important, too, e.g., high neuroticism, at least for disability measured by “days out of role” and “work absence.” Work stress characteristics were assessed using Karasek, Brisson, Kawakami, Houtman, Bongers, and Amick’s⁸⁴ Job Contents questionnaire. “Environmental” character-

78. White et al., *supra* note 69.

79. Szeto & Dobson, *supra* note 72.

80. E.g., Charlotte E. Verboom et al., *Explaining Heterogeneity in Disability With Major Depressive Disorder: Effects of Personal and Environmental Characteristics*, 132 J. AFFECTIVE DISORDERS 71, 71 (2011).

81. Mika Kivimäki, Matthew Hotopf & Max Henderson, *Do Stressful Working Conditions Cause Psychiatric Disorders?*, 60 OCCUPATIONAL MEDICINE 86, 87 (2010).

82. E.g., Marianna Virtanen et al., *Overcrowding in Hospital Wards as a Predictor of Antidepressant Treatment Among Hospital Staff*, 165 AM. J. PSYCHIATRY 1482, 1483–84 (2008).

83. Verboom et al., *supra* note 80, at 71.

84. Robert Karasek et al., *The Job Content Questionnaire (JCQ): An Instrument for Intentionally Comparative Assessments of Psychosocial Job Characteristics*, 3 J. OCCUPATIONAL HEALTH PSYCHOL. 322, 322–55 (1998).

istics (e.g., childhood trauma, adverse life events in the past year) were not important.

In a male Japanese sample, Inoue, Kawakami, Haratani, Kobayashi, Ishizaki, Hayashi, Fujita, Aizawa, Miyazaki, Hiro, Masumoto, Hashimoto, and Araki⁸⁵ found that the job stressors of job control and role ambiguity predicted long term disability due to depressive disorders. This happened independently of depressive symptoms and of the trait of neuroticism. Ford, Cerasoli, Higgins, and Decesare⁸⁶ found that depression and anxiety were among the psychological health variables that correlated with work performance. Dalgard, Sørensen, Sandanger, Nygård, Svensson, and Reas⁸⁷ found that job control, in particular, had a negative effect on worker mental health. Wang, Lesage, Schmitz, and Drapeau⁸⁸ found a relation between work stress and mental disorder involving the work stress of high demand and low control, in particular, as well as imbalance in work and family life (the results mostly involved depression and anxiety). Job insecurity was a factor only for men.

C. Conclusion

Together, these other findings on work stress and mental health⁸⁹ provide evidence that work stress in the form of job control and related factors contributes to the multiple etiological factors leading to depression and other mental disorders and to consequent effects on work performance and disability. Personal factors,

85. Akiomi Inoue et al., *Job Stressors and Long-Term Sick Leave Due to Depressive Disorders Among Japanese Male Employees: Findings From the Japan Work Stress and Health Cohort Study*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 229, 234 (2010).

86. Michael T. Ford et al., *Relationships Between Psychological, Physical, and Behavioural Health and Work Performance: A Review and Meta-Analysis*, 25 WORK STRESS 185, 185 (2011).

87. Odd Steffen Dalgard et al., *Job Demands, Job Control, and Mental Health in an 11-Year Follow-Up Study: Normal and Reversed Relationships*, 23 WORK STRESS 284, 284 (2009).

88. Jian L. Wang et al., *The Relationship Between Work Stress and Mental Disorders in Men and Women: Findings From a Population-Based Study*, 62 J. EPIDEMIOLOGY & COMMUNITY HEALTH 42, 42 (2008).

89. E.g., Ford et al., *supra* note 86.

such as neuroticism, also appear to be involved. Policy implications need to consider these relationships.

Aside from general work characteristics, such as work “stress” or “job control,” that have been implicated causally in mental health and disability, there is research on specific, more adverse stressors, such as bullying.⁹⁰ Lahelma, Lallukka, Laaksonen, Saastamoinen, and Rahkonen⁹¹ found a relationship between workplace bullying and common mental disorders in a five-to seven-year longitudinal study. Accounting for baseline common mental disorders or previous bullying did not negate the relationship. Nielsen and Einarsen⁹² conducted meta-analyses confirming a relationship between workplace bullying, mental health, and measures such as absenteeism.⁹³

Work stress also has physical effects.⁹⁴ There are usual qualifiers for this stress and related research about the multifactorial, etiological causality involved.

90. E.g., Eero Lahelma et al., *Workplace Bullying and Common Mental Disorders: A follow-Up Study*, 66 J. EPIDEMIOLOGY & COMMUNITY HEALTH 1, 1 (2012).

91. *Id.*

92. Morten Birkeland Nielsen & Ståle Einarsen, *Outcomes of Exposure to Workplace bullying: A Meta-Analytic Review*, 26 WORK STRESS 309, 311 (2012).

93. Cristian Balducci, Franco Fraccaroli & Wilmar B. Schaufeli, *Workplace Bullying and Its Relation with Work Characteristics, Personality, and Post-Traumatic Symptoms: An Integrated Model*, 24 ANXIETY STRESS & COPING 499, 499 (2011); see also Alfredo Rodriguez-Muñoz et al., *Cross-Lagged Relationships Between Workplace Bullying, Job Satisfaction and Engagement: Two Longitudinal Studies*, 23 WORK STRESS 225, 225 (2009); see, e.g., Jessica Lang et al., *Psychosocial Work Stressors as Antecedents of Musculoskeletal Problems: A Systematic Review and Meta-Analysis of Stability-Adjusted Longitudinal Studies*, 75 SOC. SCI. & MEDICINE 1163, 1163 (2012).

94. For recent research on physical effects, for musculoskeletal problems, see Lang et al., *supra* note 93; see also Angelika Hauke et al., *The Impact of Work-Related Psychosocial Stressors on the Onset of Musculoskeletal Disorders in Specific Body Regions: A Review and Meta-Analysis of 54 Longitudinal Studies*, 25 WORK STRESS 243, 243 (2011); Thomas R. Waters, Robert B. Dick & Edward F. Krieg, *Trends in Work-Related Musculoskeletal Disorders: A Comparison of Risk Factors for Symptoms Using Quality of Work Life Data from the 2002 and 2006 General Social Survey*, 53 J. OCCUPATIONAL & ENVTL. MEDICINE 1013, 1013 (2011). For cardiovascular diseases, see Eva-Maria Backé et al., *The Role of Psychosocial Stress at Work for the Development of Car-*

Stress is a factor involved in physical and mental health through its effects on basic biology in the stress response.⁹⁵ According to Gutman and Nemeroff, work stress can “provoke” depression, and stressful life events relate “causally” to depression.⁹⁶ Moreover, they maintained that genetics are also involved, in a complex etiological “interplay” between environment and biology.

Pandey, Campbell Quick, Rossi, Nelson, and Martin⁹⁷ reviewed work stressors and noted they could present challenges and positive growth and performance as well as hindrances and negative performance and withdrawal behavior. They took a broad view of work stressors to include physical demands, role demands, task demands, interpersonal demands, aggressive behavior, political behavior, justice, and emotional labor (as in customer service). Clearly, work stress is pervasive but it is not necessarily negative.

Other research did not fit well with the general themes in the literature. There are always inconsistencies in any literature, and the preponderance of the conceptualization and empirical findings could still lead to clear conclusions.

D. Expert Report Rebuttal

In this file review, the author contests the main points of the expert’s conclusions, in terms of reliable and valid assessment, causality attribution, and policy. However, the author do not address the discriminatory legal basis of the current worker compen-

diovascular Diseases: A Systematic Review, 85 INT’L. ARCH. OCCUPATIONAL & ENVTL. HEALTH 67, 75 (2012); NADINE S. BEKKOUCHE ET AL., STRESS AND THE HEART: PSYCHOSOCIAL STRESS AND CORONARY HEART DISEASE 385 (Richard C. Contrada & Andrew Baum eds., 2011).

95. DAVID A. CUTMAN & CHARLES B. NEMEROFF, STRESS AND DEPRESSION 345, 351 (Richard C. Contrada & Andrew Baum eds., 2011).

96. Maria Melchior et al., *Work Stress Precipitates Depression and Anxiety in Young, Working Women and Men*, 37 PSYCHOL. MED. 1119, 1119 (2007); Kenneth S. Kendler, Laura Karkowski & Carol A. Prescott, *Causal Relationship Between Stressful Life Events and the Onset of Major Depression*, 156 AM. J. PSYCHIATRY 837, 837 (1999).

97. ALANKRITA PANDEY ET AL., THE HANDBOOK OF STRESS SCIENCE: BIOLOGY, PSYCHOLOGY AND HEALTH 137, 138–39 (Richard J. Contrada & Andrew Baum eds., 2011).

sation practices of including only acute reactions to traumatic events as compensable, an issue, which is beyond my ken.

In rehabilitation and forensic work, a primary qualification is that assessments should be function-based and not disorder-based in determining disability. If the symptoms produce impairments that impact the role at issue, the need for assigning a disorder to summarize the symptoms and justify the conclusions is not necessary, although it is frequently done. In short, disability does not derive from a label assigned in the DSM but from the evaluation of symptoms and impairments in context of the role at issue, e.g., the specific work functions involved in one's job.

It is a truism that population-level research does not apply perfectly to individual cases, so this argument by the expert is superfluous. The expert's statement that there is the risk, that evaluating clinicians will adopt a reductionist perspective and overestimate the importance of work factors in the genesis of mental disorders is well-taken. However, rather than rejecting the validity of every and all cases in this regard, one should ascertain the education, training, and competence of assessors involved and exclude those who do not meet a high bar of qualifications to conduct evaluations in this area. It is true, as maintained by the expert, that work factors may be more readily reported by the patient to the clinician. However, once more, the remedy should not be to exclude such claims but to have qualified evaluators conduct comprehensive and unbiased assessments.

In perhaps a lapse of clear thinking, the expert stated, "more important genetic and other factors, which often are unknown or not reported, may not be directly discerned by the evaluating clinician." If the expert is asking for genetic information in every evaluation that is related to potential symptoms, disorders and diagnoses, it is quite unrealistic. Moreover, even when genetic contributions are involved in such, they are usually polygenetic and explain only a portion of the variance in the population involved.

Even if the latter variance explained is high (heritability), it is never 100% in mental disorder and, moreover, population level heritability statistics cannot be applied to individuals. For example, for IQ, the heritability might be well over 50% but that does not mean in any individual case over 50% of the person's IQ is genetically determined. As individuals, people are not defined by mean scores in tests based upon research. For genetic influence in behav-

ior, there always is a reaction range in how the environment influences the genetic expression of behavior, and the environmental influence is different in each case. In this regard, valid cases of work stress could be one of these environmental factors. Finally, to implicate genetics as a most powerful pre-existing factor for any condition could be considered as blaming the victim in an unfounded way and could act to remove any right to remedy. Granted, there are conditions, such as schizophrenia, in which genes are important, but these types of cases would not normally be encountered in work stress claims.

Disability in the rehabilitation and forensic context should be determined by the chain of causal factors, symptoms, impairments, dysfunctions, and disabilities, with the actual disorder diagnosed secondary in importance in arriving at valid conclusions. It is a straw person argument to indicate that definite causality has not been established for the DSM mental disorder categories, so that work stress cases cannot be differentiated etiologically, because the etiology of DSM categories is not or should not be at issue in the assessments of these cases, without prejudice against these categories' usefulness. More to the point, in dealing with work stress, the literature documented does indicate valid causal contributions from workplace factors toward disability, as distinct from the effects of acute responses to traumatic events at work (and, moreover, the latter type of case is not any clearer etiologically, unlike what the expert contends).

The expert correctly wrote, the clinical assessment of work causation relies on careful assessment of family, psychological, and interpersonal factors, which may also contribute to the mental condition.⁹⁸ This statement is quite exact, and implies that causality can be deciphered with careful assessment of all factors, including those originating in the workplace. However, then he gives the non-sequitur that in such assessments the evaluator will typically consider all factors as significant. Not only is this statement not supported by the expert with a reference a citation [but], also, it runs counter to the typical approach of a qualified assessor to consider all possible hypotheses based on the set of reliable and rele-

98. Len Sperry et al., *Workplace Mental Health Consultation: A Primer of Organizational and Occupational Psychiatry*, 16 GEN. HOSP. PSYCHIATRY 103, 109 (1994).

vant data gathered in a case at hand, and use scientific reasoning to assess the pros and cons of each hypothesis before arriving at reasoned and reasonable conclusions. That unqualified and incompetent assessors might be involved in work stress evaluations are not a reason to strike work stress claims from the books. Rather, it is a reason to assure that only qualified, competent assessors using comprehensive, impartial, and scientifically founded methods should be allowed to conduct the assessments and make determinations for such cases.

As the expert highlights, causality is difficult to determine in any workplace disability claim. But by using only expert assessors who are educated, trained, and examined for their capacity to consider all such factors and arrive at valid conclusions in comprehensive, impartial, and scientific assessments, such difficulties in assessments can be handled with efficacy at a preponderant level.

The opposition presented by the expert on the facility in dealing with disability in trauma event claims compared to work stress claims belies the scientific evidence, as shown. For example, traumatic event exposure is frequent, but PTSD develops rarely. It is influenced by a host of pretrauma factors, too. Further, it is quite amenable to malingering or feigning, in order to take advantage of the system. Finally, psychological tests have been developed to screen out such motivations, and they can be used equally for any type of mental disability claims in the employment context, whether trauma-related or stress-related. In short, whether in terms of pre-existing influences, a lack of one-to-one relationship to exposure to stress and having a disabling stress response, the ability to feign or malingering, and the capacity of psychological tests to be useful in assessing the claim, there is little difference in assessing reliably validly acute reactions to trauma exposure and workplace stress, assuming the assessors are qualified and competent. If one chooses to exclude consideration of one but not the other of these conditions (trauma, stress) as compensable in the work setting, the decision will not revolve around the science of the matter because, at the scientific level, to present it in any other way than the author have would be incorrect.

The expert wrote about pre-existing conditions complicating cases, as in the notion of taking victims as they are found: he argued that if this were to transpire, this might well result in blanket coverage of all mental conditions, work-related or not. This is a spurious claim and a non-sequitur. When qualified and competent

assessors are used, they are educated and trained to consider all pre-existing and extraneous causal factors in conjunction with the event at issue in determining whether or not, the preponderance of the evidence affirms a significant causality deriving from the event at issue, such as workplace stress. Note that the preponderance of the evidence constitutes the standard of proof or threshold in civil cases, and it allows for some doubt in conclusions offered.

This argument made by the expert also is a non-sequitur. If the bar for work stress disability is set at the level of a significant contribution from the work stress at issue, this is not the same as accepting as valid all mental impairments in disability claims. On the one hand, qualified and competent assessors can differentiate between degrees of impact of the work stress (e.g., none, mild, moderate, severe or marked, extreme), and degrees that the work stress is causal (e.g., absent; contributory but minimal, moderate, significant, substantial, sole) and, on the other hand, exclude diagnoses that do not pertain to work stress, such as schizophrenia at the severe end and an adjustment disorder at the mild end of the spectrum. Depression and anxiety, notably, would apply in most cases. Granted, there are problematic gray zone, quite exaggerated, feigned, and malingered cases, but qualified and competent assessors are educated and trained to deal with these complexities to the level of preponderant certainty. There are no psychological tests of causality in such cases, nor could there be. Causality is established only by clinical judgment, based on the comprehensive facts and data gathered in the assessment. Guidelines can be offered, such as ones similar to those just given, but the decision lies with the assessor after consideration of the case at hand in conjunction with knowledge of the scientific literature base. Further, checks and balances in the system, including independent psychological or psychiatric (medical) examinations, can be used to assure that the assessor has followed guidelines, e.g., the use of tests with validity indicators, if a psychologist.

The expert noted that no clinical assessment methods exist that allow clinicians to validly estimate the degree of causal attribution. However, qualified and competent mental health evaluators in rehabilitation and forensics in this area of professional practice are educated and trained in assigning ratings to evaluatees in terms of mild to moderate to severe, or the like, e.g., as in the SSA (So-

cial Security Administration)⁹⁹ guides used in the AMA (American Medical Association)¹⁰⁰ system of impairment ratings. As a policy matter, in light of the differing opinions on the question, and consistent with the rest of this report, it makes sense not to accept a low bar for the contribution of workplace stress to disability claims. Rather, it might make sense to set the bar quite high at the need for a significant or substantial causal contribution in workplace factors to an assessed disability, rather than using a threshold that is minimal or just more than minimal.

The expert had raised the average worker test. The author noted that in the broader civil arena it is referred to as the reasonable person test. But the author asks whether it is used appropriately in this context; the issue is not whether the worker reasonably perceives an event at issue as derived from work. Rather, the reasonable worker test implies that the typical person does not have the coping skills and resources to deal with overwhelming issues and, therefore, it is quite consistent with the test of taking victims as they are found. That is, no matter how the causation is examined, or the test or threshold used, qualified, educated, and trained assessors consider the multiple factors involved in a case and determine to what degree the event at issue is contributory to the legal test/threshold established relative to the remainder of the causal factors (e.g., is it at the level of significant or substantial). It is a straw person argument to refer to the typical clinician as uneducated, untrained, and unqualified in these matters. Surely, they might follow the unjustified scenarios as described by the expert but, at the same time, surely, they should be excluded to begin with from undertaking such assessments for workers compensation, or their cursory assessments quickly dismissed, and serving as the basis for an independent examination by a qualified and competent assessor. The latter will be quite aware of the need to evaluate causality from the perspective of the average person, the multiple causal factors that might be discerned, the relative significance or import of the work stress at issue, the relationship to pre-existing factors, etcetera.

99. Social Security Administration, *Disability Evaluation Under Social Security*, SOC. SEC. (2006), <http://www.socialsecurity.gov/disability/professionals/bluebook/>.

100. ROBERT D. RONDINELLI ET AL., GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT (Am. Med. Ass'n 6th ed. 2008).

E. Recommendations and Policy Implications

The file and literature reviews that the author undertook point to the following recommendations and policies. They are framed to be equitable. They might need reflection and modification if they are considered a good starting point to resolve the issues under dispute.

Whether for acute response to a traumatic stressor or chronic workplace stress, assessments need to be comprehensive, impartial, and scientifically informed. They should not be undertaken lightly by unqualified clinicians. Any disability notes that these clinicians might send to workers compensation can serve at best to initiate a reliable and valid assessment of the case at hand. All assessments of disability claims due to work stress must be undertaken by qualified and competent assessors who conscientiously undertake comprehensive evaluations, including means of detecting possible malingering and other problematic presentations. The savings to workers compensation by having these reliable and valid assessments will more than balance the collective extra costs of the assessments, absent a continued blanket refusal to consider all chronic work stress cases as non-compensable.

Complainants will need to know their obligations toward the assessments. They will have to sign release forms authorizing the collection of all relevant files, as determined by the adjudicator or assessor, such as medical, psychiatric, and military records. They will have to cooperate with the assessment and if time away from work is recommended and approved, they will have to comply with all treatment recommendations to the degree possible, and assessors and therapists will have to assign and document therapeutic assignments and the degree to which they were undertaken. Note that the assessor might determine there has been a significant work stress that is causally significant of a chronic mental condition, but that there is no work disability and that only treatment is needed. The complainant would need to comply with therapy in such cases as well.

Assessors will need to know their obligations and be consistent in applying their education and training in a judicious manner to all cases involved. They will need to attend continuing education workshops and courses, keep up to date with the relevant scientific literature, including on testing, and all relevant statutes and regulations applicable to these types of cases. They will submit

their qualifications to workers compensation if not already on their list of qualified and competent assessors. Note that the discretion to recommend a particular assessor lies with the clinician first contacted by the complainant. In addition, the recommendation could be made in concert with the complainant, although the clinician and complainant can cede the decision to the worker compensation adjudicator.

Assessors especially have to consider whether there is a work stress related mental condition that impedes functionality at work to the point of impairment and disability, aside from the question of whether there is a depressive, anxious, or similar disorder. Also, they will have to evaluate whether the work place conditions served as stressors to an important degree in the case (e.g., significant, substantial). Essentially, they will have to consider negative response biases, especially malingering, in all their assessments and deliberations. Note that psychologists are trained to administer tests that have complainant validity indicators, but malingering is attributed by considering all the reliable and relevant information gathered in a case. In this regard, both psychiatrists and psychologists are well trained to note inconsistencies and discrepancies in a file. Compelling irregularities should raise doubts and be investigated further. Their knowledge of psychopharmacological medications and reasons for lack of adherence to prescribed regimens could be helpful in this regard, too.

The adjudicators will need to know their obligations. They will function similarly to a system of checks and balances, leaving aside assessments not undertaken by qualified assessors and requesting independent "medical" examinations by accredited workers compensation evaluators. They will pass on the file to the appropriate tribunal if assessment conclusions are appropriately contested by the complainant. The tribunal might ask for another assessment by a qualified, competent assessor.

The threshold for disability in workplace cases needs to be sufficiently elevated so that it protects both the injured worker and worker compensation system from abuse, fraud, and allowing less-qualified cases to be heard. On the one hand, qualified and competent assessors can differentiate between degrees of impact of the work stress (e.g., none, mild, moderate, severe or marked, extreme), and the degree to which the work stress is causal (e.g., absent; contributory but minimal, moderate, significant, substantial, sole). On the other hand, these same assessors can exclude diagno-

ses that do not pertain to work stress, such as schizophrenia in severe cases and an adjustment disorder in mild cases (depression and anxiety, notably, would apply in most cases).

Lastly, the author will discuss the most difficult policy issue. There is a need for a workable definition of chronic work stress, one that is clinically useful and acceptable to all parties to the matter. It should not refer to simple daily work stressors, the fact that work, by definition, brings some stress, or that there are occasional ups and downs in stressors at work. For purposes of finding possible disability, it should not refer to high stress jobs, by definition, into which the worker has knowingly entered. That being said, although worker disability could not be considered in job types such as these, it is acknowledged that workers might need therapy to help them through some of the work stress. It should not refer to loss of coping ability due to aging, family stress that interferes with workplace performance, changes in the job market or economy that necessitates work changes, etc. Moreover, it should not be subjectively defined, or based on a complainant's self-report, but should instead meet operational criteria. It should not be based on one instrument, one theory, or one study.

In terms of what work stress should entail, aside from its chronic component, which itself needs a good definition, it should be a clinically useful definition that has components readily verifiable, either by the complainant, the workplace, or from work records. Some of the components of the definition should include excessive co-worker or supervisor aggressive behavior or attitude, including harassment or bullying. There should be a fairness and justice component. It should include an excessively overworked component. It should consider work stress in the physical, social, emotional, and cognitive spheres.

More importantly, the level of work stress that justifies a conclusion that a work disability exists must meet a level of being quite notable or important, and verifiably so. The adopted legal test serves as an entry-level criterion that warrants continuation of the assessment of whether a work disability exists, and therefore should be carefully considered and set at a high bar for both prudence and equity purposes. In this sense, the author recommends that the chronic work stressor involved in complainant disability evaluations must be determined to be significant.

The work stressor could be evaluated on a scale similar to the others mentioned in these recommendations – ranging on a

continuum from absent, minor, significant, substantial, to severe, for example. The “significant” level is one familiar to mental health professionals because it is commonly used in various editions of the DSM to qualify impairment (e.g., the disturbance induces clinically significant distress/ impairment in social/ occupational/ other important functional areas). Further, its choice as the threshold of work stress sufficient to continue the assessment of whether a work disability exists makes sense, given the recommendation to require showing that the causal contribution from work stress to a complainant’s disability meets the “significant” threshold.

There are some qualifiers to add. Even notable and important stressors do not automatically lead to disability. There are a number of factors to consider, including possible growth to stress challenges, and resilience. Note that a significant causal work stressor does not mean a significant level of work stress, or vice versa. Each of these aspects of the chronic work stress disability evaluation should be conducted separately. Therefore, for example, even if the work stress is considered chronic and causally significant toward disability, it might not reach the threshold of a significant work stressor.

Mental health professionals of different backgrounds can undertake assessments in this area. The assessments should be comprehensive and include interviews, collateral information, document and record review, including those of a psychiatric and psychological nature. Where the assessor is qualified, an assessment should use psychological tests for problematic presentations, particularly those that assess for malingering and related negative response biases. These instruments are used not only for work stress claims but also for acute stressor response claims such as PTSD in the workplace. PTSD claims require the same careful scrutiny for malingering as other work claims of a psychological nature. These psychological tools include personality inventories, such as the MMPI-2 (RF) and the PAI, which have complainant validity indicators; structured interviews about psychiatric feigning, such as the M-FAST and the SIRS (2); and forced-choice cognitive feigning tests, such as the TOMM for memory complaints.

V. DEFINITION OF MENTAL DISORDER IN THE DSMs AND A PROPOSAL

The closing sections of the Article address broader issues. First, the Article considers the concept of mental disorder, which is a term without a consensual definition, and makes a proposal for one. Second, the Article views the question of overarching theoretical perspectives to the field of psychological injury and law. *Psychological Injury and Law* (PIL) is a practical area but it does need models to better integrate itself. Third, the Article considers ethics in the area. PIL practitioners are confronted by ethical dilemmas in most cases and need to adopt a proactive ethical approach. The use of SVTs presents particular difficulties in these regards. The author developed a working table of ethical principles to organize an ASAPIL/ PIL journal consensus statement on SVT use in forensic and related practice in disability and related cases.¹⁰¹ These principles include five from the APA ethics code¹⁰², but the list has been augmented with five others. Together, the ten proposed ethical principles are presented in Table 1 can function to help revise the extant APA ethics and related codes.

Young¹⁰³ used the knowledge base in the area of psychological injury and law to improve the definition of mental disorder. The psychiatric field does not have one integrated, acceptable definition a state of affairs that is acknowledged in the DSM-5. However, in order to improve the DSM definition of mental disorder, Young considered the various terms in the field related to impairment, such as disability. Also, he sought a definition grounded in the biopsychosocial approach. The latter is an integrated model of psychiatric/ psychological condition that considers the multiple biological, psychological, and sociocultural factors involved and their integration.

In the DSM-IV-TR, a mental disorder is defined as a clinically significant behavioral or psychological syndrome or pattern

101. Shane Bush et al., *Psychological Assessment of Symptom and Performance Validity, Response Bias, and Malingering: Official Position of the Association for Psychological Advancement in Psychological Injury and Law*, PSYCHOL. INJ. & L. (forthcoming 2014).

102. EPPCC, *supra* note 3.

103. Young, *supra* note 22; *see also* YOUNG & HAYNES, *supra* note 22.

associated with distress that is “painful,”¹⁰⁴ or disability and impairment in important functional areas, or with significantly increased risk of death; pain; disability; or important loss of freedom. It is not simply an expected or culturally-sanctioned response. Independent of its original cause, mental disorder can be a behaviorally, psychologically, and biologically dysfunctional manifestation. Neither socially deviant behavior, such as political, religious, or sexual, nor individual-societal conflict constitutes a mental disorder, except if it is symptomatic of a dysfunction.

In the DSM-5, mental disorder is defined as a syndrome characterized by a clinically significant dysfunctional disturbance in cognition, emotion regulation, or behavior in psychological, biological, or developmental mental processes. It is associated with significant distress or disability in social, occupational, or other activities (social/ occupational/ other). As with the DSM-IV-TR, mental disorder is not an expectable, culturally-approved response. Socially deviant behavior also is not a mental disorder, unless it is dysfunctional.

Young¹⁰⁵ proposed a broader definition of mental disorder, consisting of several parts:

- *Primary Definition.* A mental health disorder is a behavioral syndrome or pattern or network of symptoms in context that is characterized as a clinically significant disturbance, distress, or dysfunction potentially evaluated as harmful to the individual, to others, or to both. It is acknowledged that establishing clinical significance requires a judgment of well-informed and trained individuals based on the gathering of reliable and relevant evidence. Primary areas of expression of the disturbance or dysfunction include cognition, mood, relations, interactions, self-regulation, and other behavior and its organization. Primary processes that might be involved include the biological, social, personal, psychological, and developmental. Primary impairments usually involved are in social, occu-

104. See DSM-IV-TR, *supra* note 6.

105. Young, *supra* note 22; YOUNG & HAYNES, *supra* note 22.

pational, or other important functional activities. These might be judged to meet thresholds of disability. Note that mental disorder, impairment, and disability are not the same as a handicap; the latter only refers to possible perception by the individual or by others.

- *Related Factors.* A mental disorder should be characterized by knowledge of original and perpetuating cause, both normatively in the population and individually for the patient. However, when knowledge of the science or of the person precludes causal understanding, a mental disorder can still be attributed. A mental disorder normally should be receptive to intervention or treatment, and knowing the cause and also isolating it as a reliable and valid category would help in this regard. However, once more, knowledge of the science or of the person might limit effective intervention or treatment.
- Nevertheless, the ultimate goal of mental health professionals, and/ or the society in which they work, is to develop scientifically informed and clinically useful mental disorder categories, dimensions, and their combinations (e.g., in diagnostic manuals) that help individuals diagnosed with mental disorders to stabilize/ recover and have or return to a healthy, functional lifestyle.
- Mental disorder has both common elements in its definition and language that allows for differentiated application to individuals depending on their context, sex, gender), majority or minority status, culture, age, history, developmental level, socioeconomic status, different informants, and societal and political considerations. Examples that do not necessarily qualify as mental disorders include an expected or culturally normative response to a common stressor or to a common loss, such as in the case of the death of a family member, or socially deviant behavior in a sexual, religious, or political ca-

capacity, or conflicts that only express discord of the individual in society.

- Overall, a mental disorder is a biopsychosocial (biopersonalsocial) expression that has a developmental etiology or causality and that also needs intervention/ treatment tailored to its developmental and biopsychosocial sources.

VI. ETHICS

The Journal, PIL,¹⁰⁶ developed a consensus statement on using symptom validity tests (SVTs) in assessments.¹⁰⁷ The new approach differed from prior consensus statements on the topic¹⁰⁸ by adopting an ethical framework for developing its recommendations. When developing the working tables presenting the ethical principles involved, the author surveyed relevant material in the APA ethics code,¹⁰⁹ the forensic specialty guidelines,¹¹⁰ and other relevant sources, as reviewed in Bush.¹¹¹ The author had to extend the five principles in the APA code by adding five other principles, such as science and ethics. Note that the tables not only help structure the appropriate use of SVTs in PIL type work but also help understand ethics globally. That is, the ethical system developed could serve in future revisions of the APA ethics code. In this regard, Martindale and Gould¹¹² have called for a revision of the APA ethics code. Its revision along the lines suggested here would help in the area of mental health disability and law.

106. As Editor-in-Chief of this *Journal*, I initiated this project.

107. Bush et al., *supra* note 101.

108. Shane S. Bush et al., *Symptom Validity Assessment: Practice Issues and Medical Necessity*, 20 ARCHIVES CLINICAL NEUROPSYCHOL. 419 (2005); see also Robert L. Heilbrunner et al., *American Academy of Clinical Neuropsychology Consensus Conference Statement on the Neuropsychological Assessment of Effort, Response Bias, and Malingering*, 23 CLINICAL NEUROPSYCHOL. 1093 (2009).

109. EPPCC, *supra* note 3.

110. American Psychological Association, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCHOL. 7, 7 (2013).

111. Bush et al., *supra* note 101.

112. DAVID A. MARTINDALE & JONATHAN W. GOULD, 11 HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 37 (Randy K. Otto & Irving B. Weiner eds., 2nd ed. 2013).

Ethics provides a superordinate code that helps build both law and sensitivity to the needs of people in addition to the help that they need. For further writing on ethics in the area of psychological injury and law, refer to Young's¹¹³ model of "broad ethics," which is a proactive one, as emphasized in Bush.¹¹⁴

VII. SYSTEMS

The area of psychological injury and law is a practical one about the interface of psychology and law. Working in the area requires an up-to-date knowledge basis in all its major sections, from evidence law to forensic psychology to the psychological injuries. However, the area of psychological injury and law is broad in scope, having over ten sections, and includes topics such as assessment and malingering, rehabilitation, and ethics. The risk is that it is such a diverse area that there is no unifying theoretical approach or guiding model. Granted, it is important to adopt a science-first and proactive ethical approach when working in the area. Nevertheless, this type of approach does not constitute a metamodel or overarching theory.

In this regard, the author has noted that one integrating model that is applicable to multiple areas in working in the area of psychological injury and law is the biopsychosocial or multifactorial model.¹¹⁵ Moreover, this model should be combined with a forensic perspective.¹¹⁶ For example, when trying to detect possible malingering and other negative response biases. In this regard,

113. YOUNG, *supra* note 49.

114. SHANE S. BUSH, ETHICAL CONSIDERATION IN MILD TRAUMATIC BRAIN INJURY CASES AND SYMPTOM VALIDITY ASSESSMENT 45 (Dominic Carone & Shane S. Bush eds., 2013).

115. GERALD YOUNG, ANDREW W. KANE & KEITH NICHOLSON, PSYCHOLOGICAL KNOWLEDGE IN COURT: PTSD, PAIN, AND TBI (Springer Sci. + Bus. 2006); GERALD YOUNG, CAUSALITY OF PSYCHOLOGICAL INJURY; PRESENTING EVIDENCE IN COURT 187 (Gerald Young, Andrew A. Kane & Keith Nicholson eds., 2007); YOUNG, *supra* note 49; YOUNG & HAYNES, *supra* note 22.

116. Gerald Young, *Psychological Injury and Law: An Integrative Model*, 1 PSYCHOL. INJ. & L. 150, 156 (2008); Gerald Young, *Psychological Injury and Law: A Biopsychosocial and Forensic Perspective*, 1 PSYCHOL. INJ. & L. 219, 221–23 (2008); YOUNG, *supra* note 49; YOUNG & HAYNES, *supra* note 22.

it appears that a more general integrating term is needed to represent the best overarching model to guide work in the field. In this sense, it should be referred to as the “biopsychosocial-forensic” model.¹¹⁷

Furthermore, the need for a broader systems approach to the area appears essential. For example, Young¹¹⁸ showed the multiple influences and factors involved in psychological injury cases. Young¹¹⁹ argued that biases affect not only examinees but also assessors and other actors in the system such as third party payers and attorneys.

In examining particular injuries and conditions in the area, a systems approach helps immensely. For example, causality needs to be seen as a multifactorial concept with multiple influences involved in outcome in psychological injury cases.¹²⁰ These factors include predisposing, precipitating, and propagating ones, as well as extraneous factors. Assessors need to consider all of them in their assessments in which causality is an issue.

The complexity of causality is illustrated by Young's¹²¹ approach to somatization. After a review of the literature, he isolated 100 factors that could influence this complicating process in pain experience and psychological symptoms. Similarly, for chronic pain, Young and Chapman¹²² found that a nonlinear dynamic systems model could help explain the development of this condition and its intractable nature.

117. E.g., Young, *supra* note 116, at 157.

118. Gerald Young, *Causes in Construction of Causal Law: A Psycho-Ecological Model*, 33 INT'L. J.L. PSYCHIATRY 73, 73 (2010).

119. YOUNG, *supra* note 49.

120. GERALD YOUNG, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT 49 (Gerald Young, Andrew A. Kane & Keith Nicholson eds., 2007).

121. Gerald Young, *Causality and Causation in Law, Medicine, Psychiatry, and Psychology: Progression or Regression?*, 1 PSYCHOL. INJ. & L. 161, 177-78 (2008).

122. GERALD YOUNG & C. RICHARD CHAPMAN, PSYCHOLOGICAL KNOWLEDGE IN COURT: PTSD, PAIN, AND TBI 181, 184-87 (Gerald Young, Andrew W. Kane & Keith Nicholson, eds., 2006); GERALD YOUNG & C. RICHARD CHAPMAN, CAUSALITY OF PSYCHOLOGICAL INJURY: PRESENTING EVIDENCE IN COURT 197, 215-19 (Gerald Young, Andrew W. Kane & Keith Nicholson, eds., 2007).

Finally, Young¹²³ developed a broad therapeutic model for work with psychological injury patients. It is componential, transdiagnostic, and aimed at the whole person rather than limited by any one school of thought or therapeutic approach.

In the end, although psychological injury and law appears focused on assessment, it includes multiple and diverse sections and, therefore, a guiding framework for conceptualizing it and working in it should be inclusive of its sections in a systemic way. In this regard, even a biopsychosocial-forensic model is insufficient to capture the wider perspective or systems that are part of the field. For example, psychological injury and law is an area that also considers the RDoC project and networks, neural circuitry, and dynamic models in psychiatry and psychology.¹²⁴ Moreover, the field of mental disability, policy (and law) is tending toward integrative approaches that are global and transdisciplinary.¹²⁵ It has much to offer all areas to which it relates, not only in a practical capacity but also on conceptual and theoretical levels, in the sense that the area of psychology and law is embedded in a mental health law and policy framework and can add to it in order to build reciprocity and dynamic relations among the fields.

Overall, both areas should adopt a systems related perspective that includes dynamic transitions and networking, among other considerations. Additionally, behavior has both evolutionary and developmental components¹²⁶ that inform psychological injury symptom manifestations and their interpretations.

123. Gerald Young, *Psychotherapy for Psychological Injury: A Biopsychosocial and Forensic Perspective*, 1 *PSYCHOL. INJ. & L.* 287, 287 (2008); YOUNG, *supra* note 49.

124. *E.g.*, OLAF SPORNS, *DISCOVERING THE HUMAN CONNECTOM* (MIT Press 2012); YOUNG & HAYNES, *supra* note 22.

125. *E.g.*, Bruce S. McEwen, *The Brain on Stress: Toward An Integrative Approach to Brain, Body, and Behavior*, 8 *PERSPECTIVES PSYCHOL. SCI.*, 673, 673 (2013); Stein et al., *supra* note 23.

126. GERALD YOUNG, *DEVELOPMENT AND CAUSALITY: NEO-PIAGETIAN PERSPECTIVE* (Springer Sci. + Bus. Media 2011).

VIII. CONCLUSIONS

Psychological injury and law is an expanding area in research and practice that has its own Journal, PIL, books,¹²⁷ and society, Association for Psychological Advancement in Psychological Injury and Law (ASAPIL). It has much to offer the field of mental health policy in terms of its scholarship, concepts, legal acuity, and professional reach. The area of forensic civil disability and tort needs the comprehensive, scientifically informed, and impartial approach that it promotes.

The authors have shown that worker compensation and other venues can profit from the rigorous assessment methods and logic used by the best practices in the area. The authors have made extensive recommendations that could improve the effectiveness of the workers compensation system in adjudicating claims.

Indeed, any area of mental health practice should consider the added value brought by the approach of psychological injury and law. For example, it has a refined understanding of causality and valid outcomes such as PTSD, but also the controversies in these areas and the need for and methods involved in malingering detection. Assessments in the area need to be governed by a proactive ethical approach. Finally, the authors have proposed an ethical model in these regards that not only extends the APA approach to the ethics code but also should generally apply well to the area of mental health law and policy.

Psychological injury and law is a new area that is not yet integrated into graduate education and professional practice registration as a separate specialty. Graduate schools should offer courses in the subject and professional and state associations should offer more continuing education opportunities on the topic.¹²⁸ Moreover, by increasing the education, training, and experience of students and professionals in the field of psychological

127. YOUNG, *supra* note 49.

128. Gerald Young, *Erretum To: Trends in Psychological/Psychiatric Injury and Law: Continuing Education, Practice Comments, Recommendations*, 4 PSYCHOL. INJ. & L. 56, 56 (2010–11); YOUNG, *supra* note 49; Gerald Young & Izabela Z. Schultz, *Trauma and Psychological Injury: Practice, Clinical, Legal, and Ethical Issues*, 2 PSYCHOL. INJ. & L. 10, 10 (2009).

injury and law, the area of mental health law and policy will be well-served.

Table 1
10 Ethical Principles: A Collective Intelligence Approach

Principle	Explanation
From APA Ethics Code	
1. Beneficence/ Nonmaleficence	Do good/ not harm
2. Fidelity/ Re- sponsibility	Establish trust with patients/ other with whom one works
3. Integrity	Emphasize accuracy/ honesty/ truthfulness
4. Justice	Involves fairness, equal access to services, its quality
5. Respect for Rights/ Dignity	Respect (a) the dignity worth of all people and (b) the individual's rights to privacy/ confi- dentiality/ auto-determination
Additions from Collective Intelligence Approach	
1. Ethics as System	Ethics is a system involving learned sources, the person, and the context, all of which are dynamically changing
2. Ethics as Science/ Sci- ence as Ethics	Ethics and science are mutually interacting and regulating
3. Ethics and Test Limits	The ethical use of tests involves knowing their strengths and acknowledging their limits
4. Ethics and Law	Ethical forensic work is based on intimate knowledge of all aspects of law and court functioning
5. Ethics in SVTs/ PVTs	The ethics that apply to psychological prac- tice, in general, and forensic-related practice, in particular, apply to SVTs/ PVTs

The APA ethics code¹²⁹ is based on five ethical principles. In elaborating a Consensus Statement on use of SVTs/ PVTs in psychological injury cases, five more principles were considered necessary as resources to cover the material on the matter. Together, the ten ethical principles form an integrated system approach toward a theory of ethics. Codes derive from principles, which should have an overarching theory. One approach to ethical thought is that in ethical thinking mental health professionals should use self-reflective judgment¹³⁰ coupled with meta-theoretical thinking. Based on this model, another was developed using the approach of Collective Intelligence, as defined in Young's¹³¹ Neo-Piagetian model of post-formal abstract thought. In this adult stage of thought, adults graduate to creating superordinate abstract structures, while putting together cognitive and emotional processes in pragmatic, lived application, and while working together in doing so. The present ethical model has added five ethical principles to the five tenets of the APA ethic code that are consistent with a Collective Intelligence approach. For example, it considers mental health ethics as systemic, and integrated with science and law, including in testing.¹³²

129. EPPCC, *supra* note 4.

130. RICHARD F. KITCHNER & KAREN S. KITCHENER, 1 ETHICAL FOUNDATIONS OF PSYCHOLOGY 3 (Samuel J. Knapp et al. eds., 2012).

131. YOUNG, *supra* note 49.

132. Bush et al., *supra* note 101.

Table 2
Consensus Statement on Use of Psychological Testing in Detecting Negative Response Bias, Including Possible Malingering: Five Ethics Principles and Comments Based on the APA Ethics Code

Principle	Explanation/ Comment (below each explanation)
1. Beneficence/ Nonmaleficence	<p>Do good not harm.</p> <p><i>Comment.</i> This quintessential, super-ordinate ethical and moral value either implicitly or explicitly governs both every general ethics and practice guideline, code, or regulation in medical and mental health and every one of its specific principles, tenets, rules, examples, and resolutions. In this sense, it applies to forensic and related work in which psychosocial tests are used, [in general, and symptom validity test/ testing (SVT) or performance validity test/ testing (PVT) is used, in particular]. The same applies to any consensus statement of the use of psychological tests in detecting response bias, including possible malingering. Neither the field nor the individual practitioner shall act in a way or condone any behavior, including in test construction and use, that violates this basic overriding governing principle of “do good and not harm.” Of course, doing good does not refer to what is best for the referral source or examinee in this context but to the highest standards of ethical and scientific work in the field.</p>

1.2. Fidelity/ Responsibility	<p>Establish trust with patients/ other with whom one works.</p> <p><i>Comment.</i> Mental health practice is a field of human interaction, one that requires establishing rapport and trust so that one's work can proceed effectively and with integrity. Good rapport is needed in addition to trust, except in cases where it is not possible in a work setting, such as consultation. In the forensic work situation, the examinee might not be the "client," who might be the referral source instead; nevertheless, the obligation on the part of the worker is to establish rapport and trust to the degree possible. Examinees might be hostile, evasive, or poor historians, but on an ethical level, the forensic worker deals dispassionately with these impediments and functions with the required integrity and without worsening the situation, so that the examinee is responsible <i>in toto</i> for her or his behavior. Granted, there might be a history of litigation/ insurance iatrogenic/ lexogenic distress and influence, but the evaluator explains at the outset his or her neutral, balanced, impartial approach and that he or she is working for the court and its requirements rather than for any one party or referral source, per se, including the examinee, her or himself. [In terms of SVTs/ PVTs, specifically], the worker approaches the function of the testing in the same way with respect to all decisions and choices made. Further, the manner of administration of all such tests are applied in a way that adds to the trust established and/ or does not alienate an already distrustful examinee. The use of the best scientific foundations for test selection</p>
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	<p>and their application constitutes the best external basis for assuring the establishment of trust in any forensic working relationship. The use of the best personal and professional strategies and tactics in creating rapport and trust constitutes the best scientific basis in this regard. Mental health workers know and apply such “common” factors in their work in any content, forensic or not. An approach such as this will serve to optimize examinee presentation and performance in the evaluation at hand, [including on SVTs/PVTs]. The ultimate responsibility of the forensic worker is to the court and self (with their calls to the highest ethical standards) rather than to the examinee or referral source, per se.</p> <p>As for other aspects of responsibility, workers strive to maintain their independence, nonpartisanship, accountability, and absence of conflict of interest by avoiding presenting to court misleading, incomplete, unrepresentative, or otherwise biased data and interpretations. [With respect to SVTs/PVTs], this would especially refer to using appropriate test selection, scoring, and interpretation, avoiding their sole use in arriving at conclusions or opinions, so that all the reliable data needed to be gathered for a case at hand are collected impartially, comprehensively, and scientifically.</p>
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1.3. Integrity	<p>Emphasize accuracy/ honesty/ truthfulness.</p> <p><i>Comment.</i> The hallmark of ethical practice and behavior lies not only in beneficence, nonmaleficence, fidelity, and responsibility but also in integrity. Forensic workers strive to present accurate, unbiased data and interpretations that reflect the truth as best can be ascertained in their cases. They consider all relevant reliable and valid data in the case at hand, gathered comprehensively and using a multitrait/source method to the degree possible, doing so in the same way no matter the referral source and their stance in the plaintiff/ defense (adversarial) divide. [In terms of application of this principle to work with SVTs/ PVTs], the forensic worker exhibits integrity in dealing with the referral source, examinee, and court or related venues, including all aspects of evaluating the examinee, selecting and administering tests, and interpreting them.</p>
1.4. Justice	<p>Involves fairness, equal access to services, its quality.</p> <p><i>Comment.</i> In the forensic context, fairness in court is a primary goal to which workers aspire. Truthfulness might be difficult to ascertain perfectly, and the standard of proof needed in a case bears a degree of uncertainty, which is more liberal in civil and tort-type and disability cases (“more likely than not” compared to “beyond a reasonable doubt”). Experts are bound to offer evidence to court that is more probative than prejudicial, fits the case, and helps the trier of fact deliberate</p>

	<p>on the ultimate issue. Forensic workers are aware of the justice concepts in court. Moreover, they function from a point of view of justice themselves, thereby providing equal access and quality services to all reliable referral sources and their referred examinees.</p>
1.5. Respect for Rights/ Dignity	<p>Respect (a) the dignity of all people and (b) the individual's rights to privacy/ confidentiality/ auto-determination.</p> <p><i>Comment.</i> Mental health workers, in general, including those in forensic positions, respect and express dignity for all individuals and groups for both their unique and group characteristics, such as culture, minority, race, language, country of origin, sex, sexual orientation, disability status, age, socioeconomic status, as well as for their rights and dignity in these regards. In the forensic-type situation, such an attitude will guide the assessment process so that it contributes legally reliable information to a court that is sensitive to and takes into account factors such as culture and minority status. Tests, [including SVTs/ PVTs used in assessments], as well as the general assessment procedure and test administration, will take into account any factors such as those mentioned that could influence the data gathered and the consequent interpretation. Moreover, the steps needed to ensure confidentiality, voluntary and informed consent, self-respect, and self-determination within the confines of the</p>

	forensic task and demands at hand, are followed rigorously. An issue in this regard relates to informing examinees of the use of SVTs/ PVTs, or tests of their nature. In one sense, these tests constitute a certain degree of deception, but they stand as necessary in these types of examinations. Therefore, they can be explained when obtaining voluntary, informed consent, in general; however, just before administering them, the examinees should not be forewarned about their upcoming administration, or their validity and utility could be compromised.
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The square brackets indicate wording specific to SVT/ PVT use; otherwise, the wording applies to psychological testing, in general.¹³³

133. Bush et al., *supra* note 101.

Table 3
Consensus Statement on Use of Psychological Testing in Detecting Negative Response Bias, Including Possible Malingering: Based on Additional Ethics Principles

Principle	Explanation/ Comment (Below each explanation)
1.6. Ethics as System	<p>Ethics is a system involving learned sources, the person, and context, all of which are dynamically changing.</p> <p><i>Comment.</i> Ethics is the result of an awareness/ thought/ behavior dynamic, a continuously interactive and evolving process among ethical theory, principles, codes/ regulations/ guidelines, rules, and items/ articles, within a broad, proactive, self-governed nexus in which the person should be reflective and personally responsible for all ethical decisions and actively involved in resolving and seeking out pertinent potential ethical dilemmas, which are often quite problematic without clear answers. No formal ethical codes, licensing proscriptions, or even legal obligations can supplant proper personal ethical awareness/ thought/ behavior and reflection in one's ethical professional practice, although contextual factors are recognized.</p> <p>In terms of forensic practice, workers need to understand the wide system in which they work, the obligations it imposes, and the personal responsibility for their behavior and work product that they bear. [As for SVTs/ PVTs use], this principle dictates that their selection, use, and interpreted results are the responsibility of the practitioner in dialogue with the appropriate ethical stance to take, rather than to the referral source, examinee, or any other stakeholder. Moreover, the worker knows the limits of the test manuals, computer</p>

	<p>print-outs, and information associated with the tests (especially the interpretation), and the science in the manuals and literature associated with the tests. In this way, in proffering evidence in court, the worker is assured of functioning at the apex of ethical activity within the system at issue.</p>
<p>1.7. Ethics as Science/Science as Ethics</p>	<p>Ethics and science are mutually interacting and regulatory.</p> <p><i>Comment.</i> Ethics is a system of regulating behavior so that it is beneficent and not maleficent, although there are risk/ benefit ratios to consider especially in some cases, such as the medical field. Science is a system, as well, oriented toward the search for replicable and valid information about the world through appropriate observation, appropriate methods, including experimentation, where possible, and appropriate reasoning. Scientists, as much as mental health practitioners are fallible, and both need constant self-supervision of ethical awareness, thought, behavior, decisions, and practice. Science informs ethics through the knowledge it provides, about the world, especially about behavior, psychological practice, and testing, in the present context. Also, ethics informs science, especially by the moral prescriptions and aspirations it holds up to it.</p> <p>In the forensic and related context, workers have been educated and trained in the scientific traditions and foundations of the profession. They have learned about how research is conducted, how tests are constructed, and how [SVTs/ PVTs] testing provides data on different degrees of probability of response bias, including possible malingering, but all in the context of</p>

	<p>associated doubt (e.g., in confidence intervals, probabilities, sensitivity, specificity, cut scores, aside from general uncertainty about research, per se (e.g., as exemplified in alpha level). The research on all aspects of forensic-type practice keeps being updated and the accumulated knowledge base one needs to know in order to practice ethically and effectively keeps changing. Workers in the field need to keep abreast of the current literature, be able to defend all components of their assessment procedures, methods, technologies, and practices, including in testing, [in general, and for SVTs/ PVTs, in particular], and be able to justify all interpretations, and opinions derived from court and related venues. Moreover, they need to be able to explain how alternative hypotheses do not explain well all the reliable data gathered in a case at hand compared to preferred ones. For both justifying preferred hypotheses and invalidating alternative ones, all the reliable data gathered is considered and analyzed. In all reasoning, the basis used is scientific, or careful, prudent, comprehensive, critical, analytic, and systematic, with all variables considered and given their appropriate weight. The reliability and validity of the opinion/ testimony offered to court, the report/ evidence at its base, and all methods/ procedures/ techniques/ tests [(including SVTs/ PVTs)] used should be unassailable.</p>
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1.8. Ethics and Test Limits	<p>The ethical use of tests involves knowing the strengths and acknowledging their limits.</p> <p><i>Comment.</i> Compromises to reliability and validity of tests in the forensic context also include the degree to which they have been normed on the population to which the examinee corresponds. This is an example of a test having limits, and in all such cases, they need to be explicated well. When the limits of a test excessively compromise reliability/ validity, and if used nonetheless, its use in assessment needs to be explained, in light of the science behind the test, as well as any data derived from the test's use in the case at hand. The task is more difficult for newer or just-released methods, procedures, tests, or techniques, and the workers bear greater responsibility in demonstrating general acceptance.</p>
1.9. Ethics and Law	<p>Ethical forensic work is based on intimate knowledge of all aspects of law and court functioning.</p> <p><i>Comment.</i> In the forensic arena, the admissibility of evidence is governed by Supreme Court decisions, in addition to the Federal Rules of Evidence and state laws often aligned with them. These decisions refer to the gatekeeping function of the court and the criteria of good compared to poor or "junk" science that it mediates. Generally, evidence proffered to court must be not only generally accepted but also falsifiable, testable, and with known error rate as well as being generally reliable (replicable), valid (which means "legally" reliable), fit (to the case), and relevant (or helpful). These are all important con-</p>

	siderations for tests, [in general, and SVTs/PVTs, in particular].
1.10. Ethics in SVTs/ PVTs	<p>The ethics that apply to psychological practice, in general, and forensic-related practice, in particular, apply to [SVTs/PVTs].</p> <p><i>Comment.</i> Their use and their data interpretation, as well as the latter's conclusions, should follow the highest of ethical standards, as per the following ten points:</p>
1.10.1.	Forensic workers in the position to use [SVTs/ PVTs] are familiar with and practice consistent with all relevant practice, ethical, and legal/legislative requirements, including the present ethics statements ¹³⁴ and extent consensus statements. ¹³⁵
1.10.2.	SVTs having the most appropriate psychometric properties should be used, and they should be chosen in light of the characteristics of the examinee and setting.
1.10.3.	The full range of possible response bias should be considered in interpreting [SVT/PVT] data. In the case of negative response bias, this includes possible mild exaggeration right up to full malingering.
1.10.4.	All interpretations so derived are based on consideration of all the relevant reliable data, and then considered in conjunction with the full data set gathered in the assessment undertaken (e.g., from examinee interview, collaterals, records), which

134. *Id.*

135. Heilbronner et al., *supra* note 108.

	<p>must be comprehensive. These other data sets might contain substantial inconsistencies/discrepancies. Only those conclusions that best fit the full data set gathered should be offered in opinions/ testimony, independent of the hopes/ needs/ pressures of the referral source.</p>
1.10.5.	<p>Malingering should be attributed only when there is incontrovertible evidence. Nevertheless, quite evident problematic presentations/ performances can be described in ways by astute observers that indicate their nature (e.g., feigning, deception, dissimulation, noncredible). The description used should always fit the nature of the data gathered.</p>
1.10.6.	<p>Evaluators list all [SVTs/ PVTs] used, all omnibus (personality) tests that include respondent validity scales, etc. The other major types of test with validity measures include standardized interview measures (e.g., of feigned psychopathology), dedicated psychological injury tests (e.g., for PTSD/ trauma), and embedded scales/ measures in a neuropsychological battery. To the degree possible, and assuming the testing context permits them, these latter measures should be distributed throughout the assessment in a fair way. These multiple assessment strategies for response bias are especially necessary when evaluatees are claiming multiple types of deficits/ impairments (cognitive, emotional, corporeal/ pain).</p>
1.10.7.	<p>Evaluators using [SVTs/ PVTs] are wary of inferring motivation, volition, intention, and consciousness when there is insuffi-</p>

	<p>cient evidence. At the same time, they do not shy away from this judgment when sufficient evidence is available. Evaluators do not consistently use preferred inferences, such as malingering or a “cry for help,” unless the evidence is excessively supportive.</p>
1.10.8.	<p>Evaluators using [SVTs/ PVTs], and related measures with response validity indicators understand the various items and definitions needed to do their work, and how to resolve inconsistencies therein in their conclusions for court. They understand the various inconsistencies within and across relevant ethics, codes, professional guidelines, practice regulations, legal/ legislative frameworks, and consensus statements, and can address them effectively to court.</p>
1.10.9.	<p>Evaluators who are evaluating whether any degree of response bias should be attributed to evaluatees should always be checking their own biases, external incentives, etc. Any influences that detract from an unbiased approach to evaluations need to be brought to the surface and countered.</p>
1.10.10.	<p>Evaluators might use the most psychometrically sound and appropriate instruments but have their biases expressed in aggregating/ combining methods over them. For example, at one extreme, they might use methods that lead to Type I error, or lean towards finding inappropriately malingering. Conversely, at the other extreme they might avoid aggregating methods altogether instead of using them judiciously, and use exclusively clinical, subjective judgments,</p>

	which has its own risks. ¹³⁶
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136. Bush et al., *supra* note 101.

Shifting the Lens: A Primer for Incorporating Social Work Theory and Practice to Improve Outcomes for Clients with Mental Health Issues and the Law Students who Represent Them

BY SUSAN MCGRAUGH,* CARRIE HAGAN**
& LAUREN CHOATE***

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INTRODUCTION

This Essay is an effort to promote the inclusion of interdisciplinary practice in our work as attorneys and in our roles as clinical legal professors. As the legal community continues its renewed emphasis on skills training, law schools should look to other professions in order to produce more lasting solutions for our clients and for more satisfactory outcomes for our lawyers. In this Essay, the authors discuss their work incorporating social work theory and practice into clinical legal education when dealing with clients who have serious mental illness. With some studies reporting up to 64.2% of inmates in the United States having a diagnosed mental illness, it is becoming imperative that law students acquire the skills necessary to adequately represent them. Two pillars of social work practice, Strengths Theory and Systems Theory, are discussed with an emphasis on the role they play in working with this demographic of clients.

I. BACKGROUND AND OVERVIEW

A. *The First Meeting*

Shay,¹ a third year law student in the Criminal Defense Clinic,² met her first client, Matthew, in the courtroom. Matthew enters the courtroom in a belly chain, his hands cuffed together in front of him and locked to a black box that sits at his waist. He wears the red jumpsuit indicative of an offender who is a special risk to the other inmates and the guards at the jail. Matthew sits with his head far down, ignoring the judge and the efforts of the courtroom personnel to engage him in the process. The jail staff advised Shay that her client is paranoid and delusional and most

1. All names have been changed to protect confidentiality.

2. The St. Louis University School of Law Criminal Defense Clinic allows law students to represent clients charged with criminal offenses under attorney supervision.

likely suffering from schizophrenia. Matthew believes that he cannot be prosecuted because he is a prophet and therefore immune to the laws of man.

Shay's clinical professor has instructed her to introduce herself to the client in an effort to persuade him to accept legal services from the clinic. He is currently unrepresented and has spent weeks in jail on a minor offense because he has not engaged the legal representation necessary to get his bond lowered. Shay is overwhelmed by the situation and afraid of attempting to make contact with someone who is so obviously in psychological distress. No class in law school has instructed her how to engage a person with serious mental illness, much less how to represent a person whose competency is in issue. Given her skills alone, Shay, third year as a law student, might not be able to handle working with this client. But in this case, Shay is not alone; at her side is a mental health social worker, Emma, who specializes in providing services to persons with serious mental illness. Together they approach the potential client.

B. *Legal Education*

Traditionally, legal education consists of a three year program of required courses, bar exam elective courses, and perhaps a course or opportunity for experiential legal learning, such as a clinic or externship. With legal education under scrutiny because of mounting student debt and a perceived lack of financial payoff, legal institutions and the American Bar Association are searching for ways to make learning not only better for the students but more cost effective on the whole.³ As recently as May 2013, the American Association of Law Schools (AALS) Curriculum Committee sent out an email to all of its members for a self-reflective analysis of what law school professors are doing and where we must go from here given the overall state of legal education.⁴

3. See Daniel Thies, *Rethinking Legal Education in Hard Times: The Recession, Practical Legal Education, and the New Job Market*, 59 J. LEGAL EDUC. 598, 610–11 (2010).

4. The email was sent to all American Association of Law Schools (AALS) members by the Curriculum Committee of the AALS, on behalf of Todd D. Rakoff, Chair, May 13, 2013. Posting of Todd D. Rakoff, Chair, Amer-

C. Promotion of Interdisciplinary Education

This Essay is an effort to participate in the positive transformation of legal education by promoting the use of interdisciplinary education to provide a fuller law school experience. Specifically, the authors discuss the documented need for improved training in interpersonal relational skills for law students, an overview of two basic social work theories and techniques that can be used in a legal education setting, as well as some examples of how these theories work in application for general use.⁵ Because of the soaring rates of defendants and inmates with serious mental illness,⁶ this Essay focuses specifically on practices that enhance students' abilities to adequately work with these clients, clients that demand a skill set which often differs from those traditionally taught to law students. For the purposes of this Essay, the authors will discuss the incorporation of social work theories into clinical legal education via interdisciplinary partnerships. It will also examine ways in which, should a social worker or interdisciplinary partnership not be accessible, one can incorporate basic social work theories into an existing curriculum, giving students a basic competence in work-

ican Association of Law Schools (AALS), to members, AALS (May 13, 2013) (on file with authors).

5. This Essay is an expansion of a session conducted by the authors titled *Empowerment Through Application: Implementing and Assessing the Intersection of Social Work Theories and Legal Pedagogy in a Classroom and Clinic Setting* presented at the 2013 AALS Conference of Clinical Legal Education in San Juan, Puerto Rico in May 2013. Susan McGraugh, Carrie Hagan & Lauren Choate, *Empowerment Through Application: Implementing and Assessing the Intersection of Social Work Theories and Legal Pedagogy in a Classroom and Clinic Setting* (May 2013).

6. Michael Schwartz, *Rikers Island Struggles with a Surge in Violence and Mental Illness*, N.Y. TIMES, March 19, 2014, at A1, available at www.nytimes.com/2014/03/19/nyregion/rise-in-mental-illness-and-violence-at-vast-jail-on-rikers-island.html?r=0 (citing one such concrete example of violence and mental illness in prison populations). See also H. Richard Lamb & Linda E. Weinberger, *Persons With Severe Mental Illness in Jails and Prisons: A Review* 49 PSYCHIATRIC SERVS. (1998), available at <http://journals.psychiatryonline.org/article.aspx?articleid=81232> (presenting statistics about the numbers of persons with mental illness involved in various stages of the criminal justice system and recommending how this population should be handled).

ing with those who have mental illness.⁷ Although the idea of integrating social work concepts into the legal profession is by no means novel, we hope to take this discussion one step further, by focusing on clients with serious mental illness and creating a primer for those who acknowledge the benefits of social work theory but who might not be familiar with the literature or techniques. This paper is written for them, to provide some techniques, which are easily adaptable to and consistent with best practices in clinical teaching. If nothing else, we hope to demonstrate how social work theory has enhanced our legal practice and teaching methods to produce lasting results for these clients and a more beneficial experience for our students.

II. INTERDISCIPLINARY EDUCATION

Interdisciplinary (also known as transdisciplinary) education is defined as “not one discipline imposing its own values, knowledge, and practices on another discipline or deciding which discipline is the best to use in certain situations. Instead it involves coming up with solutions that incorporate multiple ways of thinking, and collaboratively working together to serve clients and the community in a way that is better than segregated services.”⁸ By combining pedagogies, resources and perspectives, these partnerships allow students to think more broadly and learn more than one way of performing their work. Interdisciplinary education is not a new concept, nor is it necessarily difficult to work into one’s current approach. However, it is not always very well understood or appreciated by those who have not had exposure to the practice. Fortunately, there is an abundance of very helpful material that can

7. The authors of this Essay work at two different institutions, The Indiana University Robert H. McKinney School of Law and St. Louis University School of Law. Two clinics were involved in initial interdisciplinary work, a criminal law clinic and a civil practice clinic. Both clinics were able to have an interdisciplinary partnership implemented initially due to temporary grant funding, the expiration of which presents challenges to the continuation of this work on both campuses.

8. Stephanie K. Boys, Carrie A. Hagan & Valerie Volland, *Lawyers are Counselors, Too: Social Workers can Train Lawyers to More Effectively Counsel Clients*, 12 ADVANCES SOC. WORK 241, 242 (Fall 2011).

assist the curious practitioner in learning the various iterations of interdisciplinary practice.⁹

Law students are told from their first day of classes that one element of the law school curriculum is to teach them to think like lawyers. However, in learning a new analysis and skill set focused primarily on black letter law and interpretation, students risk the loss of some of their humanity. For instance, instead of stressing the trust relationship needed with a client (and how to build that) to gather information, the focus is instead on what information one needs to gather in order to prove a case or accomplish the immediate legal tasks at hand. There frequently isn't much discussion in law school classes on how to ask about delicate subject matter nor what to do when a client has an emotional reaction to something in the case. As a result students at times can be stymied on what their response should be. They forget, or rather shelve, many of their interpersonal and relational skills in order to prioritize the legal tasks at hand. Re-incorporating interpersonal skills with the new analytical legal skill set can be challenging – where to start? How do we get them back? Enter the world of interdisciplinary education. By combining two sets of training, theories and experiences, students can become more comfortable within their own realm, and they can also learn transitional skills that enhance their performance both in their field and out.

Experience demonstrates that law students generally are struggling with the gap in interpersonal skills education. Not only do they feel unprepared to practice law, but they also feel unprepared to meet and deal with clients. Data from a needs assessment done in 2011 at the Indiana University Robert H. McKinney School of Law in Indianapolis, Indiana, showed that law students not only felt that their legal education did not prepare them to work

9. Kim Diana Connolly, *Elucidating the Elephant: Interdisciplinary Law School Classes*, 11 WASH. U.J.L. & POL'Y 11, 23–25 (2003); Susan R. Jones, *Promoting Social and Economic Justice through Interdisciplinary Work in Transactional Law*, 14 WASH. U.J.L. & POL'Y 249, 249 (2004); Alexis Anderson, Lynn Barenberg & Paul R. Tremblay, *Professional Ethics in Interdisciplinary Collaboratives: Zeal, Paternalism and Mandated Reporting*, 13 CLINICAL L. REV. 659, 659–718 (2007); Jacqueline St. Joan & Stacy Salomonsen-Sautel, *The Clinic as Laboratory: Lessons from the First Year of Conducting Social Research in an Interdisciplinary Domestic Violence Clinic*, 47 LOY. L. REV. 317, 317 (2001).

with clients, but that learning skills with social work roots would be beneficial in assisting them to do this.¹⁰ Students reported that not only did they feel social work would allow them to help clients beyond their legal problems, but also to learn how to interact with different types of people. One student in particular noted, “I think it would be helpful to have some training in how others think and how to get [clients’] trust.”¹¹ Not only did this student identify that legal education did not provide the training they felt they needed, they also understood that looking beyond legal education was not only acceptable but would be helpful in assisting them. Again, even this small observation rests on an inference that the basic legal education we provide does not prepare our students as well as it could to develop and manage interpersonal relationships, an area in which social work can be useful in filling the skills gap.

Combining legal and social work pedagogies is a natural merger. Social work and the practice of law share more in common than one might think after a brief look at the roles and expectations of each in the field. As lawyers, we meet with clients, and no matter what type of law we practice we work toward meeting the client’s goals and improving their circumstances through legal and non-legal measures. In doing so, we have external forces that affect our abilities to work effectively along the entire timeline of the lawyer-client relationship. In social work, the scenario is generally the same: they have clients no matter what field they work in, they also need to work toward the client’s goals and generally improving a situation.¹² They similarly have external factors that can affect the nature of the work being done and any progress made.

10. A needs assessment study was done of existing Civil Practice Clinic students in 2011 to not only show the gap in legal skills education but also to provide the foundation for obtaining a grant to make the clinic interdisciplinary. A grant was awarded and the clinic made interdisciplinary in the spring of 2012. This study was done by both Professor Carrie Hagan at the Indiana University Robert H. McKinney School of Law and Professor Stephanie Boys at the Indiana University School of Social Work. Carrie A. Hagan & Stephanie Boys, Study, *Needs Assessment of Civil Practice Clinic Students*, 2011 (on file with authors).

11. *Id.* (Surveys are on file with the authors). Another student, when asked the same question, stated that they felt social work skills would be helpful as “we’re going to work with people, we need to know how to do it well.” *Id.*

12. Boys, Hagan & Volland, *supra* note 8.

Should one still not see the connection or importance, it is important to remember that working with clients presents multiple challenges no matter what the context and that representation generally necessitates a challenge of establishing a bond of trust and helping someone who is operating under substantial stress.

However, the differences in the approach each respective profession takes towards their clients and their problems are meaningful. Social workers pursue social change, most often on behalf of vulnerable and oppressed individuals and groups of people.¹³ Social workers also strive to ensure all people have access to needed information, services, resources through equality of opportunity and meaningful participation in decision-making.¹⁴ Social workers achieve these goals by employing multiple theories that guide interventions utilized by practitioners.¹⁵ Lawyers fundamentally have these same goals and objectives, but go about achieving them in different ways. There is less of a focus on wraparound services in the legal world, and the needs of the client are most often framed only legally, rather than holistically.

Wraparound services (otherwise known as holistic services) generally means client services that address more than just the issue a client comes to a service provider for. Wraparound services aim to address a range of needs rather than a singular need by looking at the client's individual needs and developing a plan based on those client circumstances.¹⁶ In other words, wraparound services is not a one-size fits all. In the legal world a client may need help with a singular legal issue, but during the course of the relationship, might mention a small claims case, issues with homelessness, a denial of food stamp benefits, etc. Rather than ignoring those issues, as they might not directly pertain to the legal issue, a

13. Jane Aiken & Stephen Wizner, *Law as Social Work*, 11 WASH. U.J.L. & POL'Y 63, 65 (2003).

14. Brigid Coleman, *Lawyers Who are Social Workers: How to Effectively Combine Two Different Disciplines to Better Serve Clients*, 7 WASH. U.J.L. & POL'Y 131, 134-35 (2001).

15. LENA DOMINELLI, *INTRODUCING SOCIAL WORK* 10 (1st ed. 2009).

16. The National Wraparound Initiative, a group focused on providing guidance on wraparound services for providers of children, youth and families, *Spending Money in All the Wrong Places: Jail and Prisons*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nwi.pdx.edu/wraparoundbasics.shtml> (last visited May 1, 2014).

wraparound service provider would explore each of those extra issues and determine appropriate sources of assistance to help the client address those as well as the legal issue.

Each discipline offers its own framework to predict or explain changes in behavior and circumstances of people.¹⁷ During schooling to become a social worker, students are taught theoretical and practical skills that provide strategies of intervention for achieving social and economic justice and for combating the cause and effect of institutionalized oppression for their specific clients.¹⁸ Similarly to the practice of social workers, lawyers work with specific clients and work towards goals of improvement through justice. The split in the professions stems from the methods by which lawyers and social workers meet and assist their clients. Social workers are taught to focus on the inherent dignity and worth of a person, while lawyers are often focused on the legal issue and the constraints it places on the situation.¹⁹ Lawyers are most inclined to immediately recognize a client's deficits, usually because those deficits are what bring them into contact with the law. Training and tools to recognize strengths as well as deficits is not generally a part of legal education.

One interesting observation about the differences in these two professions can be found in a recent survey published in the *Wall Street Journal*, which summarized a ranking by Career-Cast.com of the best and worst jobs from number one, one being the best job, to two hundred, number two hundred being the worst job.²⁰ Five criteria were used in the rankings: physical demands, work environment, income, stress, and hiring outlook. With all of our stereotypes of social work, the stress and low pay factored in, social workers are ranked forty-ninth. Lawyers fall much lower at one hundred and seventeenth. Where might an interdisciplinary

17. *Id.*

18. Aiken & Wizner, *supra* note 13, at 78.

19. CODE OF ETHIC OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, § 3.2 (1996).

20. *Best and Worst Jobs of 2013*, WALL STREET J., <http://online.wsj.com/news/articles/SB10001424127887324874204578439154095008558> (last visited May 1, 2014) (ranking 200 jobs from best to worst based on five criteria: physical demands, work environment, income, stress, and hiring outlook. The firm primarily used data from the Bureau of Labor Statistics and other government agencies).

lawyer fall in the rankings? The authors of this Essay propose that by using the interpersonal and analytical tools that social work gives us, the ranking of an interdisciplinary lawyer would at least rise well into the top one hundred, as they would not only be able to complete the legal tasks they were responsible for but could better connect and identify with clients, reducing stress on both of their parts.

There are significant hurdles for lawyers working with individual clients on an interpersonal level. This is partly due to the idea lawyers have about success, which may only be achieved by winning a case. Regardless of any effort on the lawyer's part, at times there may be little change in circumstance for the client. Additionally, lawyers often ignore both obvious and concealed emotions when meeting with a client, much to their frustration, which erects barriers between clients and lawyers. Working with clients who have a serious mental illness adds another layer of difficulty for students. More often than not, these clients come into contact with the criminal justice system because their symptoms are not being managed,²¹ and students must be able to work with clients in light of these behaviors.

A. *Revisiting the Meeting*

To illustrate how these professions work together, the authors return to the previous scenario involving Shay and Emma. Shay watches as Emma sits to the side of the client, careful not to invade his boundaries. Emma speaks to him in a calm and reassuring manner, and refers to him not by the name he is charged under, Matthew, but rather by the name he has chosen for himself, Abba. Emma engages Abba in a conversation about his well being in confinement, not mentioning his criminal charges. Abba responds to the worker, who acknowledges his perception of himself and his role in the courtroom. She affirms his belief that he is a prophet and does not label his behavior as crazy or aberrant as others have

21. The National Alliance on Mental Illness, *Spending Money in All the Wrong Places: Jails and Prisons*, NAMI, <http://www.nami.org/Template.cfm?Section=FactSheets&Template=/ContentManagement/ContentDisplay.cfm&ContentID=14593> (last visited May 1, 2014) (documenting the lack of treatment these individuals receive while incarcerated and offers various statistics on the percentages of mentally ill individuals in the criminal justice system).

done before. As they discuss his situation, Emma is able to discern that he has a caseworker at a community mental health services agency. Emma receives permission from Abba to reach out to his caseworker to discuss his situation.

Shay and Emma leave the courtroom to contact Matthew's caseworker. The caseworker informs them that Matthew is indeed a client at their agency, and that they provide him with services, including psychiatric services, housing and counseling. The caseworker agrees to come to the courtroom to speak with the judge about releasing the client and provides assurances to the court that Abba will return for his future court dates. The agency agrees to maintain contact with Abba and to encourage him to consider the use of medication to control his symptoms. Given these assurances, the judge releases Abba on his own recognizance.²² Shay is then able to stay on to assist Abba with his future legal needs, and Emma continues to provide support and services assessment. Through partnership and dual involvement, both Shay and Emma learn from each other and assist the client in more than just their limited individual capacity.

B. *Context and Theory*

1. Therapeutic Jurisprudence

The concept of integrating social work theory and skills into legal representation as a method to improve client outcomes is certainly not novel. The Therapeutic Jurisprudence (hereinafter referred to as TJ) movement, with its roots in the late 1980s, advocates for the inclusion of social science theory into legal representation. This movement focuses on the psychological impact of the law and its processes on the client who interacts with the judicial system.²³ The Therapeutic Jurisprudence model, widely attributed

22. This scenario is repeated weekly by the lawyers and the social workers at the Saint Louis University Criminal Defense Clinic. The clinic provides legal and social services to persons with serious mental illness who have become involved in the criminal justice system.

23. David B. Wexler, *Two Decades of Therapeutic Jurisprudence*, 24 *TOURO L. REV.* 17, 20 (2008).

to the works of David B. Wexler and Bruce J. Winnick,²⁴ advocates for expanding the role of the lawyer from a mere expert in legal matters into a therapeutic agent who can promote the well-being of the client. By explicitly considering the psychological needs of the client, and seeking holistic and preventive solutions to the client's legal problems, the TJ approach values the process of legal decision making as well as the outcome. It encourages lawyers to practice with an ethic of care.²⁵

The lawyer's role under the TJ model becomes one that necessarily draws on the teachings of other disciplines in order to craft effective and creative solutions to client problems. Winnick and Wexler advise that the competent lawyer incorporate teachings from the areas of psychology and social work, among others, for a fuller range of skills from which to craft long lasting solutions. Primary among the many advocacy skills promoted by Wexler and Winnick are those that lend themselves to more effective client counseling.²⁶

Although the TJ model can be applied broadly to a number of areas of legal practice, it is interesting to note that its genesis was in mental health law.²⁷ It has since been expanded and devel-

24. See Wexler, *supra* note 23; David B. Wexler, *An Orientation to Therapeutic Jurisprudence*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT 259, 259 (1993–94) (providing a thoughtful discussion of the history and impact of the TJ movement in the United States).

25. The term “ethic of care” is one that defies an easy and consistent explanation. See Susan Daicoff, *Lawyer, Be Thyself: An Empirical Investigation of the Relationship between the Ethic of Care, the Feeling of Decisionmaking Preference, and Lawyer Wellbeing*, 16 VA. J. SOC. POL'Y & L. 87, 87 (2008–09) (providing a fuller discussion of this evasive concept).

26. For example, the authors suggest two important practices for the legal clinic teacher to incorporate into the clinical setting: the “psycholegal soft spot” and the rewinding exercise. The psycholegal soft spot refers to those areas of an attorney/client relationship or the legal process that are likely to induce a negative reaction from the client. The authors encourage law professors to work with the student to identify these potential points of contention and strategies for dealing with them. The rewinding exercise allows the student to consider the outcomes of their client counseling session and how to improve in future performances. See Bruce J. Winnick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605, 605–32 (2006). *Id.* at 610–11.

27. Wexler, *supra* note 23, at 21. A seminal publication by Wexler in 1992 discussed the need for a new lens for new model of jurisprudence that

oped in the realm of criminal defense practice. In promoting the use of therapeutic jurisprudence in criminal matters, the Winnick and Wexler emphasize the dynamic role that client stresses play in the resolution of a criminal matter.²⁸ The criminal defendant brings a number of significant concerns to the attorney/client relationship. Not only is the client facing a loss of liberty and the host of civil sanctions accompanying a criminal conviction, he or she often suffers from poverty, lack of community, and personal support. Adding a mental illness into this pool of concerns often produces an attorney-client relationship with a host of potential sources of tension.

2. The Comprehensive Law Movement

Susan Daicoff crafted a similar platform from which to approach a more humanistic methodology of lawyering. The Comprehensive Law Movement, first defined by Daicoff in 2000 as “a movement towards law as a healing profession.”²⁹ According to Daicoff, the Comprehensive Law Movement is a collection of many modern legal innovations that have as their core two specific similarities: the recognition of law as a healing agent and the integration of extralegal factors into the process of lawyering and client representation.³⁰ The advances that Daicoff includes in this definition include not only the Therapeutic Jurisprudence model but also those movements that she describes as the “vectors” or

balanced the needs of the clients with the interests of justice. David B. Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 *LAW & HUM. BEHAV.* 27, 27–38 (1992). The authors would be remiss not to include the contributions of Michael Perlin, who is quite probably the most prolific author of academic literature on mental health law and the Therapeutic Jurisprudence movement. *See, e.g.*, Michael L. Perlin, *Too Stubborn To Ever Be Governed By Enforced Insanity”: Some Therapeutic Jurisprudence Dilemmas in the Representation of Criminal Defendants in Incompetency and Insanity Cases*, 33 *INT’L J. L. & PSYCHIATRY* 475 (2010); Michael L. Perlin, Keri Gould & Deborah Dorfman, *Therapeutic Jurisprudence and the Civil Rights of Institutionalized Mentally Disabled Persons: Hopeless Oxymoron or Redemptive Strategy?*, 1 *PSYCHOL. PUB. POL’Y & L.* 80–119 (1995).

28. *See* Winnick & Wexler, *supra* note 26, at 610

29. Susan Daicoff, *Law as a Healing Profession: The Comprehensive Law Movement*, 6 *PEPP. DISP. RESOL. L.J.* 1, 1 (2006), available at <http://ssrn.com/abstract=875449>.

30. *Id.* at 3–4.

lenses of the Comprehensive Law Movement: preventive law, procedural justice, creative problem solving, holistic justice, collaborative law, transformative mediation, problem restorative justice, and problem solving courts.³¹

Daicoff gives special consideration to the plight of the law student in her article *Law as A Healing Profession: The Comprehensive Law Movement*.³² Daicoff decries the typical model of lawyering as taught in most law schools with its emphasis on the importance of individual rights, standards and legal rules.³³ This emphasis on normative, rather than personal, ideals moves the student away from an acknowledgment of the human aspects of client representation towards a focus strictly on the legal problem in isolation. This focus necessarily detracts from the important work law students will someday do as peacemakers and healers. She instead advocates, like Winnick and Wexler, for law schools to focus on the ethic of care owed by future lawyers to their future clients.³⁴ Daicoff advocates for the inclusion of creative problem solving skills in the law school curriculum, which necessarily include the integration of the social sciences research and theory.³⁵

3. Relationship-Centered Lawyering

Most recently, Susan Brooks made significant contributions to the TJ literature with her discussion of the role of social work theory and practice in the legal workplace.³⁶ Her model of Relationship-Centered Lawyering,³⁷ with its discussion of the applica-

31. *Id.*

32. *Id.*

33. *Id.* at 6.

34. *Id.* at 6 (*citing* CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* 24–39 (Harvard Univ. Press 1993)).

35. *Id.* at 22–23.

36. SUSAN L. BROOKS & ROBERT G. MADDEN, *RELATIONSHIP-CENTERED LAWYERING: SOCIAL SCIENCE THEORY FOR TRANSFORMING LEGAL PRACTICE* (Carolina Acad. Press 2010).

37. Neither Brooks nor these authors claim that Brooks originated the idea of introducing social work theory into the TJ movement. Rather, Brooks' work is highlighted along with that of frequent co-authors Robert G. Madden and David M. Boulding because it provides specific instruction for integrating social work theory and practice into the law clinic curriculum. *See also*

tion of social work skills for the more effective and long-lasting resolution of client problems, provides the legal practitioner with exciting new tools for practice. The crux of the successful resolution of client problems, according to Brooks, is the formation of a sincere, honest and mutually beneficial relationship between the lawyer and the client. This emphasis on creating a situation of trust and care between the participants in a working relationship that is at once both functional and genuine.

Brooks has written extensively on the topic of introducing social work skills into the law school curriculum for the betterment of our students.³⁸ She promotes the idea of integrating not only best practices in social work into the law school paradigm, but the theories behind effective social work practice.³⁹ Although noting that students cannot achieve the professional prowess of a mental health worker during the law school experience,⁴⁰ Brooks nonetheless encourages law professors to expose students to basic social work strategies and theories.⁴¹

Brooks' most significant contribution to the area of TJ is her model of Relationship-Centered Lawyering. This model, created with co-author Robert G. Madden, promotes the idea that lawyers can and should provide optimum, or at least enhanced, repre-

Robert G. Madden & Raymie H. Wayne, *Constructing a Normative Framework for Therapeutic Jurisprudence Using Social Work Principles as a Model*, 18 *TOURO L. REV.* 487, 487 (2002).

38. Susan L. Brooks, *Practicing (And Teaching) Therapeutic Jurisprudence: Importing Social Work Principles and Techniques into Clinical Legal Education*, 17 *ST. THOMAS L. REV.* 513, 513–30 (2005).

39. BROOKS & MADDEN, *supra* note 36, at 22, 26 (citing Robert G. Madden, *From Theory to Practice: A Family Systems Approach to the Law*, 30 *T. JEFFERSON L. REV.* 429, 431 (2008)).

40. According to Brooks and Madden, the use of family systems theory in client representation can lead to better long-term outcomes in certain situations. BROOKS & MADDEN, *supra* note 36. Lawyers who incorporate a family system perspective can achieve six competencies: understanding context, using the skills of collaboration, practicing in ways consistent with cultural competency, maintaining effective relationships, engaging in multidisciplinary practice and practicing with an ethic of care. *Id.* Likewise, Brooks and Madden cite the strengths perspective and the concomitant resilience theory as two other social work theories that can enhance a person's experience both delivering and receiving legal services. *Id.*

41. BROOKS & MADDEN, *supra* note 36.

sentation to clients through the integration of social science into legal practice and knowledge base.⁴² Brooks and Madden identify the three central elements of Relationship Centered Lawyering as “(1) substantive social science perspectives representing ‘contextualized’ approaches to human development; (2) process-oriented perspectives focusing on justice as well as effectiveness; and (3) affective and interpersonal perspectives including cultural competence and emotional intelligence.”⁴³ Referring to Susan Daicoff and the Comprehensive Law Movement, the authors endorse an approach to representation that goes beyond the mere resolution of the client’s legal problems but also seeks to incite a deeper, more lasting response in the person being represented. The lawyer in this scenario is seen as an agent of change, one who can impact the long-range success of the client by engaging them not only legally but systemically as well.⁴⁴

Brooks makes an especially good case for the incorporation of relational lawyering in her article written with David A. Boulding, *Trying Differently: A Relationship-Centered Approach to Representing Clients with Cognitive Challenges*. In that article, the authors advocate for the induction of social works practices into legal representation in order to achieve the best possible outcome for a client with cognitive limitations. Such clients, Brooks and Boulding argue, require an attorney to go beyond the normal goals of legal representation to ensure continued success for the client outside of the criminal justice system. They note the need to integrate both system and empowerment approaches⁴⁵ into the representation of the cognitively limited client in order to ensure that the client is able to disengage from the behaviors that resulted in entanglement with the criminal justice system.⁴⁶

42. *Id.*

43. David M. Boulding & Susan Brooks, *Trying Differently: A Relationship-Centered Approach to Representing Clients With Cognitive Challenges*, 33 INT’L J.L. & PSYCHIATRY, 448–62 (2010).

44. *Id.*

45. BROOKS & MADDEN, *supra* note 36.

46. Boulding & Brooks, *supra* note 43, at 71. Brooks and Boulding discuss the utilization of an “external brain” to assist the client in successfully navigating the criminal justice system. This external brain is described as:

a committee of good hearted, skilled, caring people who stand in as volunteers to supervise the individual with FA/NB who

Brooks' and Boulding's discussion of the importance of relationship centered interviewing is especially relevant to a discussion about representing persons with mental health issues in criminal and family courts. They promote the process of building a relationship with a client as the primary motivator and fact finding as a secondary consideration.⁴⁷ This approach, known in the social work milieu as "meeting the client where they are," emphasizes the need for persons with mental limitations to be understood in context. Instead of interrogating a client in order to elicit only those facts necessary for legal representation, Brooks and Boulding promote the idea of focusing on those factors that caused the client to offend in the first place.⁴⁸ This approach requires, among other things, that a lawyer more fully investigate a client's situation in the community, the presence or lack of a support system and any physical or mental health factors that impact a client's well-being. Only by seeking to understand the client's impression of his place in the world can a lawyer promote lasting solutions to a client's problems.

C. Introduction to Strengths Perspective

In social work, there are multiple theories that guide the interventions utilized by practitioners. Each offers its own framework to predict, explain, or change behavior and circumstances. Two prominent social work theories and approaches that have been identified by the authors of this article as fortifying the core competency of their law students are Strengths Perspective and Systems Theory. Ultimately, Strengths Perspective dominates social work pedagogy and discussion. Strengths Perspective approaches

is committing the stupid crimes. This committee stands in and *functionally* replaces the missing brain cells and behaviors. For lawyers, it means making sure that someone takes responsibility for getting clients with FA/NB to probation on time, monitoring their friends, helping them observe curfews, helping them shop, getting them to job interviews, and regularly checking in on them. It also means explaining all about FA/NB to employers and helping them implement structures for success in the workplace.

Id.

47. *Id.* at 49.

48. *Id.* at 53.

clients through the light of their “capacities, talents, competencies, possibilities, visions, values and hopes.”⁴⁹ The major focus of practice in the Strengths Perspective is the collaboration and partnership between social worker and client. Focusing on the strengths of the client and their situations shows the client that he or she is more powerful and in control of his or her situation than might appear at first glance. This perspective empowers the individual and gives them a stronger degree of participation in the legal and social process.

The purpose of the Strengths Perspective is not to ignore the deficits that clients bring to us, but to encourage the professional to make a concerted effort to identify the strengths and assets that clients also bring to the table. Once identified, client strengths can be built upon to assist in addressing problems. This perspective also acknowledges that clients have their own strengths and resiliencies that can be used to address issues they identify now, as well as in the future, when assistance might not be available.⁵⁰ By utilizing this approach, the deterministic rationale that because someone has experienced trauma, he or she cannot escape being a victim is removed from the equation. According to Saleeby, “Strength perspective denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might be.”⁵¹

The Strengths Perspective can be extremely useful in legal representation. Discovering and acknowledging a client’s strengths can be used in a legal scenario to the benefit of our clients. For example, in criminal defense setting, judges and prosecutors are more receptive to outcomes that benefit clients when they can see the strengths the client possesses and can be assured that those strengths are being enhanced. Letting the court know that “given

49. Dennis Saleeby, *The Strengths Perspective in Social Work Practice: Extensions and Cautions*, 41 J. SOC. WORK 296, 296–305 (1996).

50. Theresa J. Early & Linnea F. GlenMaye, *Valuing Families: Social Work Practice with Families from a Strengths Perspective*, 45 J. SOC. WORK 118 (2001); B. Bernard, Presentation at the Applications of Resilience Conference in Washington, D.C. (Dec. 2011) (presenting on the role of resilience in drug abuse, alcohol abuse and mental illness).

51. Dennis Saleeby, *Power in The People: Strengths and Hope*, 1 ADVANCES IN SOC. WORK 127, 127 (2000).

the difficulties they have, and the known resources available, people are often doing amazingly well—the best they can at the time”⁵² can give the court more reason to understand the defense’s argument for less stringent sentencing measures.

Likewise, implementation of the Strengths Perspective is useful in developing strong attorney-client relationships. Given how deeply the deficit/pathology knowledge base is ingrained in our way of thinking, the Strengths Perspective often involves quite a large paradigm shift for students and practitioners. It is easy, after a relatively short time in practice, to feel that we best understand a client’s issues and to replace the client’s narrative with one of our own making, one that better fits the expert/client scenario dominating law practice philosophy. In many interactions, we consider ourselves the experts in our client’s life. However, the Strengths Perspective reminds us that the client is the expert when it comes to understanding and appreciating his or her own life. While this is obviously not the case in matters of legal strategy or process, it is certainly true in determining the outcomes the client considers most desirable.

An important corollary to the Strengths Perspective is the notion of resiliency. In social work as well as law, practitioners consistently find themselves working with people that have faced seemingly insurmountable challenges with scarce resources and virtually no emotional support. Yet, particularly when utilizing strength-based models, we see these clients using creative solutions to get their needs met and persevering through situations that others with more obvious assets could not handle. This ability to persevere through extreme difficulty is known in the social work literature as resiliency.

Social work theory uses the concepts of “risk factors” and “protective factors” to better understand how this resiliency can be nurtured in clients. Little research has been conducted on resiliency theory due to the difficulty of measuring and defining the concept. There is consensus that resiliency can be understood as “successful functioning in the context of high risk,” however it is useful for lawyers and social workers to also view it as a client’s ability to function at all in the context of high risk, as the definition of “suc-

52. *Id.*

successful functioning.”⁵³ The ability to navigate high-risk situations looks much different from the perceived definition of “successful functioning.”⁵⁴

Risk factors are considered correlates and causes of negative behaviors, attitudes, and conditions.⁵⁵ Examples of risk factors include poverty and absence of support systems. Protective factors are considered to be those that “predict future outcomes through their ability to moderate, mediate, or compensate for risk.”⁵⁶ These factors can either prevent future risk or help buffer the negative effects of current risk.

What can be most difficult about utilizing this framework is discovering the resiliencies within clients. Often, the resiliencies are hidden, because those characteristics that help a client to be successful in high-risk situations typically do not conform to the behaviors society expects from its members. For example, many clients with Borderline Personality disorder may show attachment issues and display manipulative behavior.⁵⁷ While neither is conducive to forming healthy relationships, they both can serve a resilient purpose. Manipulation may just be another tool to have their needs met, whether it is in terms of physical resources or emotional support. Low levels of attachment and connection to others can be a coping mechanism developed from years of trauma.

Implementing the Strengths Perspective into practice is also critical in dissolving the power differential that is often frustrating for clients working with lawyers. By meeting clients where they are, lawyers empower them to participate successfully in the justice system by being an expert on their own lives. The lawyer implementing the Strengths Perspective model will be able to understand the multitude of issues that the client may be facing outside the realm of the legal issues. The lawyers will treat the client holis-

53. Mark W. Fraser et al., *Risk, Protection, and Resilience: Toward a Conceptual Framework for Social Work Practice*, 23 SOC. WORK RES. 131, 131-43 (1999).

54. *Id.*

55. *Id.*

56. *Id.*

57. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

tically, and focus on solutions that serve each of the client's social, economic, and cultural needs in addition to legal needs.

D. Resources, Opportunities, Possibilities, Exceptions and Solutions

Another useful social work tool for helping students understand and appreciate a client's situation is the ROPES method. ROPES is an acronym for a practice that is used by social work practitioners to help them more easily identify a client's strengths. ROPES stands for Resources, Opportunities, Possibilities, Exceptions and Solutions. It acknowledges that the challenge for social workers, as well as lawyers, in using the strengths perspective is that there is often little understanding or acceptance of the client's situation. By utilizing the ROPES method, law students can uncover and utilize a client's strengths in their legal practice. The following chart is a tool for conducting a strengths assessment using ROPES:

Identifying Strengths: Use the ROPES⁵⁸

<u>R</u>esources:	<i>What resources are available to the client?</i> Personal Family Social environment Organizational Community
<u>O</u>ptions:	<i>What options do the clients have?</i> Present focus Emphasis on choice What can be accessed now? What is available and hasn't been tried or utilized?
<u>P</u>ossibilities:	<i>Although they may not possess it now, what is possible for the client?</i>

58. See Clay Graybeal, *Strengths-Based Social Work Assessment: Transforming the Dominant Paradigm*, 82 FAMILIES IN SOC'Y: J. CONTEMP. HUM. SERVS. 233, 233 (2011).

	Future focus
	Imagination
	Creativity
	Vision of the future
	What have you thought of trying but haven't tried yet?
<u>Exceptions:</u>	<i>What exceptions to the client's problems are there?</i> When is the problem not happening?
	When is part of the hypothetical future solution occurring?
	How have you survived, endured, thrived?
<u>Solutions:</u>	<i>How has the client solved the problem so far?</i>
	Focus on constructing solutions, not solving problems
	What's working now?
	What are your successes?
	What are you doing that you would like to continue doing?

The main benefit of ROPES is that it can be easily understood and applied to a variety of client situations. Students can use this fairly self-explanatory chart when interviewing clients. Note how it requires the student to discuss a client's perceived and actual strengths as well as the resources available to the client now and in the future. The client is asked to envision a future where their needs are being met and in doing so becomes an active partner in the problem solving process. This chart will assist the law student in conducting motivational interviewing, another tool of social work practice that is useful in creating positive client-lawyer interpersonal relationships.

E. *Application of Theories*

Let's go back to the situation with Shay. After getting to know Matthew, on the surface there appears to be hopelessness: he is homeless, does not have a full-time job, has been diagnosed with a mental illness and cannot afford his medicine, and is still facing charges for a crime that could either land him in jail or put him on probation with hefty court costs that he would be unable to pay. Rather than trapping ourselves in Matthew's deficits, when lawyers use a strengths-based perspective, lawyers and law students

find many personal assets upon which we can build a successful outcome. Matthew, although being homeless, has somehow managed to hold onto a part-time job for three years. This proves Matthew is capable of being responsible, reliable, hardworking, and a contributing member of the community. Matthew has also managed to stay safe during his six months of homelessness, a feat that is troublingly difficult to manage in a large urban area. Although his criminal charge is certainly a risk factor, it is worth noting that this is a first charge, indicating that when given the right supports, Matthew can independently take care of himself and operate safely in society. In using this perspective, Matthew's resiliency is highlighted, and his risk factors become strengths, all of which secure him different options in the long run, and allows for more creative assistance to be individually tailored to Matthew's individual needs.

As discussed previously, the low level of self-satisfaction among lawyers reinforces the need to move from a model where students feel obligated to fix clients and towards a model where students empower clients to fix themselves. Not only is it impossible to change the behavior of another person or to fix all the deficits lawyers perceive them to have, it also robs the client of his or her power to affect the change themselves and contributes to his or her feelings of powerlessness and hopelessness. By empowering the client to create his or her own solutions, lawyers transfer our power to them. This transfer of power does two things. It relieves the law student of the overwhelming burden of trying to fix another human being, with all the stress and frustration that necessarily accompanies such a commitment, while also acknowledging the potency of the client. This in turn empowers the client to become her own advocate and source of strength.

F. Introduction to Systems Theory

A second pillar of social work theory that has both clinical and legal implications is Systems Theory. Systems Theory understands the world to be a group of systems (such as family, religion, work, school, legal) in which all people operate and interact. These systems influence people and in turn, people influence the systems, creating a feedback loop that can have positive or negative consequences. Simply stated, the whole is greater than the sum of its parts. On the surface, individual systems may seem to have little

influence on a person's life. However, when one examines how all these influences are compounded upon each other, it's easy to understand the role each system plays.

The duty of the social worker is to organize the interactions between different parts of the system to facilitate positive outcomes for people. There are three levels of system groups: micro, mezzo, and macro. Micro systems are small systems in which most people operate, such as their biological system, psychological system, and family systems. Mezzo systems consist of larger group systems, such as someone's neighborhood, school, church, or workplace. Macro systems are large systems such as culture, laws, and government programs. A sample of what this looks like can be seen below:

SYSTEM LEVELS

Micro Systems

Mezzo Systems

Interpersonal Relationships

School

Family

Church

The

The Individual (health systems)

Workplace

The Individual (psychological systems)

Neighborhood

Macro Systems

Cultural Environment

Laws

Government Programs

Religion

The authors propose that the most effective way to implement these thinking tools is to integrate them into law students' legal training before they join the legal community as practicing attorneys. As lawyers, achievements might be recognized without a clearer idea of the range of positive impact, no matter how small, lawyers can have on client circumstances. As lawyers are not traditionally trained in incorporating theory-based interpersonal skills into representation, lawyers need to be able to think creatively as

how others implement this skill, and do it well. Lawyers also need to be able to recognize the positive impact that we can have on our clients' circumstances in order to find our work fulfilling.

Integrating System Theory into the law school curriculum will greatly improve a law student's problem-solving abilities. It is said that to a surgeon, all solutions point to surgery. So to a law student all presenting problems appear to be legal. They flock to the usual legal remedies for problem solving such as litigation, estoppel, or plea bargaining. The actual answer to the problem may, however, be more relational than legal. By failing to acknowledge the extrajudicial solutions available to legal clients, as well as the social science behind them, law schools deprive both the student and their future clients of the opportunity to achieve the best possible results. As educators, we owe our students the full range of experiential and theoretical education in order to provide them with a toolbox full of resources.

As discussed above, Systems Theory suggests that no legal client exists in a vacuum.⁵⁹ Rather, clients are part of a unique and dynamic system of interrelationships that create the client's reality and worldview. Because the system creates the world in which the client functions, successfully or unsuccessfully, to fully understand a client's situation the lawyer must understand the relational aspects of the client's reality. What may appear at first glance to be a legal problem may in fact be the result of a serious dysfunction in the client's relational sphere. For example, a client who has become entangled in the family justice system may appear to have a legal problem in that they have been accused of child neglect. Upon closer examination of the issue, however, the real problem may be an inability to access the financial means of supporting the child because of a breakdown in the family system at the mezzo level. Similarly, a criminal problem may be due to an inability to access the mental health system.

The primary tool for demonstrating systems theory in social work is the systems map. By creating a systems' map, the social worker plots out the various systems that affect, and are affected by the client. Some of the systems are intimate to the client, family relations, for instance. Other systems are larger, such as the Medicaid system or the client's religious affiliation. These systems in-

59. Saleeby, *supra* note 52.

teract not only with the client but also with each other. By creating and studying the map, law students will become aware of the web of micro, mezzo and macro relationships in which the client dwells. This exercise is particularly helpful when discussing the concept of holistic legal services. By utilizing the map, the students can begin to understand the various interrelated systems that the client must navigate in order to successfully solve their problems. Resolving only the legal problem is a valid yet unsatisfying solution; the client risks reentry into the judicial system because the root dysfunction remains unresolved. The student who creates a system map with the client can trace the source or sources of the dysfunction and work to resolve the issues underlying the legal problems.

Let's return again to the client Matthew. Systems Theory was used as a way to distinguish which systems Matthew was interacting with that could be helpful in facilitating his immediate release. The client did not immediately note any family members (micro system) that could provide him with stable housing. Matthew also did not seem to be able to access the medication he needed (macro system), did not have a job providing him with income (mezzo system) and was being confined by the state (macro system). To his advantage however, Matthew did have a caseworker at a local community mental health organization (mezzo system), who could connect him to government housing and medication programs (macro system).

By identifying the gaps in the systems that Matthew interacts within, the student lawyer can begin to map out a plan for action. Shay, the law student, seeks to identify systems that are positively interacting with Matthew, which can be optimized, and systems that are negatively impacting his circumstances and ways in which to address those systems. Emma now has a starting plan of action. She can begin to address housing, medication, and vocational rehabilitation needs.

By addressing these concerns, Emma is able to impact the systems that are causing Matthew's interaction with the criminal justice system, leading to better judicial outcomes for Matthew as their client and more long-term successes for him as someone struggling within systems that are working against him.

III. IMPLEMENTATION IN A LAW SCHOOL SETTING

While an obvious answer may be to integrate mental health training into the law school curriculum, this is not a solution likely to be implemented on a widespread level. In a time when law schools struggle to reconfigure their curriculum to meet both the demands of reduced enrollment and criticism from the private bar, it is naive to expect that law schools will add courses designed to help lawyers recognize and represent persons with mental health deficits. Additionally, there are generations of lawyers currently practicing criminal defense who have no training in mental health. The question becomes this: given these deficits, how do we improve the quality of representation of mentally ill and mentally disabled defendants within the current system?

One way to do this is by incorporating the social work training as outlined above into existing clinical law programs. This training furthers the authors' main premise that teaching law students basic principles of social work theory as well as ways in which to integrate the practices which flow from these principles will provide future lawyers with skills imperative to practice with mentally disabled clients.

A second option is the creation of continuing legal education seminars for practicing attorneys that brings awareness and training to address these issues for those that are already licensed. This avenue will not only allow for dissemination of these ideas on a much larger level, but it will impart knowledge to individuals that may not have been exposed to this sort of thinking before, and who may have already been working with mentally ill clients.

A third option is to partner with local agencies and non-profits that focus on these clients/issues, and create impact projects to address those issues in surrounding communities. Examples of impact projects might be collecting data on what services are available/unavailable and making recommendations on improvements; creating legal fact sheets about common scenarios facing these individuals and legal options/resources available to them; or developing resource sheets that can be made available to the local bar should attorneys come into contact with mentally ill clients and not know where to refer them. All of these impact projects can easily be accomplished through a law and social work interdisciplinary partnership, as both sets of individuals can contribute their pedagogical knowledge and skills in a combined effort.

A guide to implementation at the law school level might be as follows: during pre-semester orientation or beginning classes, training on mental illness (overview of common conditions; defining mental illness; examples of past clients; specific interviewing/counseling skills relative to these individuals; techniques grounded in theories from both disciplines on combating client behavior; etc.) should be incorporated or used as a main focus depending on the clients students will be working with. Past clients, issues, and resolution of difficult situations are a good place to start deriving this initial framework from.

Second, making ongoing reflection and discussion about the work that is going on and how issues are being dealt with encourages students to support each other as peers, as well as obtain feedback from supervisors about strategies going forward.

Third, having concrete office policies in place to assist with certain identifiable issues as they occur can help ease any confusion about what steps to take should an issue arise. One example might be if a client comes in heavily intoxicated, how should the student handle that situation and are there recommended steps that should be taken? Another might be if a client has any sort of psychotic episode while at the office, how should the student handle that situation, whom might they call for assistance, and are there any recommended steps that should be taken?

Fourth, when working with this series of clients, conversations about the definition and re-definition of what success means are important. Many times law students view success as engaging in litigation, oral argument, or negotiating a case. Sometimes these clients do not need to go that far to improve their situation, and success might just be connecting them with resources, taking small actions outside of court on their behalf, even just giving them someone to talk to. By reorienting our view of what success looks like, representation can be more meaningful for the client and the student, and existing mental or emotional issues don't have to stand in the way of what is perceived as a victory.

Last, feedback from the students should be obtained at the beginning and end of the semester to assess their knowledge and comfort level with these clients and issues at the beginning, as well as whether the training and guidance provided gave them enough resources to work with the clients throughout the semester. Other helpful questions might be to ask what training the students would recommend for the future, and what was/was not helpful. What to

ask, how to train, what to include in that training, and how to provide it all may depend on the context and clientele the students will have. Examples of how this framework operates are shown below in two specific clinical contexts, criminal and civil.

IV. CLIENT CHALLENGES IN THE CRIMINAL JUSTICE SYSTEM

Any lawyer who has practiced criminal law for even a short period of time will come into contact with a client who suffers from a mental health problem. There can be no argument that a criminal defense lawyer must possess, at minimum, a rudimentary knowledge of the symptoms and consequences of mental illness in a client. But effective representation goes beyond the ability to spot mental illness. It requires that a lawyer possess the interpersonal skills necessary to communicate with a client who has cognitive deficits or who actively suffers from a mental illness.

Persons with mental illness or cognitive deficits who become involved with the criminal justice system present a host of challenges to the criminal defense lawyer. Primary among these is the inability to interact in a meaningful way with the mentally impaired client. The genesis of this shortcoming is found in the law school curriculum. Traditionally, law schools have focused on legal doctrine and skills, leaving the instruction on mental health to those educators better acquainted with the science of the human mind.

Of course, there are those students who enter law school having completed an undergraduate degree in psychology or social work, but that number is low. The majority of lawyers for criminal defendants enter the criminal defense arena with no training on the special needs of mentally ill clients. Anecdotally, the authors of this article have observed that most lawyers lack the ability to recognize all but the most obvious symptoms of mental illness in a client. The specialized interviewing and counseling techniques that are proven to be most effective in advising the person with mental illness escape the grasp of the typical attorney. Even fewer attorneys possess the ability to access the supportive services and mental health treatment necessary to ensure a client's recovery.

The Saint Louis University School (SLU) of Law Criminal Defense Clinic represents those persons whose serious mental illness has caused them to interact with the criminal justice system. Students in the SLU Criminal Defense Clinic not only work in tan-

dem with social workers but receive instruction on social work theory and practice along with the typical lessons on legal practice. This instruction is done formally in the classroom as well as informally during the practice of representing clients during the semester. Using an interdisciplinary educational model, the clinic is co-taught by both a clinical law professor and a mental health social worker. Although the law professor must by necessity be the primary supervisor in this scenario, the MSW social worker interacts with both the law students and the clients in order to ensure the best possible outcome for both groups.

The SLU Criminal Defense Clinic students are taught to integrate both strengths and systems theories into their representational skill set. Students are taught to consider the client within the systems they inhabit: the family system, the judicial system and the community system, among others. For instance, students become familiar with the client's family and significant others during the course of representation. Students also meet with caseworkers from community agencies to get their input on a client's progress. By teaching students how to place a client's legal situation in a context that makes meaningful reference to the other parts of his or her life, law students can begin to see the interconnectedness and interplay of the factors that will lead to successful resolution of the legal case. This also allows for a discussion of future consequences and options for the client that is more easily comprehended than the typical limited discussion of legal issues and consequences. Rather, this analysis serves to mitigate the limited level of sophistication of most clients, who are often prevented from fully appreciating the legal consequences of their situation because of their limited cognitive abilities. By problem solving with the client, rather than for the client, the law student can truly achieve the client-centered representation that we expect them to model but sometimes fall short of teaching them to apply.

A. Motivational Interviewing

One social work practice that has proven to be especially effective in implementing a systems approach with clients is motivational interviewing. For example, the SLU Criminal Defense Clinic integrated instruction on a third theory, that being motivational interviewing, into the classroom component of the course. One session, two hours in length, is conducted by the MSW level

social worker employed by the Clinic as a mental health practitioner. During that session, the social worker makes the class aware of the basics of motivational interviewing and role plays an interview for the students to observe. Motivational interviewing allows law students to assist clients in discussing and realizing goals for their future. For example, a typical motivational interview with a client would begin with the student inquiring of the client where they would like to see themselves in the future, either short term or long term. Often, the answer is “in my own apartment” or “holding a job.” Certainly these are not “legal” goals one would associate with criminal defense representation. But in order for the client to become motivated to participate successfully in whatever tasks must be accomplished to resolve their criminal case, they must be able to see the utility in complying with the demands of the court or the probation officer. One might imagine that the goal of “not going to jail” would be motivation enough. However, in our experience with seriously mentally ill clients, the future repercussions of non-compliance are difficult for the client to comprehend. Instead, we focus on those goals that the client has identified as being important to them.

Once the student attorney has established the nature of the client’s goals, they then ask how, in the client’s mind, those goals can be achieved. Although the client is encouraged to create the steps necessary to achieve their goals, one important step in the process is always the resolution of the criminal matter. For example, the client who wishes to have a job must first resolve the criminal matter in a way that will not entail a jail sentence. The student will discuss with the client those steps that must be taken to get to a beneficial resolution of the charges. The client might need to finish community service hours or to attend meetings with his or her caseworker or probation officer in order to complete probation. Armed with the knowledge that the end result will be an opportunity for housing, our experience has been that the client willfully embraces those tasks, which will successfully resolve their criminal charges. Instead of avoiding a negative repercussion, the client reaches towards a positive goal. The student is not part of the system but a participant in the client’s success, a role that greatly enhances the attorney-client relationship as well as the possibility of success. This model also ensures that the representation is truly client centered for the client decides not only on the resolution of the case but the appropriate path to be taken to resolution.

B. Client Challenges in the Civil Court System

As outlined above, there are several challenges involved in working with clients in the criminal system, many of which are echoed in the civil system. Some differences arise out of the types of cases that are handled in the civil setting – notably family law, domestic violence, consumer, child support, environmental, etc. These cases not only contain different issues, but also affect a client differently than a criminal case (i.e. instead of facing imprisonment as in a criminal case, a client might lose parenting time with their child or be ordered to pay a higher amount of child support).

The students in the Indiana University Robert H. McKinney School of Law Civil Practice Clinic (CPC) also work with clients who present a host of mental, physical and emotional issues. CPC students work on family, environmental, guardianship, consumer, small claims, housing and child support cases, among others. One of the most common cases are civil protective orders, cases that by their very nature contain a lot of emotional content and disturbing information.⁶⁰ An interdisciplinary partnership at the CPC was formed in the Spring of 2012 due to emotional client challenges that law students and their supervising attorney were faced with. In the CPC partnership, the clinic operates on an interdisciplinary basis each spring, with both law and social work students enrolled and partnered on cases together. The class is also taught by both a law and social work professor, who model the partnerships they apply. As in the criminal clinic above, students are taught to integrate both strengths and systems theories into their representational skill set. These skills are taught via interactive lectures, role plays, and classes specifically developed by the

60. National Institute of Mental Health, *What is Post-traumatic Stress Disorder (PTSD)?*, NAT'L INST. HEALTH, <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml> (last visited May 1, 2014) (providing an overview of causes and symptoms of PTSD). Given the amount of work with domestic violence survivors, one recurring issue is that of post-traumatic stress disorder. *Id.* PTSD causes survivors to avoid events that remind them of the negative experiences, be emotionally numb, and have memory issues, notably with the violent events. *Id.* These are some of the challenges in working with a client who has PTSD, not the least of which is that their avoidance and memory loss.

social work students for the benefit of their legal counterparts. Interdisciplinary case rounds also allow for both sets of students to break down client scenarios and issues using the different theoretical lenses.

Law students in the CPC initially struggled with the emotional component of a lot of their cases and would routinely vehemently state at the beginning of the semester that they “were not a hugger” or “weren’t there to be their client’s friend.” Rather than feeling comfortable with having to deal with human emotions, the law students were instead hiding behind their legal work so as not to have to confront the emotionally charged situations. Students were also unsettled when clients presented with mental illness, as oftentimes the mental illness would interfere with basic components of representation, such as the ability to remember conversations, clarity of communication, or comprehension. This reluctance and lack of professional training inhibited their abilities to connect with their clients on a different level, and to provide the best service that they were able.

One example of this is when a client of the CPC showed up to the office heavily intoxicated for an initial client interview. Rather than recognize the situation and postpone the interview, the law student instead proceeded with the meeting, even going to far as having the client sign all necessary forms for the representation to take place. After the meeting, the student then called the police on the client, giving them both the make and model of the car and the direction the client would be driving home. The law student did not see anything wrong with the actions they had taken, and instead were indignant that they postpone the interview.

The above scenario resulted not because of incompetence on the law student’s part, nor did it happen because training was not provided regarding client interviewing and counseling. The scenario resulted because a professional skill set was missing, one that needs to be re-incorporated into legal training. Law students know how to work with clients; they know how to identify the legal problems; they know how to research and write. What they do not know is how to incorporate alternative approaches into their legal work, approaches that make handling the non-legal peripheral emotional content smarter and easier in the long run. As discussed above, social work offers these alternate approaches, and the learning really is twofold – the law students learn a different framework

for their objectives, and the social workers learn more about the legal system's workings and motivations.

CONCLUSION

This Essay outlined the benefits of integrating social work theory and practice into the clinical law school curriculum. While it is helpful to discuss anecdotal evidence of the success resulting from the fusion of the two fields, it is important that we, as a profession, see ways in which to further research the outcomes for law students who are exposed to social science learning during their law school experience. Large-scale change in law school pedagogy will not come without empirically demonstrating that these new interpersonal skills result in better results for clients. Law professors must also attempt to discern what, if any, improvement in well-being on the part of lawyers and law students results from the introduction of social work theory and practice into the legal academy. Only if law practice and legal scholarship continue to expand on recent efforts to create a body of empirical research on legal systems can we truly assert that our efforts at integrating social work practices into legal representation and education are successful.

By familiarizing young attorneys with a skill set borrowed from the social sciences, law schools will create a generation of lawyers who can not only advocate for their clients but solve problems with them to achieve lasting change on a personal level, particularly for such a vulnerable population such as those with mental illness. At a time when the legal profession is challenged by a growing level of dissatisfaction amongst its practitioners, those lawyers who are able to implement practices that bring about lasting change will realize more success not only for their clients, but also for themselves.

A Critique of The Uganda Mental Health Treatment Act, 1964

BY CHRISPAS NYOMBI,* ALEXANDER KIBANDAMA**
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The scarcity of research into the deplorable state of Uganda's mental health laws is a grave lacuna that needs urgent redress. Firm in mind that academic scholarship is a collaborative enterprise with deep roots in constructive criticism, this paper aims to fill this gap. This paper provides a circumspect examination of mental health laws in Uganda. The paper reviews the Mental Health Treatment Act 1964 and highlights the main areas that need reform. It keeps the jurisprudential analysis of applicable international treaties and conventions such as the United Nations Convention on Rights of Persons with Disabilities to a minimum. This paper will inform legal, academic and healthcare circles on the current state of mental health law in Uganda.

I. INTRODUCTION

The Uganda Mental Health Treatment Act 1964 (MHTA)¹ was drafted in line with the Mental Health Act, 1959 of England.²

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While the English have ironed out numerous injustices through a series of reforms culminating in the Mental Health Act, 1983,³ Uganda continues to harbor a mosaic of outdated statutory frameworks that are ominously out of touch with modern society. Mental health is dependent on a balance between social, psychological, biological and physical factors, paramount to the well being of an individual's state of mind.⁴ Although it may seem trivial to some Parliamentarians, who in 2011 rejected the Mental Health Treatment Reform Bill (MHTRB),⁵ for a government that claims to have lifted the tyranny of human rights abuses and social degradation associated with its predecessors, this was clear neglect for the rights of a vulnerable group. However, the protection of vulnerable groups is formally recognized under article 21(2) of the Ugandan Constitution and widely recognized as a mark of civil society.⁶ Charitable organizations such Mental Health Uganda and the National Union of Disabled Persons of Uganda (NUDIPU) continue to rally the seemingly myopic Ugandan government by developing proposals for reforming the MHTA, which remains over half a century behind its British counterparts, and in some cases, appears to be in contempt of the United Nations Universal Declaration of Human Rights (UNUDHR).⁷ Having become signatory to the United Nations Convention on Rights of Persons with Disabilities

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1. The Mental Health Treatment Act, (1964) 279 LAWS OF UGANDA.
2. Mental Health Act, (1959) 72 HALS. STAT.
3. Robert Bluglass, *The Origins of the Mental Health Act 1983: Doctors in the House*, 8 PSYCHIATRIC BULLETIN, 127–34 (1984).
4. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
5. Chrispas Nyombi, *A Critical review of the Uganda Mental Health Treatment Bill, 2011*, 18 E. AFR. J. PEACE & HUM. RTS. 499–13 (2012).
6. Jo C. Phelan et al., *Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and is it to be Feared?*, 41 J. HEALTH & SOC. BEHAV. 188–207 (2000).
7. Universal Declaration of Human Rights, (1948) 217 G.A. RES.

(CRPD) in 2006,⁸ Uganda sought to bring its mental health laws in line with the demands of the international community. The Convention galvanized the push for a review of mental health laws culminating in the MHTRB.

A. Domestic Legal Framework

National laws protect individuals with mental health disabilities, and this law is consistent with the Ugandan constitution. For persons with mental health disabilities, having rights under the Ugandan constitution, such as voting rights, serves to place them in the same class as every other citizen. However, in an era defined by the increased acceptance of mental health laws around the world, it is tempting to forget the magnitude of the task that befell the Ugandan government when they instigated the reforms of 1964.⁹ The Ugandan government eliminated a tangled mass of stigmatizing procedures from earlier statutes and achieved a remarkable degree of legal simplicity by placing a broad measure of discretion on psychiatric opinion.¹⁰ This remarkable journey began in 1916 when healthcare services became nationally recognized under the influence of the evolving mental health laws in England. Circa 1927, structural changes emerged with a Mental Health Unit in the infamous Hoima Prison built to house those adjudged by society to be mentally unfit.¹¹ The apparent success of the Hoima Unit and increased awareness towards mental health disabilities culminated in further structural developments in 1934 through the building of another Mental Health Unit at Mulago Hill.¹² In that era, mental health was yet to be legally recognized as a disability,

8. THE UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (2007), available at <http://www.unhcr.org/refworld/docid/4962270c2>.

9. *Social Stigma and Mental Health in Uganda*. Kampala, Uganda: Basic Needs UK, BASIC NEEDS UGANDA (2005).

10. Sheila Ndyabangi et al., *Uganda Mental Health Country Profile*, INT'L REV. PSYCHIATRY 16, 54–62 (2004).

11. Mulumba Moses, *Analysis of the Uganda Mental Treatment Act from a Human Rights and Public Health Perspective* (2007), available at SSRN: <http://ssrn.com/abstract=1006230> or <http://dx.doi.org/10.2139/ssrn.1006230>.

12. The Uganda Mental Health Policy Draft, (2000–2005) ¶1.2. LAWS OF UGANDA.

leaving a trail of prejudice, stigma and abuse in its path. The advent of the Mental Treatment Ordinance in 1935 (MTO) was a long-awaited recourse for many who never imagined the possibility of legal intervention.¹³ The Ordinance contained a legal framework for the management and protection of persons with mental health disabilities in communities.¹⁴ It took a twin approach of protecting the mentally disabled and providing measures for communities in dealing mentally disabled persons.

The Ordinance inspired another structural change through the construction of another Unit at Butabika.¹⁵ The sheer size of the Unit, with a capacity of 1970 beds, was sign of the growing recognition of mental health challenges in Uganda at a period when few countries in Africa were willing to take on the challenge. These legal, institutional and structural developments laid the foundation for the 1939 Uganda Lunacy Act (Emergency admission of people of unsound mind to mental Hospital signed by gazetted chiefs, senior police, and senior civil servants).¹⁶ The law provided that once a senior police officer, gazetted chief or any civil servant had certified an individual as possessing a mental disability, this would render them as such. There were no notable changes to mental health laws in the 1950s, apart from the intensification in recruitment and training of mental health professionals. A monumental change came a decade later when a move to decentralize mental health services took place in 1962 and lasted until 1973.¹⁷ This resulted in the opening of prison-like mental health units, with a three-bed capacity, in eight districts across Uganda. At the onset of the decentralization, an equally monumental change surfaced in the form of a MHTA, to govern the care of persons of unsound mind and management of mental health hospitals. This Act formed a trellis of legal powerhouse upon which the management and provision of mental health care in Uganda is governed to this day, with few reforms along the way. These glorious pre-independence days

13. *Id.* ¶1.2.

14. Mulumba Moses, *Analysis of the Uganda Mental Treatment Act from a Human Rights and Public Health Perspective* (2007), available at SSRN:<http://ssrn.com/abstract=1006230> or <http://dx.doi.org/10.2139/ssrn.1006230>.

15. *Id.* at 2–3.

16. *Id.*

17. Ndyabangi et al., *supra* note 10, at 54–62.

necessitated for the medical excellence of Makerere University based psychiatrists such as John Cox,¹⁸ Allan German¹⁹ and John Orley²⁰; the pioneering minds that stirred Uganda's health care reforms of the 1960s.²¹ These psychiatrists helped people with strong cultural coloring to cast aside the impulse to look at those with mental health disabilities as demonic figures whose only sanctuary was the house of a traditional healer.

In ensuing decades, these glorious reforms would become scattered, along with the many pioneering medical minds,²² due to the dictatorial tyranny that engulfed Uganda until the incumbent National Resistance Movement (NRM) seized power in 1986. Mental health reform in Uganda remained in the shadows of its past, with only a structural change in 1987 when mental health gained a seat in the ministry of health headquarters. This was a period when most western democracies were reviewing and reforming mental health laws, most notably the Mental Health Act, 1983 in England, yet the Ugandan government cast a blind eye on these changes. Nonetheless, they stepped up their reform efforts in 1996 by launching a Uganda Mental Health Program (UMHP) followed by the National Policy and Health Sector Strategic Plan in 2000 (NPHSSP).²³ The strategic plan aimed to provide minimum health care packages for all persons including those with mental health disabilities. It also aimed to integrate mental health into Primary Health Care (PHC). Courtesy of the African Development Bank, Butabika Hospital was offered redevelopment funds that

18. John L. Cox, *Post-natal Depression: A Comparison of African and Scottish Women*, 18 *SOC. PSYCHIATRY* 25–28 (1983).

19. Allen G. German & O. P. Arya, *Psychiatric Morbidity Amongst a Ugandan Student Population*, 115 *BRIT. J. PSYCHIATRY* 1323–29 (1969).

20. JOHN H. ORLEY, *CULTURE AND MENTAL ILLNESS: A STUDY FROM UGANDA*, (Nairobi: E. Afr. Pub. House 1970); John H. Orley et. al., *Psychiatric Disorders in Two African Villages*, 36 *ARCHIVES GEN. PSYCHIATRY* 513–20 (1979).

21. Alexander Odonga, *THE FIRST FIFTY YEARS OF MAKERERE MEDICAL SCHOOL AND THE FOUNDATION OF SCIENTIFIC MEDICAL EDUCATION IN EAST AFRICA*, KAMPALA (1989).

22. *Id.* at 34.

23. Frederick Mugisha & Juliet Nabyonga-Orem, *To What Extent Does Recurrent Government Health Expenditure in Uganda Reflect its Policy Priorities?*, 8 *COST EFFECTIVENESS & RES. ALLOCATION* 19 (2010).

resulted in 450 bed capacity and six Regional Units with thirty-four bed capacities built.²⁴ These funds came at a time when Butabika Hospital was facing logistical and structural challenges in accommodating patients and meeting the necessary healthcare standards. The challenges of mental health regulation are now part of the National Health Policy, which is responsible for reviewing and developing the relevant legal instruments to govern and regulate health and health-related activities in Uganda.²⁵ Under the policy, the government is mandated to reform and enforce laws all persons including those with disabilities, and those capable of being denied or stigmatized due to poor health or incapacity.²⁶

Today, this incredible journey finds us at period when human rights are universal.²⁷ Long gone the lunacy that left scars on those with mental health disabilities in so many countries around the world.²⁸ Importantly, mental health has gained the impromptu of the courts and a spot in the healthcare budget. However, the funding is a mere 0.07% of the total budget.²⁹ This lack of funding is partly due to a lack of knowledge about mental health disabilities, which is continually being viewed as a sub-category of disability.³⁰ Despite that, mental health units were built at twelve regional referral hospitals and thus reducing numbers at the national psychiatric hospital by half. The transformation of Butabika Hospital from the traditionally large and neglected mental health slum into a beautifully painted and maintained hospital, serving the mental health needs of the local community as well as its primary health care needs, is a remarkable change that few could have envisioned.

24. World Hope Organization, *Aims Report on Mental Health System in Uganda*, MINISTRY OF HEALTH, KAMPALA, UGANDA, 10 (2006) [hereinafter WHO-Aims].

25. National Policy & Health Sector Strategic Plan, ¶13.1, available at <http://www.health.go.ug/docs/HSSPIII2010.pdf>.

26. *Id.* at ¶13.2.

27. AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS (1981).

28. World Health Organization, *The World Health Report 2001: Mental Health: New Understanding*, NEW HOPE, GENEVA: WORLD HEALTH ORG. (2001).

29. WHO-Aims, *supra* note 24.

30. Lwanga-Ntale, *Chronic Poverty and Disability in Uganda*, 14 J. AFR. ECON., 4, 603–31 (2003).

The Ugandan government has enacted a number of laws that give weight to the disability movement, mainly driven by the demands of the international community. Article 123 (2) of the constitution provides that parliament shall make laws to govern ratification of treaties, conventions or other arrangements emanating from the international sphere.³¹ The Persons with Disabilities Act, 2006 contains provisions for the elimination of all forms of discriminations against people with disabilities and promotion of equal opportunities.³² In a bid to promote social integration, the Local Government Act, 1997, Parliamentary Elections Statute, 1996, and the Movement Act, 1998 were enacted with provisions to increase the representation of disabled persons in the public sphere such as local councils.³³ The Parliamentary Elections Statute, under section 37, allows five seats in Parliament for representatives of persons with disabilities. Furthermore, the National Council for Disability Act (No. 14), 2003 enabled the monitoring and evaluation of the rights of persons with disabilities as set out in international conventions and legal instruments.³⁴ In line with the CRPD, The Business, Technical, Vocational Education and Training (BTVET) Act, No. 12, 2008, was enacted for the sole purpose of promoting equitable access to education and training for all disadvantaged groups, including disabled persons.³⁵ Other notable policies include the National Policy on Disability, 2006, which provides a human rights-based framework for responding to the needs of persons with disabilities.³⁶ The abovementioned enactments are in line with The Uganda Vision, 2025 and the Poverty Eradication Action Program (PEAP), which provides a long-term development framework and initiatives aimed at sustaining rapid

31. REPUBLIC OF UGANDA [CONSTITUTION] (1995) (Constitution of the Republic of Uganda. Kampala, Uganda: Government of Uganda).

32. The Persons with Disabilities Act, (2006) LAWS OF UGANDA.

33. Local Governments Act, (1997) LAWS OF UGANDA; Parliamentary Elections Statute, (1996) LAWS OF UGANDA; The Movement Act, (1998) LAWS OF UGANDA.

34. National Council for Disability Act, (2003) 14 LAWS OF UGANDA.

35. Chrispas Nyombi & Alexander Kibandama, *Access to Education by Persons with Disabilities in Uganda's Education System*, 19.1 E. AFR. J. PEACE & HUM. RTS., 74, 74–94 (2013).

36. NATIONAL POLICY ON DISABILITY IN UGANDA, (2006) MINISTRY OF GENDER, LABOUR & SOC. DEV.

economic growth and tackling poverty.³⁷ However, it should be remembered that these laws are mainly targeted at physical disability rather than mental health disabilities.

Despite the monumental developments in the field of disability law, the challenges are still many, with stigmatization, lack of information and distasteful practices, still running unabated. However, decentralization has meant that hospitals have become home to community activity.³⁸ This helped the stigma campaign, as more people have come to realize that mental health illness is treatable.³⁹ A more worrying concern, however, is not necessarily the poor ratio of psychiatrists to the population being at 1:1,900,000⁴⁰ but the mosaic of outdated legal provisions in the MHTA that ought to bring a sigh of disbelief to anyone who would muster the courage to peruse it.

II. A CRITIQUE OF THE MENTAL HEALTH TREATMENT ACT, 1964

Before exploring the shortfalls of the MHTA, one should keep in mind that the Act has not been well enforced.⁴¹ Mental health cases are rarely subject to review by the magistrates, leaving doctors to make decisive decisions without checks or balances. Legal recourse is a rare route no matter the case and admissions to hospital are mainly voluntary through self-referral or at the request of a relative. Thus in practice, the MHTA has no voice, it has been sucked away in a vacuum of neglect and poor enforcement.

37. MINISTRY OF FINANCE, PLANNING & ECONOMIC DEVELOPMENT 2008, *DISABILITY & POVERTY IN UGANDA: PROGRESS & CHALLENGES IN PEAP IMPLEMENTATION* (MFPED, KAMPALA 1997–2007).

38. NATIONAL UNION OF DISABLED PERSONS OF UGANDA, (1995). *Decentralization of NUDIPU through building cross disability coalitions at district level, and developing their capacity for self-management.*

39. PHILIP BEAN & PATRICIA MOUNSER, *DISCHARGED FROM MENTAL HOSPITALS* 124 (Houndmills et al. eds., 1993).

40. Irene Among, *Working Together to Promote Community Mental Health*, DAILY MONITOR, Apr. 7, 2006, at 20.

41. Fred. Kigozi et al., *An Overview of Uganda's Mental Health Care System: Results from an Assessment Using the World Health Organization's Assessment Instrument for Mental Health Systems*, 4(1) INT'L J. MENTAL HEALTH SYS. 1 (2010).

First and foremost, in few areas of Ugandan social policy have attitudes changed so drastically as in mental health. Due to decentralization and increased public awareness, the chains, whips and fetters of previous centuries have been rendered to history. The ignorance, superstition and inhumanity which could have left a patient in Hoima prison chained to a wall for years has also been rendered to history. Even some of the fears and ridicule that produced labels such as “imbecile” and “lunatic” are descriptions of the past. While public attitudes should be commended,⁴² professional attitudes should be lamented, given that the MHTA, the landmark that gave statutory protection to persons with mental health disabilities, labels them as ‘idiots’ under section 1(f).⁴³ The outdated and highly offensive language spurs prejudice, which damages the promotion and deliverance of community-based treatment. Community care was largely neglected by the Act but has become an important feature of medical practice. The word idiot itself is synonymous with low intelligence; surely low intelligence on its own does not make a person a danger to a community or themselves. Thus, it is vitally important to remove this derogatory language when drafting future legislation in order to avoid prejudicial reference.

Second, the Act fails to differentiate between different mental disorders, leaving all mentally ill persons being treated in the same way. A mental disorder means ‘mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind.’⁴⁴ For example, if a person has significant impairment of intelligence due to incomplete development of mind, that may fall outside of the exhaustive categories of mental disorders because such an individual may not be abnormally aggressive or incapable of social functionality. Given the lack of clarity over the different types of mental disorders, from a human rights perspective, the Act leaves plenty of room for abuse and exploitation. In future legislation, there should be provisions that

42. BASIC NEEDS UGANDA, SOCIAL STIGMA AND MENTAL HEALTH IN UGANDA (2005).

43. UGANDA'S MENTAL HEALTH TREATMENT ACT, (1964) § 1(f) LAWS OF UGANDA (defining persons with mental disabilities as an idiot or a person who is suffering from mental derangement) [hereinafter MHTA].

44. *Id.* This Act, however, does not also define mental illness.

allow treatment for mental disorders outside the four categories, and a different approach to admission and treatment for different illnesses.

Third, the Ugandan government must recognize that the Act should be looked at in light of history, the practicalities of current psychiatric treatments and recent legislative difficulties. Thus, future legislation must take a legislative rather than a welfarist approach to mental health reform since mental health legislation has historically been described as a “pendulum swinging between two opposing schools of thought.”⁴⁵ The welfarist or medical model specifically focuses on promoting the role of medical professions in their admission and treatment process.⁴⁶ This was the approach taken when the MHTA was being drafted and it left substantial powers in the hands of medical professionals.⁴⁷ The downsides of this approach were recognized by the Percy Commission in England which viewed mental illness as an illness just like any other and thus it should be treated as such.⁴⁸ Given that the MHTA vests substantial powers in the hands of medical professionals to make decisions about the initial and subsequent detention, without adequate reviews, this could lead to wrongful detentions and the abuse patients’ rights.⁴⁹ Instead, legal reformers should endorse the legalistic or libertarian approach, which places substantial emphasis on the legal rights of the detained individual. The approach focuses on legal safeguards and supervision, which also enhances the status of psychiatric patients by providing them with a number of procedural rights.⁵⁰ This approach is likely to upset the current process of

45. See Larry O. Gostin, *Contemporary Social Historical Perspectives of Mental Health Reform*, 10 J. L. & S. 47, 70 (1983).

46. CLIVE UNSWORTH, *THE POLITICS OF MENTAL HEALTH LEGISLATION* (Oxford Univ. Press 1985); KATHLEEN. JONES, *ASYLUMS AND AFTER: A REVISED HISTORY OF THE MENTAL HEALTH SERVICES* (Athlone Press 1993).

47. For example, medical certificates under section three of the Mental Health Treatment Act. UGANDA’S MENTAL HEALTH TREATMENT ACT, (1964) § 1(f) LAWS OF UGANDA.

48. E.O. Lewis, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*, 2 J. INTELL. DISABILITY RES., 130–44 (1957).

49. Larry O. Gostin, 1 A HUMAN CONDITION INSTITUTE OF ADVANCED LEGAL STUDIES (1975).

50. UNSWORTH, *supra* note 46, at 341.

certification by a magistrate and two medical staff under section 3(1) MHTA, due to increased safeguards. Under this approach, future legislation will boast an enlightened and humane approach towards the treatment of the mentally disabled.

However, it should be emphasized that the possibility of having a team of professionals to make the admission decisions cannot be achieved given a shortage of qualified professionals. Thus it is critically important that courts or tribunals decide on the compulsion while mental health specialists decide on treatment. It should be remembered that compulsion deprives an individual of his/her liberty and as result the individual could view the action of society as, at best, a gross imposition and at worst, a malevolent action of aggression, and this could spur dangerous behaviors. It should also be emphasized that the ultimate purpose of law is to protect and enhance liberty yet mental health law is bent on restricting liberty. Given the poor state mental health law in Uganda finds itself, compulsion powers should be for those exceptional circumstances where a patient's mental disorder warrants detention in hospital for treatment or reception into guardianship, under the patient's consent. However, the MHTA does not use compulsion as a last resort, rather as the starting point for anyone with mental health disabilities. For a patient who is undergoing an episodic crisis, compulsion may not be the right remedy. Thus, as emphasized on countless occasions, mental health patients in Uganda are being treated under a welfarist model, premised on segregation rather than rehabilitation.

Future legislation should therefore attempt to place limits on the exercise of medical discretion. This can be achieved through the introduction of an admission criteria and increased control over the administration of certain treatments. Safeguards against wrongful detention should also be introduced in future legislation. This may open up new channels for reviewing detentions. For policy reasons, a commission should be set up to oversee the implementation of future legislation because it is essential to have service users involved in the decision making process. There is also a lack of legal enforcement, this does not necessarily mean abuses are scarce; rather, the victims are unaware of their rights or unable to pursue the legal route due to cost and other limiting factors. On that basis, the government needs to strike a balance between providing full and adequate protection to staff against mischievous

or frivolous prosecutions while strengthening access to justice for persons with mental health disabilities.

Fourth, as aforementioned, the triumph of legalism was achieved by the MTO whereby outpatients and voluntary patients were encouraged to admit to hospital.⁵¹ Then came the MHTA, which made compulsory detention an essentially medical decision under MHTA, section 2(4). However, patients' consent to treatment was never considered.⁵² Non-objecting incapacitated patients subject to detention were not protected by the MHTA. Thus the position under the MHTA is not respectful of the rights of non-objecting detained patients. According to section 2(4), a person arrested under section 2(3) will be subject to "medical examination or the production of evidence regarding the state of mind". Given the lack of procedural safeguards such as the right to compulsory review of detention, and a criterion upon which medical professionals must base their certification, the Act remains in contempt of the Human Rights Convention.

Fifth, although the detention of patients in hospitals is allowed under section 4 of MHTA, the Act does not expressly authorize their compulsory treatment. When devising a provision to fill this gap, the government should take into consideration the Butler Committee's recommendations,⁵³ namely, treatment should only be imposed against the patients consent if it is necessary to save life, prevent deterioration in condition, or prevent violence.⁵⁴ Lack of clarity over the legal position of doctors who are treating patients, especially patients that do not consent, needs to be addressed in future legislation. In order to clarify the legal position, the new Act should have a provision that gives doctors a right to administer treatment to a non-consenting patient, in light of the Butler Committee's recommendations.

51. MENTAL TREATMENT ORDINANCE, (1935) 4 LAWS OF UGANDA.

52. See M. Potter, *Mental Health, Capacity And Non-Consensual Intervention: A Human Rights Perspective*, 5 NI HUMAN RTS. COMMISSION REV. (Summer 2007), available at www.Nihrc.org/dms/date/NIHRC/attachments/dd/files/71/HRC_Review_5_web.pdf.

53. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. REPORT OF THE COMMITTEE ON MENTALLY ABNORMAL OFFENDERS (1975).

54. BUTLER COMMITTEE, THE BUTLER COMMITTEE ON MENTALLY ABNORMAL OFFENDERS (1975).

Last but not least, the bedrock upon which the 1964 Act rested was the principle that people suffering from mental disorder should, as often as possible, be treated in the same way as those suffering from physical disabilities. Despite that, care remained behind custody and there was limited emphasis on community care under section 2(8) MHTA. The Act failed to explain the rights or conduct of those in custody of a mentally disabled person thus leaving plenty of room for abuse. Rather, the emphasis was on preventing the individual from causing harm to the public. This welfarist approach endorses continued reliance on institutional care. This is provided under section 4 (3) which state that “magistrate may make a reception order for the detention, care and treatment of a person adjudged to be of unsound mind at a mental hospital”. Although the shift towards community care gained recognition in the 80s,⁵⁵ the mishmash of alterations and afterthoughts which had emerged in Uganda over the years failed to recognize the importance of community care and to root out section 4(3). Thus, a radical rethink of the delivery of care is needed. Future legislation must reflect the major changes in treatment, philosophy and practice espoused by the international community. The legislation should abandon the welfarist approach and allow care to be provided in less restrictive settings, mainly in the community with guardianship provisions in place. Guardians should have three essential powers, namely, to be given access to the patient; to require the patient to stay in a particular place; and to attend places for training, occupation and medical treatment.⁵⁶ However, despite the benefits community care, the high profile homicides by mentally disabled persons in England are a constant reminder of its challenges.⁵⁷

55. Nhlanhla et al., *Community Access to Mental Health Services: Lessons and Recommendations*, 11 S. AFR. HEALTH RES. J. 103, 113 (2008).

56. *Reform and Modernisation of Mental Health and Learning Disability Services, Strategic Priorities for the First Phase of Review Implementation*, BAMFORD REVIEW, Aug. 2007, at 23.

57. See DAVE SHEPPARD, *LEARNING THE LESSONS* (Zito Trust 1998) (discussing the mental health inquiry reports published in England and Wales between 1969 and 1994 and their recommendations for improving practice for a fuller account of tragedies and inquires).

III. THE INTERNATIONAL LEGAL FRAMEWORK

Many African countries, including Uganda, have risen to the demands of global citizenship through a series of legal and social developments, to revise outdated legal frameworks left behind by the somewhat less informed colonial powers. Enshrined in the Ugandan Constitution, Principle XXVIII of the foreign policy objectives requires the country to respect principles of international law and treaty obligations and opposition to all forms oppression, exploitation and discrimination. Thus, domestic law must be consistent with the international framework to which Uganda is party.⁵⁸ For domestic law to be consistent with international law, fundamental human rights must be adhered to especially in regards to psychiatric treatment and admission through appropriate legislative provisions and rights of persons with disabilities must be consistent with those in the national constitution.

It should also be emphasized that international human rights organizations recognize resource constraints placed on third world countries like Uganda.⁵⁹ According to the International Committee on Economic, Social and Cultural Rights (ICESCR),⁶⁰ which is responsible for implementing, monitoring and enforcing economic, social and cultural rights, the measure is mainly the steps which the state has taken towards the progressive realization of right to the “maximum available extent of its resources.”⁶¹ Regardless of resource constraints, the state must ‘ensure the satisfaction of, at the very least, minimum essential levels’ of each of the

58. See E. ROSENTHAL & C. SUNDRAM, *THE ROLE OF INTERNATIONAL HUMAN RIGHTS IN NATIONAL MENTAL HEALTH LEGISLATION* (2004), available at http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf; WORLD HEALTH ORGANIZATION, *MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION* (2005), available at http://www.who.int/mental_health/policy/legislation/policy/en/.

59. For example, the International Committee on Economic, Social and Cultural Rights (ICESCR) under Article 2(2) recognizes that third world countries may not be able to invest as much as first world countries in research and development and health care needs.

60. GENERAL ASSEMBLY RESOLUTION, (1966) 2200A (XXI) (entry into force on Jan. 3, 1976).

61. See UGANDA’S MENTAL HEALTH TREATMENT ACT, (1964) § 2(2) LAWS OF UGANDA.

rights in the ICESCR.⁶² However, the Ugandan government has made little effort to transform these treaties and conventions into their domestic law.⁶³

Despite that, international treaties and conventions ratified become part of national law and the courts can pencil in on them. In addition to the UNUDHR, Uganda is also a party to the African Charter on Human and Peoples Rights (ACHPR), and recently the CRPD.⁶⁴ Notably, Article 16(1) of the African Charter allows every person to have the right to enjoy the highest attainable “state of physical and mental health.”⁶⁵ Equally, Article 16 (2) obliges Uganda to take the necessary measures to protect the health of their people and to ensure that they receive medical treatment. The Public Health Act⁶⁶ is the main legislation concerned with the protection of public health; however, it has generally failed to keep pace with changes in science and technology, especially in relation to prevention, treatment and care. The Act is overly reliant on criminal sanctions as an enforcement mechanism and even the penalties under Part XI are not punitive enough to achieve the intended aim.⁶⁷ The constitution obliges the state to “take all practical measures to ensure the provision of medical services to the population”⁶⁸ and to ensure that all Ugandans enjoy “rights and opportunities and access to . . . health service”⁶⁹ The ACHPR provisions are found in the National Objectives and Directive Principles of State Policy (NODPSP) and can be effectively applied by

62. See International Committee on Economic, Social & Cultural Rights, ¶ 43, cmt. 14.

63. S. Cooper et al., *The Mhapp Research Programme: Viewing Uganda's Mental Health System Through a Human Rights Lens*, 22(6) INT'L REV. PSYCHIATRY 578–88 (2010).

64. M. Jones, *Can International Law Improve Mental Health? Some Thoughts on the Proposed Convention on the Rights of People with Disabilities*, 28 INT'L J. L. & PSYCHIATRY 183–05 (2005).

65. See AFR. CHARTER ON HUMAN & PEOPLES RTS. 16(1).

66. PUBLIC HEALTH ACT, 281 LAWS OF UGANDA (1935).

67. MICHAEL L. PERLIN, *MENTAL DISABILITY LAW: CIVIL AND CRIMINAL* 3 (2nd ed. 1999).

68. REPUBLIC OF UGANDA [CONSTITUTION], (1995) XX (Constitution of the Republic of Uganda. Kampala, Uganda: Government of Uganda).

69. *Id.* at § XIV.

courts.⁷⁰ Importantly, Article 18(2) of the Charter provides people with disabilities enhanced rights that are subject to a non-discretionary provision under Article 2. Although disability is not expressly mentioned, the categories of discrimination are not exhaustive. This was affirmed by the African Commission on Human and Peoples' Rights⁷¹ which held that the non-discrimination provisions encompass mental disability.⁷²

The ACPHR provides a range of rights for people with mental disabilities in Uganda.⁷³ First and foremost, Article 7 gives a right for all to be heard by the court under the guidance of Article 3 which gives the right of equality and equal protection in law. Although Article 7 provides a right to an independent hearing into involuntary psychiatric admissions, without a criterion on which to base the judgment, it is nearly impossible to conduct a hearing. It also protects the property rights of persons with mental disabilities under Article 14 from misuse by their guardians. Article 14 also allows them to continue to make decisions regarding their property. There are no provisions in the MHTA relating to property rights, and it can be argued that in practice, many hurdles, mainly informational and financial, obscure the right of equality and equal treatment in law.⁷⁴ Second, Article 4 promotes the right to life and dignity for all persons. However, this could obscure the right to health, for example, in the Indian case of *Paschim Banga Khet*

70. *Kesavananda Bharati v. State of Kerala*, A.I.R. 1973 S.C. 1461 (India), available at <http://judis.nic.in/supremecourt/imgs1.aspx?filename=29981>. The Supreme Court stated that although Article 37 of the Indian Constitution expressly provides that the Directive Principles of State Policy (DPSP) are not enforceable by any court, they should enjoy the same status as traditional fundamental rights. *Id.*

71. The African Commission on Human and Peoples' Rights and the African Court of Human and Peoples' Rights are both established by the African Charter on Human and Peoples' Rights. The Commission was created a number of years before the Court, and was for a number of years the only arbiter established by the Charter.

72. *See Purohit & Moore v. The Gambia*, Comm. No. 241/2001 (2003), available at <http://www.escri-net.org/docs/i/401249>.

73. *See INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS*, (Jan. 1976) 3.

74. Joshua Ssebunnya et al., *Stakeholder Perceptions of Mental Health Stigma and Poverty in Uganda*, BMC INT'L HEALTH & HUM. RTS., March 31, 2009, at 1.

Mazdoor Samity & Ors v. State of West Bengal & Anor,⁷⁵ in which the plaintiff suffered head injuries due to an accident. He was turned away from obtaining treatment at a government hospital and had to resort to a private hospital for treatment. However, the Indian Supreme Court disagreed and ruled that the state had to protect the health of all persons in line with Article 21.⁷⁶

In terms of protecting the dignity of mentally disabled persons, case law from other African countries provides that the use of words such as “lunatic” is a perverse violation of this right. Thus, the continued use of the word “idiot” in reference to those with mental health disabilities is in itself a violation of this Charter. Fourth, Article 5 prohibits cruel, inhumane, or degrading treatment or punishment. Under this Article, appropriate standards of care must be maintained in psychiatric hospitals and any mental facility to ensure that the Article is not contravened. Last but not least, Article 6 of ACPHR provides a right to liberty and freedom from arbitrary detention. For persons with mental disabilities, the availability of a criterion upon which an appropriate panel can base compulsory psychiatric admissions is a key requirement. However, in *Purohit & Moore v. The Gambia*,⁷⁷ the African Commission controversially ruled that this Article did not apply to persons in need of hospitalization for medical reasons. Clearly, involuntary admission and detention of a person in a psychiatric facility falls under this section and should be the subject of an established criterion given its implications. It is important that the African Court on Human and Peoples' Rights reviews this ruling, as it is a blatant disregard for basic human rights. For nationals, the African Commission on Human, an organization charged with ensuring the

75. *Paschim Banga Khet Mazdoor Samity & Ors v. State of West Bengal & Anor*. A.I.R. 1973 S.C. 1461 (India), available at <http://judis.nic.in/supremecourt/imgs1.aspx?filename=29981>. The Supreme Court stated that although Article 37 of the Indian Constitution expressly provides that the Directive Principles of State Policy (DPSP) are not enforceable by any court, they should enjoy the same status as traditional fundamental rights. *Id.*

76. *See also* López, Glenda y otros c. Instituto Venezolano de los Seguros Sociales, Expediente 00-1343, Sentencia No. 487 (1997) (the Supreme Court of Venezuela held that the denial of access to certain medicines such as ARVs constituted a violation of the right to life).

77. *See* *Purohit & Moore v. The Gambia*, Comm., No. 241/2001 (2003), available at <http://www.escri-net.org/docs/i/401249>.

promotion and protection of human rights throughout the African continent, has done little to illuminate some of the conundrums in regard to mental health disability rights. Thus, it is hoped that the new African Court of Human and Peoples' Rights will do more to explain the scope and approach of the Banjul Charter.

In addition to the ACPHR, under Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), everyone has a right to the highest attainable standard of physical and mental health. Uganda also ratified the International Labor Organization (ILO) Convention Concerning Discrimination in Respect of Employment and Occupation, 1958, (No. 111) in 2005 and the ILO Convention Concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, (No. 159) in 1990. The ILO maintains the goal to promote opportunities for all persons including those with disabilities. They aim to promote decent work for all through education, training, and advocacy. In line with ILO obligations, Uganda implemented the Decent Work Country Programme and The Persons with Disabilities Act of 2006, as a guiding framework for delivering the necessary ILO treaty obligations. Uganda also works to implement the Action Plan established for the African Decade of Persons with Disabilities, extended to December 2019.

IV. THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND LEGAL REFORM IN UGANDA

The biggest driver for reform in Mental Health has been the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol. Among others, the Convention calls for a strategic review of mental health structures and care systems.⁷⁸ The general principles of the Convention include non-discrimination of any sort against persons with disabilities; enablement of full and effective inclusion and participation in society; equality of opportunities; access to healthcare, education, employment, and other public services; respect for dignity and autonomy; among others. These principles can only be achieved through

78. Rosemary Kayess & Phillip French, *Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities*, 8 HUM. RTS. L. REV. 1, 3 (2008).

strong domestic legal frameworks and policy changes aimed at promoting equality.

In Uganda, the National Council for Disability (NCD) was assigned the role of implementing the Convention. The NCD has since driven forward a number of legal reforms. The rights enshrined in the CRPD were domesticated under the Disabilities Act of 2006. In line with Articles 32 and 35 of the Uganda Constitution, the Disabilities Act aims to deter all forms of discrimination against persons with disabilities and promote equal opportunities.⁷⁹ However, these rights have not been transformed into concrete programmes and few reforms have been made. Since 2006, regulations for implementing the Disabilities Act have not been issued. The state of disability law in Uganda was summed by the Disability Scoping Study as follows:

Uganda is indeed at [a] crossroads with regard to disability policy and practice because on the one hand, it has enacted progressive, forward thinking legislation and ratified the CRPD; on the other hand, it faces a significant challenge in implementing effective and efficient disability services and policies due to a significant implementation gap.⁸⁰

A notable shortfall of the Disabilities Act is its definition of disability under section two as “a substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participation.” The CRPD follows a legal model that does not require a health professional to examine physical or sensory limitations of an individual. This definition follows a medical model, which means that only those who meet the medical criteria are entitled to protection under the Disabilities Act. The model requires proof of

79. The Persons with Disability Act of 2006, (2006) § 12(a) LAWS OF UGANDA (2006).

80. Raymond Lang & Ambrose Murangira, *Disability Scoping Study: Final Report*, (2009), available at http://www.ucl.ac.uk/lc-ccr/downloads/06052009_Disability_Scoping_Study_Uganda.pdf.

limitation in daily life activities.⁸¹ Clearly, the Disability Act fails to implement the principles of the Convention to the detriment of thousands of persons with disabilities in Uganda.

V. THE MENTAL HEALTH TREATMENT BILL, 2010

Three years after ratifying the CRPD, the Ugandan government sought to reform an area that has been largely ignored for nearly half a century. The move to reform the Mental Health Treatment Act, 1964 culminated in the Mental Health Treatment Bill, 2010. The Bill has gone through a series of modifications to ensure that it falls within the ambit of the CRPD and other international requirements. Given that the 1964 Act refers to persons with mental disabilities as “idiots,” there was an urgent need to shelve the 1964 Act and put in force a modern legislation that conforms with the demands of the international community. In a review of the Uganda Mental Health Reform Treatment Bill (MHRTB) carried out by Chrispas Nyombi, the legal scholar branded the 1964 Act as one that “spurs more injustice than justice.”⁸² He criticized the Ugandan government’s reluctance to pass the Bill into law as follows:

[D]espite the rallying calls from numerous academics, practitioners and support organizations to reform this mosaic of outdated domestic laws relating to mental health, the Ugandan government remain reluctant to pass the Mental Health Treatment Bill through Parliament. While the due process in parliamentary proceedings must be respected, it is clear that the lack of support for mental health law reform is the cause for the delays dressed up in political and bureaucratic rhetoric. A chronic lack of interest in mental health laws has succeeded in trampling the rights of vulnerable service users. For a country that has experienced the trauma of war and human

81. See Chrispas Nyombi, *A Critical Review of the Uganda Mental Health Treatment Bill, 2011*, 18 E. AFR. J. PEACE & HUM. RTS., 499, 499–513 (2012).

82. *Id.* at 264–65.

rights neglect, it is highly unacceptable that a law aimed at promoting equality and protecting vulnerable groups remains a contentious issue.⁸³

The Bill itself has not given full effect to the principles of the CRPD. First and foremost, similar to the 1964 Act, the Bill contains no provisions on accepted levels of skill needed to determine mental disorder. However, the Bill specifies the categories of individuals who are responsible for determining mental disorder such as psychiatrists. Thus, provisions in relation to the accreditation of health professionals should form part of the reform Bill. Second, the Bill failed to specify that persons should be treated in a humane manner. The use of aggressive treatment in the treatment of persons with mental disabilities in Uganda is well documented.⁸⁴ Third, although the Bill outlaws forced labor or inadequate remuneration, it fails to provide provisions for minimum conditions expected in mental health facilities to be therapeutic, safe, and hygienic.

Last but not least, the medical model will impact on the ability to promote community care and deinstitutionalization because powers over detention and other aspects of care are placed in the hand of medical professionals. The 1964 Act is premised on hospitalization and seclusion, and fail to recognize community care and family involvement in the care process. The Bill has missed out on a number of important provisions in relation to community care. There are no provisions for the involvement of family members in the care plan. This is a major shortfall because “family is the focal point in rehabilitation . . . to move away from the arcane hospitalization model, provisions for family involvement must be in place.”⁸⁵ Provisions for families and caregivers would enable them to appeal decisions on involuntary admission on behalf of a patient who may lack capacity. Furthermore, there is no criterion upon which a person’s incapacity can be judged, in respect to admission, treatment, and other decision-making.⁸⁶ A lack of criteria for ca-

83. *Id.* at 264.

84. *See* ORLEY, *supra* note 20, at 34–62.

85. *Id.* at 270.

86. The Mental Health Treatment Bill, (2010) §3 LAWS OF UGANDA.

capacity and incompetence leaves plenty room for abuse and degrading treatment.

VI. CONCLUSION

In conclusion, the Essay shows that mental health legislation in Uganda is outdated, piecemeal, and simply inadequate in protecting the right to health and access to treatment. The MHTA makes compelling reading for its sheer disregard for basic human rights and being out of touch with modern societal values. The largely poor domestic laws have been accompanied by a slew of international treaties and convention ratified in a bid to improve mental health care in Uganda. The CRPD has played a momentous role in building mental health law in Uganda but little progress has been made since 2006, and although the bricks have been laid on the foundation of a strong mental health legal framework, the Bill remains largely redundant in some areas such as community care. Despite that, mental health policy is slowly taking shape and public attitudes are continually changing although faster than those of most Parliamentarians in Uganda.

From Chaos to Coping: An Argument for Including the Family in Involuntary Commitment

BY TORI EDGAR*

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I. INTRODUCTION

“And so for weeks, we had been locked in a game of chicken: waiting for my father to do something clearly dangerous; praying like hell that it would not be his suicide, accidental death, or the death of someone else.”¹ Jeneen Interlandi’s description of the chaos that ensued after her father began suffering from another episode of bipolar disorder has a ring of familiarity with families with a severely-mentally-ill family member.² To protect civil liberties, many state courts adhere to strict standards that require an individual to be dangerous before he will be admitted to a hospital against his will.³ But when combined with the scarcity of community resources,⁴ these involuntary commitment standards leave

1. Jeneen Interlandi, *A Madman in Our Midst*, N.Y. TIMES MAG., June 24, 2012, at 24.

2. See Pete Earley, *Parents Share Horror Stories but There’s Reason for Hope*, PETEEARLEY.COM, Oct. 1, 2012, <http://www.peteearley.com/2012/10/01/parents-share-horror-stories-but-theres-reason-for-hope>. One mother explains that her inability to control her son’s psychotic behavior resulted in him spending over four years in prison with no discussion of his mental illness during his sentencing and no follow up mental health treatment once he was released from prison. *Id.* Another parent explains frustrations stemming from the local community mental health organization refusing to continue treatment for her son after he wrote a threatening letter to an employee. *Id.*; see also Judy Beckman, *My First View of Mental Illness*, NAMI VOICE, Summer 2012, at 6, available at <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=166917> (describing the pervasiveness of growing up with a mother with a severe mental illness and the responsibilities given to a young child when a parent is hospitalized for mental illness).

3. See Adam Lamparello, *Why Wait Until the Crime Happens? Providing for the Involuntary Commitment of Dangerous Individuals Without Requiring a Showing of Mental Illness*, 41 SETON HALL L. REV. 875, 886–87 (2011) (explaining that most states require a finding of mental illness and danger to himself or others before ordering involuntary commitment).

4. The shortage of psychiatric beds in the United States is undeniable. While in 1955 there were 340 beds for mentally ill patients for every 100,000 people, in 2005 this number dropped to seventeen beds for every 100,000 people. E. FULLER TORREY ET AL., *THE SHORTAGE OF PUBLIC HOSPITAL BEDS FOR MENTALLY ILL PERSONS: A REPORT FOR THE TREATMENT ADVOCACY CENTER* (2008), available at http://www.treatmentadvocacycenter.org/storage/document/s/the_shortage_of_publichospital_beds.pdf. Expert psychiatrists recommend that there are fifty beds for every 100,000 people. *Id.*; see also Nina Bernstein, *Storm Weakened a Fragile System for Mental Care*, N.Y. TIMES, Dec. 17, 2012, at A1

families on their knees begging courts and mental health professionals to help their loved one.⁵ In some extreme cases, authorities have even hinted that families should lie under oath to commit their severely-mentally-ill⁶ family member, simply because there was no other way to get help.⁷

Although commitment of a severely-mentally-ill family member should only occur when all other options fail, obtaining hospitalization is stressful and burdensome to family members.⁸ This creates a system in which “[t]he families and friends of the disabled are the ‘true clients’ of the institutionalization system.”⁹ Although family members are able to petition the court to involun-

(highlighting the recent flooding of psychiatric hospitals after Hurricane Sandy, which were already strained and overly full prior to the additional stress of the hurricane).

5. See Pete Earley, *From the Mail Bag: Vermont Mom Frustrated by System Son Had to Get Arrested to Get Help*, PETEEARLEY.COM (Feb. 9, 2012), <http://www.petearley.com/2012/02/09/from-the-mail-bag-vermont-mom-frustrated-by-system-son-had-to-get-arrested-to-get-help/> (commenting on a mother’s inability to have her son committed to a hospital because he was not “dangerous to himself or others” until he committed a crime).

6. Severe mental illnesses include “major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder” and affect about one in seventeen Americans. *Mental Illnesses*, NAMI, http://www.nami.org/template.cfm?section=about_mental_illness (last visited Apr. 7, 2014); *Mental Illness: Facts and Numbers*, NAMI, http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155 (last visited Apr. 7, 2014).

7. Patrick Condon, *Shootings Expose Cracks in U.S. Mental Health System*, USA TODAY, Oct. 1, 2012, <http://www.usatoday.com/story/news/health/2012/10/01/shootings-expose-cracks-in-us-mental-health-system/1607127/> (summarizing the “sly suggestions” that police officers gave parents of people like Andrew Engeldinger, who shot multiple employees at a local sign company before committing suicide, and Kevin Earley, who broke into a local household to take a bubble bath).

8. See Pete Earley, *Want My Advice? Go to Another County for Help*, PETEEARLEY.COM (Jan. 30, 2012), <http://www.petearley.com/2012/01/30/want-my-advice-go-to-another-county-for-help/> (“Forcing someone into a hospital for treatment is a desperate act that is traumatic for the person who is ill and their entire family. It should only be done when all other options have failed.”).

9. *Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1990) (quoting ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATIONS OF MENTAL PATIENTS AND OTHER INMATES* 384 (1961)).

tarily commit another member,¹⁰ emotional harm and disruption to family life are not considered when a court analyzes a petition for commitment.¹¹ Additionally, the current mental health system does not involve a family in a severely-mentally-ill family member's long-term treatment plan.¹²

State involuntary commitment statutes should be amended to allow for commitment of an individual who is not dangerous but is causing serious emotional harm to family members.¹³ In addition, involuntary commitment problem-solving courts should be created to follow up on the severely-mentally-ill individual's treatment and provide assistance and support for family members caring for a severely-mentally-ill individual.¹⁴ By creating involuntary commitment courts with the participation of a judge, mental health specialists, and family members, severely-mentally-ill individuals will receive meaningful treatment.¹⁵ Meanwhile, their families will also be provided with a support system to assist in the care and rehabilitation of their family member.¹⁶

This Note promotes reformation of involuntary commitment standards so that families are able to commit a severely-mentally-ill individual who is causing serious emotional harm to the family but is not dangerous.¹⁷ Next, this Note endorses enactment of involuntary commitment courts, so that families have the ability to be involved in the long-term treatment of the severely-mentally-ill family member.¹⁸ Part II chronicles the history of mental health care in the United States,¹⁹ then discusses the history of involuntary commitment laws, current state statutory schemes, and

10. Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 40 (1999); *see also infra* Section I.B.

11. Iowa is the only state that takes into account emotional injury to family members when deciding whether to involuntarily commit an individual. *See discussion infra* Part III.

12. *See infra* Part II.

13. *See infra* Section IV.A.

14. These problem-solving courts would be rooted in therapeutic jurisprudence and modeled after mental health courts. *See infra* Section III.B.

15. *See infra* Section IV.B.

16. *See infra* Section IV.B.

17. *See infra* Section IV.A.

18. *See infra* Section IV.B.

19. *See infra* Section II.A.

more recent problem-solving courts based on therapeutic jurisprudence.²⁰ Part III produces a fifty state survey of involuntary commitment standards, emphasizing one state's standard that allows for involuntary commitment when the severely-mentally-ill individual is causing harm to the family.²¹ Part IV then calls for revision of state standards of commitment to acknowledge nonphysical injuries of family members caused by severely-mentally-ill individuals and recommends that states implement involuntary commitment problem-solving courts.²² Involuntary commitment courts would be grounded in the therapeutic jurisprudence theory used by other problem-solving courts,²³ follow up on patients' treatment, provide patients with goals to stabilize the disease, hold patients accountable for these goals, and allow families to be involved in review hearings.²⁴ Finally, Part IV provides an example of how an involuntary commitment court would hypothetically function.²⁵

II. MENTAL HEALTH: PAST AND PRESENT

Although mental health has long been pushed aside or ignored in society, the mental health system has recently taken the spotlight as a system in desperate need of policy reforms.²⁶ A thorough understanding of the history of mental health care is imperative because the past has played an important role in shaping current mental health laws.²⁷ Also important is an understanding of involuntary commitment proceedings, which "bridge the gap" between the mental health care system and the court system.²⁸

20. See *infra* Sections II.A-B.

21. See *infra* Part III.

22. See *infra* Section IV.B.

23. A problem-solving court is defined as "a specialized court that matches community resources to litigants whose problems or cases may benefit from those resources." BLACK'S LAW DICTIONARY 410 (9th ed. 2009).

24. See *infra* Section IV.B.

25. See *infra* Section IV.C.

26. Liz Szabo, *Newtown Shooting Prompts Calls for Mental Health Reform*, USA TODAY (Jan. 13, 2013), <http://www.usatoday.com/story/news/nation/2013/01/07/newtown-shooting-mental-health-reform/1781145/>.

27. See *infra* Section II.A.

28. Reese McKinney, Jr., *Involuntary Commitment, A Delicate Balance*, 20 QUINNIPIAC PROB. L.J. 36, 36 (2006).

A. The History of Mental Health Care

From the beginning, the public perception of severe mental illness has affected the type of care that is available to those suffering from these diseases.²⁹ The Egyptians, for example, treated mental illness as a physical illness.³⁰ The Romans, on the other hand, noted the need for a guardian during bouts of mental illness and also addressed the role the guardian would play during relapses.³¹ In the Middle Ages, those suffering from mental illnesses were placed in jail, rather than treated, because they were thought to be at fault for their illnesses.³²

In colonial America, families were expected to care for mentally ill family members without assistance from the government.³³ The idea of an institution for the mentally ill came into light during urbanization in the nineteenth century.³⁴ State asylums began opening throughout the country, and psychiatry became an

29. Unite for Sight, *A Brief History of Mental Illness and the U.S. Mental Health Care System*, MENTAL HEALTH ONLINE COURSE, <http://www.unitefor-sight.org/mental-health/module2> (last visited Apr. 7, 2014).

30. *About Stigma: The Evolution of Stigma*, ST. N.J. GOVERNOR'S COUNCIL ON MENTAL HEALTH STIGMA, <http://www.state.nj.us/mhstigmacouncil/about/evolution/> (last visited Apr. 7, 2014).

31. Jennifer Fischer, Note, *A Comparative Look at the Right to Refuse Treatment for Involuntarily Hospitalized Persons with a Mental Illness*, 29 HASTINGS INT'L & COMP. L. REV. 153, 153 (2006).

32. David A. Hoort, *Mental Illness and the Courts*, MICH. B.J., June 2012, at 28.

33. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972) (citing AM. BAR ASS'N, *THE MENTALLY DISABLED AND THE LAW* 4 (Samuel Brakel, Jr. & Ronald S. Rock eds., 1971)).

34. GERALD N. GROB, *THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL* 23, 25 (1994). Dorothea Dix began the movement to end asylums after she witnessed mentally ill individuals chained to walls and forced to sleep on cold floors in dungeon cells. N.C. Dep't of Health & Human Servs., *Biography of Dorothea Dix*, N.C. DEP'T ST. OPERATED HEALTHCARE FACILITIES, <http://www.ncdhhs.gov/dsohf/services/dix/bio.htm> (last updated Aug. 28, 2012). Dix witnessed this horrific event when she volunteered to teach a Sunday school class in the jail. *Id.* She then decided to travel from state to state to research conditions of the mentally ill, finding equally inhumane conditions in other states. *Id.* She lobbied state legislatures for change and went on to lobby for changes for the mentally ill throughout the world. *Id.*

innovative medical specialty in the United States.³⁵ Because asylums were thought to be the best and most efficient place to manage treatment of mental illnesses,³⁶ half of the states adopted statutes that provided for involuntary commitment when an individual presented a “need for treatment.”³⁷ Commitment proceedings during this time were very informal, and the family was primarily given the responsibility of committing a mentally ill family member.³⁸ Commitments were normally granted when a physician certified that the patient was in need of care,³⁹ which provided families with a method of obtaining treatment for a family member they were unable to treat through less restrictive means.⁴⁰ Commitments were generally made based on evidence of extreme behavior,⁴¹ but a few documented cases allege that some family members used asylums as a tool to control a family member’s estate or independence.⁴²

35. GROB, *supra* note 34, at 52–53, 55.

36. DAVID W. JONES, MYTHS, MADNESS AND THE FAMILY: THE IMPACT OF MENTAL ILLNESS ON FAMILIES 11 (2002) (stating that opponents of this viewpoint feel that asylums were created to control deviant behavior, much like workhouses and prisons).

37. John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL’Y & L. 377, 381 (1998) (discussing the implications of *Kansas v. Hendricks*, 521 U.S. 346 (1997), which upheld involuntary commitment of sexually violent offenders after their incarceration based upon states’ police and *parens patriae* powers). Standards for involuntary commitment were broad “so as to encourage early and prompt treatment.” *Id.* (quoting ALBERT DEUTSCH, *THE MENTALLY ILL IN AMERICA* 432 (2d ed. 1949)). Asylums housed predominately male patients because those exhibiting physically violent behavior were committed most often. KATHLEEN JONES, *ASYLUMS AND AFTER: A REVISED HISTORY OF THE MENTAL HEALTH SERVICES: FROM THE EARLY 18TH CENTURY TO THE 1990S*, at 117 (1993).

38. GROB, *supra* note 34, at 80.

39. BRUCE J. WINICK, *CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL* 140 (2005).

40. *Id.* at 80–81.

41. For example, reports indicate that family members sought to have other family members committed who refused to eat or threatened to kill themselves or others. *Id.* at 81.

42. *Id.* (“While wrongful commitment was by no means unknown, it was relatively rare.”). John Armstrong Chaloner, a wealthy but eccentric man, was involuntarily committed when his family felt he was no longer able to care for himself because of his erratic behavior. Carole Haber, *Who’s Looney Now?: The*

Although initially asylums were highly acclaimed, it soon came to light that the quality of life in asylums was horrific.⁴³ Patients were regularly lobotomized, sterilized, and kept in confinement for their entire lives.⁴⁴ Many argued that the deteriorated and overcrowded hospitals fostered mental illnesses.⁴⁵ By World War II, asylums were viewed so negatively that they were thought of as “snakepits” and subjected to heavy criticism.⁴⁶ A turning point came in 1946, when *Life Magazine* published “Bedlam: Most U.S. Mental Hospitals Are a Shame and a Disgrace,” which included a case study focused on a patient being tortured by hospital staff.⁴⁷ Other books and magazines followed that spread awareness of the atrocious conditions in asylums.⁴⁸

Insanity Case of John Armstrong Chaloner, 70 BULL. HIST. MED. 177, 177–79 (1986). Throughout his hospitalization, Mr. Chaloner contended that his family confined him because they did not want him to be able to reveal fraudulent family financial practices. *Id.* at 179. Mr. Chaloner escaped from the hospital and took great strides to prove his sanity, ultimately being declared competent in a neighboring state. *Id.* at 182–84. Unfortunately, Mr. Chaloner’s eccentric behavior continued after being declared sane, causing him to kill a neighbor and live as a recluse for most of his life. *Id.* at 189.

43. GROB, *supra* note 34, at 79–80. This was still an improvement from Nazi Germany, where the Nazis put the mentally ill in the rear cargo area of vans and gassed them with carbon monoxide. AUSCHWITZ: INSIDE THE NAZI STATE (BBC America 2005); *Orders and Initiatives*, PBS, http://www.pbs.org/auschwitz/about/transcripts_2.html (last visited Apr. 7, 2014).

44. Veronica J. Manahan, *When Our System of Involuntary Civil Commitment Fails Individuals with Mental Illnesses: Russell Weston and the Case for Effective Monitoring and Medication Delivery Mechanisms*, 28 LAW & PSYCHOL. REV. 1, 8 (2004).

45. LeRoy L. Kondo, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Jurisprudence*, 24 SEATTLE U. L. REV. 373, 386 (2000).

46. GROB, *supra* note 34, at 127. Asylums were frequently referred to as “nontherapeutic waystations ‘that disregarded the rights of sick and dependent persons and subjected them to cruel abuse.’” Cornwell, *supra* note 37, at 385 (quoting GERALD N. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875, at 5 (1973)).

47. Albert Q. Maisel, *Bedlam 1946*, LIFE MAG., May 6, 1946, at 102.

48. For example, Frank L. Wright’s OUT OF SIGHT OUT OF MIND and Albert Deutsch’s THE SHAME OF STATES, the former published in 1947 and the latter published in 1948, addressed reforms for mental institutions. GROB, *supra* note 34, at 204–05. Furthermore, Mary Jane Ward’s novel THE SNAKE PIT,

The end of the World War II brought an opportunity for change in the entire healthcare system. In 1946, President Truman signed into law the National Mental Health Act, creating the National Mental Health Advisory Council and the National Institute of Mental Health.⁴⁹ At this time, psychiatrists began prescribing psychiatric drugs, which created a new set of problems, including concerns regarding effectiveness, misadministration, and adverse side effects.⁵⁰ Although these new drugs made it easier to treat mental illnesses, courts' requirements for involuntary commitment were still arbitrary and without clear standards.⁵¹

which highlighted problems in institutions, was consolidated into a *Reader's Digest* article in 1946 and made into a movie in 1948. *Id.* at 206.

49. *Id.* at 208, 210.

50. Fischer, *supra* note 31, at 154–55. The introduction of the first psychotropic drug, chlorpromazine, improved hospital conditions and family optimism. GROB, *supra* note 34, at 230. But the drugs only alleviated symptoms—they did not cure diseases. One professor noted that “[f]ew would claim that our current wonder drugs exercise anything more than a palliative influence on psychiatric disorders.” JONES, *supra* note 37, at 150. A director of a mental hospital in the Netherlands referred to the drugs as a “chemical mask.” Toine Pieters & Steven Snelders, *Mental Ills and the ‘Hidden History’ of Drug Treatment Practices*, in *PSYCHIATRIC CULTURES COMPARED: PSYCHIATRY AND MENTAL HEALTH CARE IN THE TWENTIETH CENTURY: COMPARISONS AND APPROACHES* 381, 392 (Marijke Gijswijt-Hofstra et al. eds., 2006). Side effects such as “jaundice, cardiac problems, fever, hypotension or parkinsonian symptoms” were common, and some women taking the medication even grew beards. *Id.* These drugs also caused familial problems if patients returned home to live with their families because families were ill equipped to deal with the behavior caused by the medication. *Id.* at 392.

51. See Christyne E. Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 *VAND. L. REV.* 959, 963 (2008) (explaining that states were not consistent in involuntary commitment standards prior to the 1970s). Prior to 1976, Iowa’s statute provided one example of an unclear statute, which was found to violate substantive due process when it only required a finding of mental illness, rather than a finding of dangerousness. *Stamus v. Leonhardt*, 414 F. Supp. 439, 449–50 (S.D. Iowa 1976). The statute provided that the individual must be “‘believed to be mentally ill, and a fit subject for custody and treatment in the hospital.’” *Id.* (quoting IOWA CODE § 229.1 (1975)). On the other hand, England began having justices of peace certify patients for admittance into mental hospitals much earlier. JONES, *supra* note 37, at 112–13.

President Kennedy then shifted the focus of mental health treatment to a community mental health approach,⁵² eventually leading to the deinstitutionalization of mental health services.⁵³ Deinstitutionalization gained widespread support because it was thought to be the solution to the inhumane conditions in state hospitals.⁵⁴ Further, the 1960s Civil Rights Movement encouraged protection of the rights of the mentally ill by ensuring due process before a civil commitment could occur.⁵⁵ Advocates of this movement argued that mentally ill individuals maintained the competency to choose the course of their treatment without intervention.⁵⁶

Today, it seems that the shift toward deinstitutionalization has swung the pendulum too far the other way, leaving families desperate to find treatment for severely-mentally-ill family members who, because of their mental illnesses, often do not believe they are ill.⁵⁷ While there were 559,000 residents in mental hospi-

52. See GROB, *supra* note 34, at 204–05 (stating that the federal government provided three billion dollars to create community mental health centers that would replace state psychiatric hospitals); see also Christina Canales, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1732 (2012).

53. Ferris, *supra* note 51, at 966. Deinstitutionalization caused many unstable patients to be released, frequently resulting in poverty and homelessness. *Id.*

54. Canales, *supra* note 52, at 1733.

55. WINICK, *supra* note 39, at 141.

56. Fischer, *supra* note 31, at 156. Amongst other reasons, institutionalization was questioned because it was unclear whether mental health professionals had the ability to accurately predict if an individual would be dangerous in the future. See Randy K. Otto, *On the Ability of Mental Health Professionals to “Predict Dangerousness”*: A Commentary on Interpretations of the “Dangerousness Standard,” 18 LAW & PSYCHOL. REV. 43, 44–45 (1994). This skepticism remains a concern today.

57. “‘We’re protecting civil liberties at the expense of health and safety,’ says Doris A. Fuller, the executive director of the Treatment Advocacy Center, a nonprofit group that lobbies for broader involuntary commitment standards. ‘Deinstitutionalization has gone way too far.’” Interlandi, *supra* note 1, at 26; see also Justine A. Dunlap, *Mental Health Advance Directives: Having One’s Say?*, 89 KY. L.J. 327, 379 (2001) (explaining that the mentally ill must often choose treatment plans on their own); Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1317–18 (2000) (“[P]ersons with mental illness who reject voluntary treatment are not doing so because of rational free choice. Rather, changes in their brain structure . . . render them incapable of appreciating the profundity of their illness. Since

tals in 1955, by 1980 this number was down to 149,000.⁵⁸ Deinstitutionalization of mental health services was completed by the 1990s, and most of the institutions closed down.⁵⁹ In 2008, only 51,413 psychiatric beds were left in the United States.⁶⁰

Deinstitutionalization caused many community mental health centers to close their doors due to lack of funding,⁶¹ leaving many severely-mentally-ill individuals homeless or in jails and prisons.⁶² In fact, the largest mental health treatment facilities today are Rikers Island, the Cook County Jail, and the Los Angeles County Jail.⁶³ In the aftermath of deinstitutionalization, the severely mentally ill are being left to “die with their rights on.”⁶⁴

B. *Legal Justifications for Involuntary Commitment*

Civil, or involuntary, commitment is defined as “[a] commitment of a person who is ill, incompetent, drug-addicted, or the like, as contrasted with a criminal sentence.”⁶⁵ Involuntary commitment proceedings are initiated with a petition, which can be

they do not believe that they are ill . . . it is perfectly rational to refuse proffered treatment.”).

58. TORREY ET AL., *supra* note 4.

59. CHRIS KOYANAGI, *LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 1* (Kaiser Comm’n on Medicaid & Uninsured ed., 2007).

60. TORREY ET AL., *supra* note 4.

61. *See, e.g.*, Charles Thomas, *State Budget Crisis Straining Mental Health Efforts*, ABC7CHICAGO, July 27, 2012, <http://abclocal.go.com/wls/story?section=news/politics&id=8752171>; Paul Gionfriddo, *My Son Is Schizophrenic. The ‘Reforms’ That I Worked for Have Worsened His Life*, WASH. POST, Oct. 15, 2012, http://www.washingtonpost.com/national/health-science/my-son-is-schizophrenic-the-reforms-that-i-worked-for-have-worsened-his-life/2012/10/15/87b74a98-eadd-11e1-b811-09036bcb18_2b_story.html (explaining that a lack of funding for community mental health centers causes many mentally ill individuals to be housed in jails).

62. *See* PETE EARLEY, *CRAZY: A FATHER’S SEARCH THROUGH AMERICA’S MENTAL HEALTH MADNESS* 71–72 (2006).

63. Gionfriddo, *supra* note 61.

64. EARLEY, *supra* note 62, at 159 (borrowing a phrase coined by Wisconsin psychiatrist Dr. Darold Treffert).

65. BLACK’S LAW DICTIONARY 279 (9th ed. 2009). The definition continues to say: “In contrast to a criminal commitment, the length of a civil commitment is indefinite because it depends on the person’s recovery.” *Id.*

made by a mental health professional, family member, or other concerned person with personal knowledge of the severely-mentally-ill individual's actions.⁶⁶ Even if a family member does not initiate this petition, at least one state requires a family member or close relative to be identified in the petition for commitment.⁶⁷ The petition must allege that the individual is mentally ill and must include specific incidents that suggest that the individual is in need of hospitalization.⁶⁸ The allegedly mentally ill individual will then receive notice of the petition, and a formal hearing will follow.⁶⁹

Involuntary commitment is undisputedly a deprivation of an individual's liberty and freedom.⁷⁰ Many individuals who are committed to treatment involuntarily experience a "loss of freedom, loss of employment, and loss of self-control and determination."⁷¹ Therefore, although treating mental illness is important,⁷² the severely-mentally-ill individual must receive due process for the involuntary commitment to be constitutional.⁷³

66. See ALA. CODE § 22-52-1.2 (2012); 405 ILL. COMP. STAT. 5/3-601 (2012) (allowing for any person over 18 to file a petition); WIS. STAT. § 51.20 (2012) (requiring three adult individuals to sign the petition, at least one with personal knowledge).

67. 405 ILL. COMP. STAT. 5/3-601 ("The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses.").

68. *Id.*

69. Winick, *supra* note 10, at 40.

70. WINICK, *supra* note 39, at 59.

71. Donald H. Stone, *Giving a Voice to the Silent Mentally Ill Client: An Empirical Study of the Role of Counsel in the Civil Commitment Hearing*, 70 UMKC L. REV. 603, 607 (2002).

72. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 609–10 (Kennedy, J., concurring) ("It must be remembered that for the person with severe mental illness who has no treatment, the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our powers to describe.").

73. See generally EARLEY, *supra* note 62 (explaining the importance of a son receiving treatment for his severe mental illness and how difficult the legal system makes this process).

1. Constitutional Requirements for Involuntary Commitment

State law governs involuntary commitment, but the Supreme Court answered constitutional questions regarding involuntary commitment in cases such as *O'Connor v. Donaldson* and *Addington v. Texas*.⁷⁴ First, when a person with a severe mental illness is unable to care for his own material needs, the state is able to intervene under the *parens patriae* concept, which allows the state to provide care for its citizens if they are unable to do so.⁷⁵ Second, when a person has a mental illness and is dangerous to himself or others, the state is able to intervene under the police power to protect the community from dangerous persons.⁷⁶

a. *Parens Patriae* Concept

The *parens patriae* concept is derived from European law⁷⁷ and is defined as the state acting “in its capacity as provider of protection to those unable to care for themselves.”⁷⁸ This allows for commitments that protect mentally ill individuals who lack the ability to determine their own best interests.⁷⁹ The court then has the power to use its own decision making in place of the individual’s decision making regarding treatment when a person is unable to take care of himself.⁸⁰ The court’s focus is “understanding,

74. See *Addington v. Texas*, 441 U.S. 418 (1979); *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

75. See Fischer, *supra* note 31, at 164.

76. See *id.*

77. Manahan, *supra* note 44, at 4; see also *Lessard v. Schmidt*, 349 F. Supp. 1078, 1085 (E.D. Wis. 1972) (“The doctrine could be justified as a derivation of an English law, under which the King was appointed the guardian of the person and goods of a lunatic.”).

78. BLACK’S LAW DICTIONARY 1221 (9th ed. 2009).

79. *Addington*, 441 U.S. at 426 (“The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.”); see also WINICK, *supra* note 39, at 66.

80. WINICK, *supra* note 39, at 66; *Kent v. United States*, 383 U.S. 541, 554–55 (1966) (“The State is *parens patriae* rather than prosecuting attorney

guidance, and protection,” rather than “criminal responsibility, guilt, and punishment.”⁸¹

The Supreme Court was directly confronted with the constitutional substantive standards for involuntary commitment in 1975 in *O'Connor v. Donaldson*.⁸² After Donaldson experienced chronic delusions, his father petitioned a Florida court to commit Donaldson under the state’s law, resulting in a fifteen-year confinement in a state psychiatric institution.⁸³ The Supreme Court held that this confinement was unconstitutional and that a mental illness alone is not enough to involuntarily confine a person even under the *parens patriae* power.⁸⁴ Although the Court noted that the term “dangerous” could be interpreted as neglect of one’s needs, the Court held that a commitment is unjustified when a person is “capable of surviving safely in freedom by himself or with the help of willing and responsible family or friends.”⁸⁵

Still, the Court did not go as far as ruling that dangerousness is required before an involuntary commitment is constitutional,⁸⁶ which ultimately provided the basis for states to enact statutes that allowed for *parens patriae* commitments.⁸⁷ For example, the

and judge. But the admonition to function in a ‘parental’ relationship is not an invitation to procedural arbitrariness.”).

81. Joel F. Handler, *The Juvenile Court and the Adversary System: Problems of Function and Form*, 1965 WIS. L. REV. 7, 10.

82. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

83. *Id.* at 565.

84. *Id.* at 565, 575 (“A finding of ‘mental illness’ alone cannot justify a State’s locking a person up against his will and keeping him indefinitely in simple custodial confinement.”).

85. *Id.* at 575–76. States, therefore, are still constitutionally able to civilly commit individuals who are gravely disabled. Cornwell, *supra* note 37, at 384 (“This inclusion of dangerousness language within the definition of grave disability, coupled with the preference of some states to subsume grave disability within their definition of danger to self, suggests the interrelationship between the two standards.”).

86. *Donaldson*, 422 U.S. at 574 n.10; see Cornwell, *supra* note 37, at 384.

87. The American Psychiatric Association (APA) showed strong support for states enacting *parens patriae* standards of commitment in its Model Commitment Law in 1982. See AMERICAN PSYCHIATRIC ASS’N, GUIDELINES FOR LEGISLATION ON THE PSYCHIATRIC HOSPITALIZATION OF ADULTS (1982), available at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.173.2921&rep1&type=pdf>. The APA did, however, require a showing of a severe mental illness, so that the individual liberties of those experiencing mild symptoms of

Court did not deem commitments invalid if the commitment was based upon an individual's need for treatment when the patient was truly receiving treatment.⁸⁸

b. Police Power

Police power is defined as “[a] state’s Tenth Amendment right, subject to due process and other limitations, to establish and enforce laws protecting the public’s health, safety, and general welfare, or to delegate this right to local governments.”⁸⁹ Under the state’s police power, the state is able to protect its citizens against a person who is both mentally ill and dangerous.⁹⁰ Even before the Supreme Court decided *O’Connor*, many federal district courts placed emphasis on an individual being both imminently dangerous and mentally ill before being civilly committed.⁹¹ After the

mental illness or acting eccentrically were not compromised by *parens patriae* statutes. See Cornwell, *supra* note 37, at 387. Although hesitant to adopt the Model Rule, states eventually began replacing statutes centered strictly on the dangerous requirement with statutes that included *parens patriae* commitments. *Id.*

88. Cornwell, *supra* note 37, at 384 (“*Donaldson* did not, on its face, invalidate commitments based solely on a need for treatment where treatment was in fact provided.”).

89. BLACK’S LAW DICTIONARY 1276 (9th ed. 2009).

90. WINICK, *supra* note 39, at 59.

91. *Id.* In *Lessard v. Schmidt*, a landmark case, the Eastern District of Wisconsin ruled that the Constitution required that the individual be imminently dangerous, a standard that many courts subsequently followed. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1103 (E.D. Wis. 1972). Furthermore, when a state commits a person under the police power, the state may only require the least restrictive treatment available to diminish dangerousness. *Id.* at 1097. One state upheld an order of involuntary commitment when the individual, who suffered from chronic paranoid schizophrenia, was convinced police officers were plotting a conspiracy against him and was likely to be violent if threatened, although experts only classified this danger as “likely,” rather than agreeing that it was “imminent.” *In re Mental Health of A.S.B.*, 2008 MT 82, ¶¶ 27-29, 342 Mont. 169, 180 P.3d 625. Another state refused to uphold an involuntary commitment although the individual was verbally abusive, refused to leave her parents’ home, bit a police officer while resisting arrest, made racial remarks while hospitalized that could have provoked an attack on her, and refused medication. *In re Doe*, 78 P.3d 341, 343, 367 (Haw. 2003). The court reasoned that even these circumstances did not constitute clear and convincing evidence that the individual was imminently dangerous. See *id.* at 554.

decision in *O'Connor*, most states revised their statutes to require “dangerousness” as a basis for involuntary commitment,⁹² which turned “imminent dangerousness” into the “gold standard” for involuntary commitment.⁹³

Imminent dangerousness is still the ideal involuntary commitment standard required by courts.⁹⁴ Although some states provide other standards for commitment today, every state’s statute includes the dangerous standard.⁹⁵ In addition to being mentally ill and dangerous, many judges often only commit individuals who are unable to control their own behavior.⁹⁶

c. Standard of Proof

The standard of proof is intended to provide adequate due process before a mentally ill individual is committed against his will.⁹⁷ In 1979, the Court addressed the required standard of proof for involuntary commitment proceedings in *Addington v. Texas*.⁹⁸ The Court held that the Fourteenth Amendment requires clear and

92. Cornwell, *supra* note 37, at 386 (noting that between 1970 and 1985 practically all states revised their statutes to include dangerousness, when only half of the states included dangerousness in their statutes before 1970). Danger is still reflected in states’ commitment standards. For example, a person in Hawaii may be committed for involuntary hospitalization if he is “imminently dangerous to self or others.” HAW. REV. STAT. § 334-60.2 (2012).

93. Dora W. Klein, *When Coercion Lacks Care: Competency to Make Medical Treatment Decisions and Parens Patriae Civil Commitments*, 45 U. MICH. J.L. REFORM 561, 567 (2012).

94. *Id.*

95. *See infra* Subsection II.B.2.

96. *See* WINICK, *supra* note 39, at 60. Thus, the mental illness must cause an inability to control potentially dangerous behavior. *See id.* This distinguishes why a person who is mentally ill and dangerous is able to be civilly committed, while a person who is not mentally ill, but dangerous, is unable to be committed. *Id.* But *see* *Kansas v. Crane*, 534 U.S. 407, 413 (2002) (holding that a person is not required to have an absolute lack of control before being civilly committed). Still, this case failed to provide a precise mathematical equation to determine at what point lack of control is enough for commitment.

97. Alexander Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253, 260 (2011).

98. *Addington v. Texas*, 441 U.S. 418, 423 (1979).

convincing evidence of the need for an involuntary commitment.⁹⁹ By requiring a middle ground between the beyond a reasonable doubt standard and the preponderance of evidence standard, the Court ensured that individuals were not committed erroneously or unjustly,¹⁰⁰ while ensuring that states retained the ability to care for disabled individuals and protect the community from harm.¹⁰¹

2. State Statutes for Involuntary Commitment

Although the Supreme Court addressed the constitutionality of standards for involuntary commitment, the Court consistently reserved to the states the right to determine these standards individually.¹⁰² States vary in the criteria used for involuntary commitment based on danger:¹⁰³ some require that the potential harm result in serious injury,¹⁰⁴ some require “imminent danger,”¹⁰⁵ and

99. Each portion of the involuntary commitment statute must be proven by clear and convincing evidence. In this case, the statute’s factors were “whether the proposed patient is mentally ill” and “whether he requires hospitalization in a mental hospital for his own welfare and protection or the protection of others.” *Id.* at 420–21. States are free to employ the beyond a reasonable doubt standard, but may not fall below the “constitutional minimum.” *Id.* at 431.

100. *See id.* at 426–27 (“At one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable.”).

101. *See id.* at 430–31.

102. Cornwell, *supra* note 37, at 378.

103. Mark S. Kaufman, Note, ‘Crazy’ Until Proven Innocent? Civil Commitment of the Mentally Ill Homeless, 19 COLUM. HUM. RTS. L. REV. 333, 346–54 (1988).

104. *See, e.g.*, IDAHO CODE ANN. § 66-329 (2012) (using the language “likely to injure himself or others”); ME. REV. STAT. tit. 34-B, § 3864 (2012) (using the language “[the] person’s recent actions and behavior demonstrate that the person’s illness poses a likelihood of serious harm”).

105. *See, e.g.*, GA. CODE ANN. § 37-3-1 (2012) (requiring “a substantial risk of imminent harm to that person or others”); MONT. CODE ANN. § 53-21-126 (2012) (requiring “an imminent threat of injury to the respondent or to others because of the respondent’s acts or omissions”). One court held that committing someone who is not imminently dangerous is unconstitutional. *Suzuki v. Yuen*, 617 F.2d 173, 178 (9th Cir. 1980).

some require an overt dangerous action.¹⁰⁶ Other states allow for commitment in a broader sense, including commitment of those who are gravely disabled.¹⁰⁷

All fifty states allow for involuntary commitment when an individual is dangerous,¹⁰⁸ with most statutes specifically allowing for involuntary commitment when an individual is “dangerous to himself or others.”¹⁰⁹ However, these statutes differ as to the precise requirements for dangerousness.¹¹⁰ Recently, states have provided for involuntary commitment of a person who is likely to be dangerous but who has not yet committed an overtly dangerous act.¹¹¹ For example, Illinois allows an individual to be involuntarily committed if it is expected that the patient’s condition will deteriorate to a point that will cause him to be dangerous.¹¹²

106. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 574.035(e)–(f) (West 2012) (providing that to constitute clear and convincing evidence that an individual is in need of involuntary inpatient or outpatient treatment “the evidence must include expert testimony and evidence of a recent overt act or a continuing pattern of behavior that tends to confirm” the need for treatment); WIS. STAT. § 51.20 (2012) (requiring that there is a substantial likelihood of dangerousness evidenced by an overt act).

107. See, e.g., CONN. GEN. STAT. § 17a-495(a) (2012) (requiring that a person is at risk of “serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety . . . and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired”); IDAHO CODE ANN. § 66-317(13) (defining gravely disabled as a person who, because of mental illness, is “[i]n danger of serious physical harm due to the person’s inability to provide for any of his own basic personal needs, such as nourishment, or essential clothing, medical care, shelter or safety” or “[i]acking insight into his need for treatment and . . . if he does not receive and comply with treatment, there is a substantial risk he will continue to . . . deteriorate to the point that the person will . . . be in danger of serious physical harm”).

108. Klein, *supra* note 93, at 561.

109. See, e.g., CONN. GEN. STAT. § 17a-498.

110. WINICK, *supra* note 39, at 61–64. State statutes’ different requirements include: a likelihood of danger, an immediate danger, a specific kind of danger, or combination of these criteria. *Id.*

111. *Covell v. Smith*, No. 95-501, 1996 WL 750033, at *4 (E.D. Pa. Dec. 30, 1996) (holding that a “finding of ‘dangerousness’ does not require an overt act by the individual”).

112. 405 ILL. COMP. STAT. 5/1-119(3)(iii) (2012). The statute also provides for commitment if the individual will deteriorate to a point where he will be

Because federalism allows states to devise their own standards for civil commitment,¹¹³ many states have narrowly defined the criteria for involuntary commitment. Kentucky's state statute, for example, is very narrow in that it guarantees a jury trial and requires proof beyond a reasonable doubt before an individual will be committed.¹¹⁴ Pennsylvania's statute makes very explicit the requirements to show dangerousness to others by stating that it must be established by clear and convincing evidence that "within the past thirty days the person has inflicted or attempted to inflict serious bodily harm on another and that there is reasonable probability that such conduct will be repeated."¹¹⁵ This statute also provides that in order to be dangerous to himself, it must be proven that the person is (1) unable to care for himself and serious bodily injury or death would result within thirty days if not treated; (2) the person has attempted suicide and will commit suicide if not committed; or (3) the person has mutilated himself and is likely to continue without treatment.¹¹⁶

At least nine states provide for commitment when a person is gravely disabled.¹¹⁷ Under the gravely disabled standard, a person is able to be committed, even if he is not dangerous, by showing that he is too impaired to care for himself.¹¹⁸ The gravely disabled standard is permissible under the *parens patriae* power.¹¹⁹ It was first implemented due to concern that state statutes requiring dangerousness inhibited individuals suffering from severe mental

unable to provide for his personal needs. *Id.*; see also MONT. CODE ANN. § 53-21-126(d) (2012).

113. *Addington v. Texas*, 441 U.S. 418, 431 (1979).

114. KY. REV. STAT. ANN. § 202A.076(2) (West 2012) (requiring proof beyond a reasonable doubt and providing the option to request a jury trial). Some other states require proof beyond a reasonable doubt, and others have nuances included in the statutes that require proof beyond a reasonable doubt for specific elements. See Tsesis, *supra* note 97, at 274.

115. 50 PA. CONS. STAT. §§ 7301, 7304 (2012).

116. *Id.* § 7301.

117. See, e.g., ALASKA STAT. § 47.30.755(a) (2012); ARIZ. REV. STAT. ANN. § 36-540(A) (2012); CAL. WELF. & INST. CODE § 5213(a) (West 2012); CONN. GEN. STAT. § 17a-498(c) (2012); HAW. REV. STAT. § 334-60.2 (2012); IDAHO CODE ANN. § 66-329(11) (2012); KY. REV. STAT. ANN. § 202A.011; LA. REV. STAT. ANN. § 28:55 (2012); WASH. REV. CODE § 71.05.280 (2012).

118. Interlandi, *supra* note 1, at 46.

119. Cornwell, *supra* note 37, at 385-86.

illness from obtaining treatment, which in turn increased the mentally ill homeless population.¹²⁰

Some states have also undertaken minority approaches to involuntary commitment. For example, Ohio's statute allows for commitment upon infringement of the "substantial rights of others."¹²¹ At least three states allow for commitment when an individual is unable to understand his "need for treatment."¹²² Many states include provisions that allow for commitment when an individual's condition will significantly deteriorate if left untreated.¹²³ Other states have designed involuntary commitment statutes so that the burden of proof is different for different elements in the commitment to ensure due process.¹²⁴

a. Involuntary Outpatient Commitment

Still, providing treatment for patients who are committed on an inpatient basis is difficult because states are not constitutionally required to provide treatment to a point where the individual is completely rehabilitated or stable.¹²⁵ Rather, states are required to provide "minimally adequate or reasonable training to ensure safety and freedom from undue restraint."¹²⁶ To provide for better

120. *Id.* Washington was the first state to include the gravely disabled provision in its statute in 1979, allowing for commitment when an individual was unable to provide for his basic needs. *Id.* at 386. Other states expanded this even further by allowing commitment for those who were unlikely to be able to provide for their basic needs in the near future, although they were able to at the present time. *Id.* at 386.

121. OHIO REV. CODE ANN. § 5122.01 (LexisNexis 2012).

122. *See* 405 ILL. COMP. STAT. 5/1-119 (2012); KAN. STAT. ANN. § 59-2946(f) (2012) (providing that the individual must be unable to understand his need for treatment and likely to cause harm to himself in the near future or unable to provide for his basic needs); MINN. STAT. § 253B.02(a) (2012).

123. *See, e.g.,* ALA. CODE § 22-52-10.4 (2012) (stating that "the respondent will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently").

124. *See* Tsesis, *supra* note 97, at 275. Montana's statute requires proof beyond a reasonable doubt for medical evidence and the proof of the mental illness itself "to a reasonable medical certainty," but the clear and convincing standard for all other evidence, such as the evidence of the individual's behavior that indicates mental illness. *See* MONT. CODE ANN. § 53-21-126 (2012).

125. *See* Youngberg v. Romeo, 457 U.S. 307, 319 (1982).

126. *Id.*

treatment, most states have laws providing for involuntary outpatient commitment of the mentally ill, which have sometimes been enacted in response to incidents in which people with untreated mental illnesses killed or attempted to kill innocent bystanders.¹²⁷ These laws allow courts to prevent deterioration or relapse of mental illness by ordering an individual to take medication, attend therapy, live in a supervised living community, or to participate in any other service that would be beneficial to the individual.¹²⁸

States differ as to whether the standards for outpatient commitment are identical to standards for inpatient commitment.¹²⁹ When states have statutes for involuntary outpatient commitment that are different and less rigid than standards for involuntary inpatient commitment, states are able to treat individuals who would be unable to meet the standards for inpatient commitment.¹³⁰ In general, three types of involuntary outpatient commitment exist.¹³¹ The first is preventative commitment, which allows a person to be committed who does not meet the standards for inpatient commitment.¹³² The second is “hospital diversion” commitment, which allows commitment for people who can be treated in the community, although they are eligible for inpatient commitment.¹³³ Lastly,

127. Some examples of these laws include Kendra’s Law in New York, Kevin’s Law in Michigan, Laura’s Law in California, and Nicola’s Law in Louisiana. CAL. WELF. & INST. CODE § 5345 (West 2012); LA. REV. STAT. ANN. § 28:66 (2012); N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2012); MICH. COMP. LAWS § 330.1472(a) (2012). Still, not all states differentiate between the standards used for inpatient and outpatient treatment. Ilissa L. Watnik, Note, *A Constitutional Analysis of Kendra’s Law: New York’s Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1191–92 (2001) (suggesting that creating different standards for outpatient commitment would allow more people to be treated who do not meet the standards for inpatient treatment).

128. Hoort, *supra* note 32, at 30–31.

129. See ALA. CODE § 22-52-10.3 to 10.4 (2012) (distinguishing standards for inpatient and outpatient commitment and requiring that there is “a real and present threat of substantial harm to self and/or others” because of mental illness to be committed on an inpatient basis).

130. Watnik, *supra* note 127, at 1191–92.

131. Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment*, 31 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 109, 110 (2005).

132. *Id.*

133. *Id.*

conditional commitment exists to provide individuals with follow up care after they are released from inpatient commitment.¹³⁴

b. Therapeutic Jurisprudence and Mental Health Courts

The emerging theory of therapeutic jurisprudence aims to find interdisciplinary ways to use the law in a way that is therapeutic to the individual.¹³⁵ This approach asks decision makers to take into account the effect that a legal proceeding has on the individual psychologically.¹³⁶ Therapeutic jurisprudence also asks the legal community to weigh the effects of the law on individuals, family members, and the community so that the system can be beneficial to all.¹³⁷ Without this model, there are often “damaging outcomes for individuals, even if they ‘win’ a case.”¹³⁸ Furthermore, thera-

134. *Id.*

135. See David Wexler, *Putting Mental Health into Mental Health Law: Therapeutic Jurisprudence*, 16 LAW & HUM. BEHAV. 27, 27–32 (1992); see also Winick, *supra* note 10, at 38 (defining therapeutic jurisprudence as “an interdisciplinary field of legal scholarship and approach to law reform that focuses attention upon law’s impact on the mental health and psychological functioning of those it affects”). The term “therapeutic” is defined as “beneficial in the sense of improving the psychological or physical well-being of a person.” Keri K. Gould & Michael L. Perlin, “Johnny’s in the Basement/Mixing Up His Medicine”: *Therapeutic Jurisprudence and Clinical Teaching*, 24 SEATTLE U. L. REV. 339, 348 (2000).

136. Gould & Perlin, *supra* note 135, at 344.

137. Robert G. Madden & Raymie H. Wayne, *Social Work and the Law: A Therapeutic Jurisprudence Perspective*, SOC. WORK, July 2003, at 338, 340. The Supreme Court briefly addressed therapeutic jurisprudence in *Parham v. J.R.*, noting that it is important to recognize how the hearing itself could contribute to successful mental health treatment for the patient. *Parham v. J.R.*, 442 U.S. 584, 610 (1979) (“[I]t is appropriate to inquire into how such a hearing would contribute to the successful long-range treatment of the patient.”). Although it is unclear how much weight this theory will be given, the Court’s acknowledgement of the notion of therapeutic jurisprudence gives the theory credibility. Wexler, *supra* note 135, at 33. The district court for the Eastern District of Wisconsin also addressed the issue in *Lessard v. Schmidt*, noting that “patients respond more favorably to [mental health] treatment when they feel they are being treated fairly and are treated as intelligent, aware, human beings.” *Lessard v. Schmidt*, 349 F. Supp. 1078, 1101–02 (E.D. Wis. 1972).

138. Madden & Wayne, *supra* note 137, at 343 (quoting Janet Weinstein, *And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System*, 52 U. MIAMI L. REV. 79, 82 (1997)).

peutic jurisprudence specifically assesses the therapeutic or non-therapeutic consequences of the law on members of society who are generally unnoticed or treated marginally by the legal system.¹³⁹

So-called “problem-solving courts” became a national trend in the 1980s.¹⁴⁰ Drug courts were the first of these courts to appear, attempting to better manage judges’ caseloads and provide improved monitoring of treatment for drug abusers.¹⁴¹ Although problem-solving courts and therapeutic jurisprudence were developed independently, therapeutic jurisprudence was used to support the success of many problem-solving courts.¹⁴²

It has been said that “[i]n a courthouse filled with sad stories, [those of the mentally ill] are among the saddest of all.”¹⁴³ In an effort to balance punishment and treatment of mentally ill and developmentally disabled perpetrators of nonviolent crimes, the first mental health court was established in Broward County, Florida in 1997, which eventually became a model for other jurisdictions.¹⁴⁴ Although it would be impossible for mental health courts to entirely solve the problems created by the years of incoordination between the mental health and justice systems, preliminary

139. Kondo, *supra* note 45, at 380 (arguing that therapeutic jurisprudence “maintains that the law asserts beneficial therapeutic or detrimental anti-therapeutic psychological or other consequences upon individuals that are often minimized by the legal community”).

140. William J. Heaphy, Jr., *Wayne County’s Mental Health Court*, MICH. B.J., Aug. 2010, at 36, 37.

141. Kondo, *supra* note 45, at 399.

142. Therapeutic jurisprudence was used as the “jurisprudential theory” behind drug courts, but therapeutic jurisprudence was first developed to address all legal topics. Teresa W. Carns, Michael G. Gotchkin & Elaine M. Andrews, *Therapeutic Jurisprudence in Alaska’s Courts*, 19 ALASKA L. REV. 1, 5 (2002) (quoting Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System’s Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 449 (1999)). Therapeutic jurisprudence principles and close monitoring of offenders in drug courts, wellness courts, and mental health courts in Alaska have been shown to reduce rates of recidivism. *Id.* at 53–54.

143. Kondo, *supra* note 45, at 412.

144. Debra Baker, *Special Treatment: A One-of-a-Kind Court May Offer the Best Hope for Steering Nonviolent Mentally Ill Defendants into Care Instead of Jail*, A.B.A.J., June 1998, at 20.

research showed reduced rates of recidivism as a result of these courts.¹⁴⁵

Today, forty-three states have established their own mental health courts.¹⁴⁶ Each court has different standards of eligibility regarding the offense that allows for an individual to be admitted into the mental health court.¹⁴⁷ All mental health courts, however, function in a similar way in that they have a specialized docket of cases involving individuals with evidence of a mental illness; a collaborative group of players in the proceedings, usually including a judge, prosecutor, and an individual from a community mental health organization; a working relationship with this same community mental health organization; and a system that requires compliance with the program by setting in place rules and sanctions for noncompliance.¹⁴⁸ Participants in mental health courts proceed through the mental health court in a number of phases.¹⁴⁹

145. *See id.*

146. E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 520 (2012).

147. In Michigan, for example, mental health courts differ as to whether they allow felony offenders to be eligible for mental health court. *See* 72d Judicial Dist. Court Mental Health Court Div., Procedural Manual (Nov. 2011) (on file with author) (setting forth that only offenders of misdemeanors are eligible for the mental health court); *cf.* Genessee Cnty. Mental Health Court, Procedural Manual (on file with author) (allowing admittance to offenders of felonies at the district court level and misdemeanors). Other courts instead list the specific crimes that will make a defendant ineligible, for example sex crimes, crimes against children, and crimes committed with a weapon. THE SUPREME COURT OF OHIO JUDICIAL & COURT SERVS. DIV. SPECIALIZED DOCKETS SECTION, MENTAL HEALTH COURT DOCKET: A HANDBOOK FOR OHIO JUDGES 20 (2008) [hereinafter OHIO MENTAL HEALTH COURTS], available at <http://www.courts.state.tx.us/tjc/pdf/handbookmentalhealth.pdf>.

148. Nancy Wolff, Nicole Fabrikant & Steven Belenko, *Mental Health Courts and Their Selection Processes: Modeling Variation for Consistency*, 35 LAW & HUM. BEHAV. 402, 403 (2011).

149. Mental health courts in Ohio, for example, are divided into four phases. OHIO MENTAL HEALTH COURTS, *supra* note 147, at 29. First, a participant begins in the orientation phase, where the participant is familiarized and oriented with the rules of the program, is introduced to the treatment team, and attends an initial hearing. *Id.* Second, the participant moves to the stabilization phase, where the participant attends scheduled review hearings to ensure that the participant is complying with treatment. *Id.* at 30. Third, when the participant is stable for a certain period of time, the participant moves to the community reintegra-

Imperative to the success of mental health courts is a judge with a thorough understanding of mental illness.¹⁵⁰ For maximum success, the judge must be qualified for a position in the mental health court by having specialized knowledge of mental illnesses, an understanding of therapeutic jurisprudence, and a commitment to applying therapeutic jurisprudence to the courtroom.¹⁵¹ Thus, the judge becomes more than a “mere adjudicator of charges” by taking an “active role” in treating the offenders.¹⁵²

Mental health courts are able to create a better model for treatment because the collaborative work with community mental health organizations holds the individual accountable for participation in treatment, and the unique system of rewards and sanctions allows for an open flow of communication between the judge, mental health professionals, and the participants.¹⁵³ Further, although a guilty plea is normally necessary for eligibility in mental health court, mental health courts are able to minimize jail time for a mentally ill offender by relying on probation and periodic reporting to the mental health court.¹⁵⁴ This allows mental health courts

tion phase, which addresses other needs outside of psychiatric treatment to transition the participant back into the community. *Id.* at 31. Fourth, the participant enters the maintenance phase, where the treatment team focuses on teaching the participant discipline so that the participant will have the ability to maintain the same level of structure after she graduates from the mental health court. *Id.* at 32. In the maintenance phase, the amount of case management will decrease. *Id.* In order to graduate from this phase, some examples of goals the participant must accomplish are to follow psychiatric treatment plans, obtain permanent housing and employment, and find a stable support system. *Id.* Finally, a graduation ceremony occurs if the participant successfully completes the requirements of the mental health court, which is the “ultimate reward” for the participant. *Id.* at 32–33.

150. Baker, *supra* note 144, at 22. This necessity becomes difficult when judges do not receive regular training or education regarding mental health. Jessie B. Gunther, *Reflections on the Challenging Proliferation of Mental Health Issues in the District Court and the Need for Judicial Education*, 57 ME. L. REV. 541, 549 (2005) (describing that education of Maine judges primarily consists of on the job training).

151. Kondo, *supra* note 45, at 287–88.

152. *Id.* at 287.

153. See generally Mike Eidelbes, *Mental Health Court Shows Promise*, MICH. B.J., Jan. 2008, at 16 (describing the early success of Michigan mental health courts).

154. *Id.*

to promote voluntary treatment for mental illnesses, while keeping the mentally ill out of jail.¹⁵⁵

III. INVOLUNTARY COMMITMENT STATUTES RECOGNIZING THE FAMILY

Most family members caring for a severely-mentally-ill family member need professional assistance in providing care at some point.¹⁵⁶ Caring for a mentally ill family member becomes difficult when the family member does not believe he is in need of treatment or is uncooperative or unwilling to be treated.¹⁵⁷ Although petitioning for involuntary commitment was once the first step in obtaining treatment for a family member, today it is regarded as a last resort.¹⁵⁸ Additionally, because most states only commit individuals when they are dangerous,¹⁵⁹ “[f]amily members’ efforts to intervene are often frustrated by the very laws which were designed to protect their mentally ill loved one.”¹⁶⁰ Other difficulties arise because many families seeking to involuntarily commit another family member are unaware of the legal requirements of involuntary commitment or are unprepared to present a case that will satisfy these requirements.¹⁶¹ Obtaining information from individuals suffering from mental illnesses may also be diffi-

155. Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 *FORDHAM URB. L.J.* 1055, 1059 (2002) (explaining that mental health courts “seek to divert from the criminal justice system and to persuade them to voluntarily accept treatment while in the community”).

156. Liza Long, *‘I Am Adam Lanza’s Mother’: A Mom’s Perspective on the Mental Illness Conversation in America*, *THEBLUEVIEW*, Dec. 14, 2012, <http://thebluereview.org/i-am-adam-lanzas-mother/> (“When I asked my son’s social worker about my options, he said that the only thing I could do was to get Michael charged with a crime. ‘If he’s back in the system, they’ll create a paper trail,’ he said. ‘That’s the only way you’re ever going to get anything done. No one will pay attention to you unless you’ve got charges.’”).

157. See McKinney, Jr., *supra* note 28, at 44.

158. *Id.* at 37.

159. See *supra* Subsection II.B.2.

160. McKinney, Jr., *supra* note 28, at 44–45.

161. Robert J. Kaplan, *Keys to Commitment*, *TREATMENT ADVOC. CENTER* (1998), <http://www.treatmentadvocacycenter.org/component/content/article/358>.

cult because the severe mental illness may cause a lack of trust in others.¹⁶²

Iowa is the only state to have a statute that unambiguously recognizes the impact that severely-mentally-ill individuals have on their families when the individual is not dangerous.¹⁶³ In Iowa, a person will be involuntarily committed if the court finds by clear and convincing evidence that the person is “seriously mentally im-

162. See Stone, *supra* note 71, at 606.

163. ALA. CODE § 22-52-10.4(a) (2012); ALASKA STAT. § 47.30.755(a) (2012); ARIZ. REV. STAT. ANN. § 36-540(A) (2012); ARK. CODE ANN. § 20-47-207(c) (2012); CAL. WELF. & INST. CODE § 5213(a) (West 2012); COLO. REV. STAT. § 27-65-101(b) (2012); CONN. GEN. STAT. § 17a-498(c) (2012); DEL. CODE ANN. tit. 16, § 5001(7) (2012); D.C. CODE § 21-545 (2012); FLA. STAT. ANN. § 394.467(1) (West 2012); GA. CODE ANN. § 37-3-1(9.1) (2012); HAW. REV. STAT. § 334-60.2 (2012); IDAHO CODE ANN. § 66-329(11) (2012); 405 ILL. COMP. STAT. 5/1-119 (2012); IND. CODE § 12-7-2-53 (2012); IOWA CODE § 229.1 (2012); KAN. STAT. ANN. § 59-2946(f) (2012); KY. REV. STAT. ANN. § 202A.011 (West 2012); LA. REV. STAT. ANN. § 28:55 (2012); ME. REV. STAT. tit. 34-B, § 3864 (2012); MD. CODE ANN., HEALTH-GEN. § 10-632 (West 2012); MASS. GEN. LAWS ch. 123, § 8 (2012); MICH. COMP. LAWS § 330.1438 (2012); MINN. STAT. § 253B.02(a) (2012); MISS. CODE ANN. § 41-21-61(e) (2012); MO. REV. STAT. § 632.350(5) (2012); MONT. CODE ANN. § 53-21-126(1) (2012); NEB. REV. STAT. § 71-908 (2012); NEV. REV. STAT. § 178.425 (2012); N.H. REV. STAT. ANN. § 135-C:34 (2012); N.J. STAT. ANN. § 30:4-27.15 (West 2012); N.M. STAT. ANN. § 43-1-12 (2012); N.Y. MENTAL HYG. LAW § 9.01 (McKinney 2012); N.C. GEN. STAT. § 122C-268 (2012); N.D. CENT. CODE § 25-03.1-02(12) (2012); OHIO REV. CODE ANN. § 5122.01(B) (LexisNexis 2012); OKLA. STAT. tit. 43A, § 1-103(13)(a) (2012); OR. REV. STAT. § 426.005(e) (2012); 50 PA. CONS. STAT. § 7301(a) (2012); R.I. GEN. LAWS § 40.1-5-8 (2012); S.C. CODE ANN. § 44-17-580 (2012); S.D. CODIFIED LAWS § 27A-1-2 (2012); TENN. CODE ANN. § 33-6-501 (2012); TEX. HEALTH & SAFETY CODE ANN. § 574.035 (West 2012); UTAH CODE ANN. § 62A-5-312(13) (West 2012); VT. STAT. ANN. tit. 18, § 7101(17) (2012); VA. CODE ANN. § 37.2-815 (2012); WASH. REV. CODE § 71.05.280 (2012); W. VA. CODE § 27-5-4(1) (2012); WIS. STAT. § 51.20(2) (2012); WYO. STAT. ANN. § 25-10-101(xiii) (2012). Other states, however, do include the family in the portion of the statute that allows for commitment when an individual is a danger to himself or others. See, e.g., KY. REV. STAT. ANN. § 202A.026 (providing “a danger or threat of danger to self, family or others as a result of the mental illness”). The Florida Supreme Court, similarly, held that an individual can be committed when he is an individual “likely to inflict emotional injury to another,” but the family is not explicitly recognized in Florida’s statute. *In re Beverly*, 342 So. 2d 481, 487 (Fla. 1977); FLA. STAT. ANN. § 394.467(1).

paired.”¹⁶⁴ Iowa defines “seriously mentally impaired” as “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.”¹⁶⁵ As a result of the mental illness, the individual must exhibit one of three criteria for commitment.¹⁶⁶ One of these criteria is that the individual 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.”¹⁶⁷ Iowa defines “serious emotional injury” as “an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.”¹⁶⁸

The Supreme Court of Iowa interpreted “severe emotional injury” to mean more than mere emotional trauma in 1996 in *In re J.P.*¹⁶⁹ In this case, a mother, while suffering from either a delusional disorder or major depression, removed her children, eight and twelve years old, from the family home to a women’s shelter without informing her spouse.¹⁷⁰ The court overturned the judicial hospitalization referee’s finding that the children suffered from emotional trauma from the mother’s removal of her children to the shelter and the referee’s order of outpatient commitment, stating that “a finding of emotional trauma is an insufficient basis for in-

164. IOWA CODE § 229.12 (2012).

165. *Id.* § 229.1(17).

166. *Id.*

167. *Id.* § 229.1(17)(b). The other two criteria are: “likely to physically injure the person’s self or others if allowed to remain at liberty without treatment” and “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.” *Id.*

168. *Id.* § 229.1(16). The court will then grant the petition and commit a person for treatment if “the court finds by clear and convincing evidence that the respondent has a serious mental impairment.” *Id.* § 229.13(1).

169. See *In re J.P.*, 574 N.W.2d 340, 344 (Iowa 1996).

170. *Id.* at 341–43.

voluntary hospitalization.”¹⁷¹ The court also noted its reluctance to hold that a woman removing herself and her children to a battered women’s shelter would be grounds for involuntary commitment as a matter of public policy.¹⁷²

Because the court has made no other rulings on the portion of the statute regarding “serious emotional injury” to a family member, the unique facts in this case make it difficult to predict how Iowa courts will apply this statute in the future.¹⁷³ Still, although the Iowa Supreme Court did not provide a clear definition of “serious emotional injury,” it did indicate that “serious emotional injury” is more than emotional trauma.¹⁷⁴ Thus, the Iowa Supreme Court’s holding acknowledges that severely-mentally-ill individuals who cause their family “serious emotional injury” may be committed, while still requiring that clear and convincing evidence of an injury that “can be recognized and diagnosed by a licensed physician or other mental health professional” exists before the court will grant a petition.¹⁷⁵ Iowa’s standard for involuntary commitment, therefore, recognizes that severely-mentally-ill individuals may require commitment if their behavior is causing serious emotional harm to the family, even if their behavior is not dangerous, without jeopardizing their right to be free from wrongful commitment.¹⁷⁶

IV. IMPROVING INVOLUNTARY COMMITMENT

Current involuntary commitment statutes are unsuccessful because they provide treatment too late or not at all.¹⁷⁷ Recent pro-

171. *Id.* at 342, 344.

172. *Id.* at 344.

173. *See id.*

174. *See id.*

175. *See* IOWA CODE § 229.12 (2012); *id.* § 229.1(16).

176. Daily Iowan Editorial Bd., *Involuntary Commitment Standards Remain Sufficient*, DAILY IOWAN, Apr. 13, 2011, <http://www.dailyiowan.com/2011/04/13/opinions/22782.html>.

177. *See* Marshall Frank, *Marshall Frank: Mental Health System Broken; Just One Reason Why It’s Difficult to Prevent Gun Tragedies*, TCPALM (Jan. 11, 2013, 4:00 A.M.), <http://www.tcpalm.com/news/2013/jan/11/marshall-frank-mental-health-system-broken-just/>. In describing the recent school shootings in Connecticut and the tragic school shooting in Columbine, Mr. Frank suggests

posed reforms center on dangerousness and violence, but fail to address severely-mentally-ill individuals who are in need of treatment but are not violent or dangerous.¹⁷⁸ Additionally, these proposed reforms are not enough to fix a “broken mental health system.”¹⁷⁹

A more appropriate focus would be to expand involuntary commitment standards so that families are able to get treatment for an individual who is not dangerous but is causing serious emotional injury to family members. This, in turn, could alleviate the challenges that families face when navigating the system looking for treatment for their loved ones.¹⁸⁰ Families are often unable to successfully have their severely-mentally-ill family member treated, sometimes because he refuses treatment.¹⁸¹ Although Iowa pro-

that “[p]eople closest to the killers were witness to out-of-touch behavior, but nothing could be done until crimes were committed”—it was too late. *Id.*; see also Pete Earley, *From My Mailbag: A Daughter’s Frustration with Her Sick Father*, PETEEARLEY.COM (Aug. 13, 2012), <http://www.peteearley.com/2012/08/13/from-my-mailbag-a-daughters-frustration-with-her-sick-father/>. Mr. Earley responds to a blog reader’s letter discussing the difficulties of obtaining treatment for her bipolar father. *Id.* The daughter asks: “What did it take for the ‘experts’ to listen to us? What it took was him going completely psychotic.” *Id.* Earley responds by stating that family members must “continue to advocate for a better system and better laws.” *Id.*

178. Christopher Gordon, Letter to the Editor, *Sunday Dialogue: Treating the Mentally Ill*, N.Y. TIMES, Feb. 3, 2013, at P2 (explaining that a “tiny minority” of mentally ill individuals commit serious crimes).

179. Recently, proposed legislation “include[s] strengthening mental health services, lowering the threshold for involuntary commitment and increasing requirements for reporting worrisome patients to the authorities.” Erica Goode & Jack Healy, *Focus on Mental Health Laws to Curb Violence Is Unfair, Some Say*, N.Y. TIMES, Feb. 1, 2013, at A13.

180. Kaplan, *supra* note 161. It is suggested that family members who would like to have a mentally ill family member detained because of disruptive behavior call police officers for help between Thursday and Sunday. *Id.* Furthermore, it is also suggested that family members choose words wisely when describing psychotic episodes to police officers. *Id.* For example, they should describe altercations with the family member in words that emphasize the violence in the behavior. *Id.*

181. See James Andrews, Letter to the Editor, *Sunday Dialogue: Treating the Mentally Ill*, N.Y. TIMES, Feb. 3, 2013, at P2 (“My colleagues and I regularly encounter family members of mentally ill defendants who plead with us to somehow get treatment for their loved one before they do something unthinkable.”); see also Gary Tsai, Letter to the Editor, *Sunday Dialogue: Treating the*

vides the first steps to improve the family's circumstances by including the family's non-physical injuries in a standard for involuntary commitment,¹⁸² states must do more to ensure that the interests of the family caring for the mentally ill individual are heard during and after the commitment, when follow up on treatment is crucial.¹⁸³

A. *The Need for Other States to Enact Statutes Similar to Iowa's Statute*

State inpatient and outpatient commitment standards should be expanded to allow for involuntary commitment when a severely-mentally-ill individual is causing harm to his family without being blatantly dangerous, as seen in Iowa.¹⁸⁴ Currently, more than sixty percent of those who suffer from a first episode of a severe mental illness return to live with their family after hospitalization.¹⁸⁵ Family members of the severely mentally ill are in desperate need of a system that enables the family and the individual to function as a cohesive unit in treatment and recovery.

The other forty-nine states' involuntary commitment statutes fail to take into account the serious consequences that failure to commit a disruptive severely-mentally-ill family member will have on the family. This is at odds with the history of the family as

Mentally Ill, N.Y. TIMES, Feb. 3, 2013, at P2 ("For my mother, and for hundreds of thousands of others with severe mental illness, declining treatment is not about providers not listening, side effects of medications or stubborn denial. She fundamentally does not believe she needs help, despite a wealth of reality-based evidence to the contrary.").

182. See *infra* Section IV.A.

183. See *infra* Section IV.B.

184. See IOWA CODE § 229.1(17)(b) (2012). The need for change in commitment standards is evident in a graduate student's experience watching a police officer beat up a severely-mentally-ill individual so that the individual would exhibit enough symptoms of mental illness to be committed to a hospital. Mark J. Heyrman, Professor, Univ. of Chi. Law Sch., Address at the Michigan State University College of Law Journal of Medicine and Law Symposium: The Criminalization of Mental Illness: Turning Patients into Inmates (Feb. 8, 2013).

185. Christine Barrowclough, *Families of People with Schizophrenia*, in FAMILIES AND MENTAL DISORDERS: FROM BURDEN TO EMPOWERMENT 1, 1 (Norman Sartorius et al. eds., 2005).

a self-supporting unit in times of need.¹⁸⁶ The family has been regarded as an asset in terms of a patient's medical care for a number of reasons: (1) the family is usually the most concerned about the well-being of the patient; (2) the family is recognized as a unit capable of making responsible decisions about the welfare of its members; and (3) to be recognized as a member of a family in a society in which community support systems have all but disappeared is important in maintaining one's self-worth.¹⁸⁷ These rationales are also true of the families of severely-mentally-ill individuals and justify the need for the family to be involved and acknowledged in standards for involuntary commitment.

Other areas of the law take into account third parties, including families, whose rights are adversely affected during legal proceedings.¹⁸⁸ For example, federal prosecutors are guided to recognize third-party interests, such as a patient's interest, as a "constraint on punishment" when prosecuting health care fraud.¹⁸⁹ On one hand, because health care fraud is costly to the public, the Justice Department weighs the same factors typically used in criminal law: deterrence and culpability.¹⁹⁰ But, at the same time, punishment of this crime also looks outside of the traditional deterrence and culpability theories of punishment by taking into account patients whose treatment will be affected by the punishment of their health care provider.¹⁹¹

186. See *Moore v. City of East Cleveland*, 431 U.S. 494, 504–05 (1977) ("Out of choice, necessity, or a sense of family responsibility, it has been common for close relatives to draw together and participate in the duties and the satisfactions of a common home.").

187. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED., BIOMEDICAL & BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS* 128–29 (1983) (identifying five reasons why the family is important in decision making for incompetent adults).

188. See Darryl K. Brown, *Third-Party Interests in Criminal Law*, 80 TEX. L. REV. 1383, 1385–86 (2002) (arguing that recognizing a third party interest is also uncommon in criminal punishments).

189. *Id.* at 1387–89.

190. *Id.* at 1388.

191. *Id.* Third parties are also addressed in bankruptcy proceedings when deciding how to reorganize assets so that employees or family members are protected. *Id.* at 1409.

Similarly, federal judges can take a criminal defendant's dependent family members into account during sentencing.¹⁹² Judges can consider family circumstances and the effect that incarceration of a parent or other family member who acts as a primary caregiver will have on the remaining family members.¹⁹³ For example, a sentence might be reduced due to the fact that children are often unable to form relationships with their incarcerated parents because they are left to grapple with the difficult visitation schedules and policies in jails and prisons.¹⁹⁴

Turning to involuntary commitment, the family is the third party who suffers from injuries, emotional and physical, when another family member fails to receive treatment for a severe mental illness. When third-party rights are recognized in other areas of law, it is because the third party has a "clear, direct, and concentrated" injury.¹⁹⁵ Family members of those subject to involuntary commitment fit this standard because they experience injuries as a result of the mental illness. Some examples include: becoming victims of the symptoms of the mentally ill individual's disease, even absent direct violence;¹⁹⁶ suffering grief over the "loss" of their

192. *Id.* at 1390. In 1984, the federal government created the Federal Sentencing Guidelines, created and published by the Federal Sentencing Commission, which were then mandatory for judges to use in their decision making. Lara Waters, Note, *A Power and a Duty: Prosecutorial Discretion and Obligation in United States Sentencing Guidelines*, 34 CARDOZO L. REV. 813, 816 (2012). Judges, however, are not required to use the Guidelines after the Supreme Court's decision in *United States v. Booker*, 543 U.S. 220 (2005). The Federal Sentencing Commission was instructed to create guidelines that take into account "family ties and responsibilities" to "the extent that they do have relevance." 28 U.S.C. § 994(d) (2006), amended by Secure and Responsible Drug Disposal Act of 2010, Pub. L. No. 111-273, 124 Stat. 2858. Although most state courts do not have explicit guidelines recognizing third parties, it may be that interests of third parties are regularly incorporated into decisions on prosecution and sentencing. Brown, *supra* note 188, at 1390.

193. See Chesa Boudin, *Children of Incarcerated Parents: The Child's Constitutional Right to the Family Relationship*, 101 J. CRIM. L. & CRIMINOLOGY 77, 98 (2011).

194. See *id.* at 98-103 (assuming that this relationship is in the best interests of the child).

195. Brown, *supra* note 188, at 1402.

196. DIANE T. MARSH, *SERIOUS MENTAL ILLNESS AND THE FAMILY: THE PRACTITIONER'S GUIDE* 58 (1998).

severely-mentally-ill family member, even if the individual is still living;¹⁹⁷ experiencing a disruption in family life; and experiencing added stress.¹⁹⁸ These injuries could be addressed in states' laws by amending involuntary commitment statutes to include "serious emotional injury to the family" as one criterion for involuntary commitment.

B. *Involuntary Commitment Problem-Solving Courts That Include the Family*

Although states expanding statutes for involuntary commitment would alleviate some of the family's burden, enacting this standard will not "bridge the gap" between families, courts, and mental health care providers.¹⁹⁹ Involuntary commitment problem-solving courts should be enacted so that families are incorporated into their severely-mentally-ill loved one's plan of care during commitment, inpatient or outpatient, and after release.²⁰⁰ Because mental health courts have been successful in balancing punishment and treatment for mentally ill offenders of crimes, it seems that others who suffer from mental illnesses, but who have not committed a crime, could benefit from the structure of a similar system—as opposed to being involuntarily committed and subsequently re-

197. *Id.* at 56; *see also* A SISTER'S CALL (Greyhawk Films & Tekiela Creative 2012). This film follows a sister who must care for her mentally ill brother, Call, when he returns home after disappearing for twenty years. *Id.* She explains that her "dream is for Call to be normal." *Id.*

198. All family members experience at least some of the following problems: "household disarray, financial difficulties, employment problems, strained marital and family relationships, impaired physical and mental health, and diminished social life." MARSH, *supra* note 196, at 58.

199. McKinney, Jr., *supra* note 28, at 452.

200. The family as a unit has routinely been held to be of utmost importance to society, even deserving of great constitutional protections. *See* Stanley v. Illinois, 405 U.S. 645, 651 (1972) (emphasizing the importance of family to the Court); Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (giving parents exclusive rights to care, custody, and control of their children); Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (allowing parents to determine the manner in which they raise their children).

leased without follow up care.²⁰¹ Because mental health courts currently only accept mentally ill individuals who have committed a crime, a separate involuntary commitment court is necessary to provide this same model of collaborative treatment for severely-mentally-ill individuals who have not committed a crime.²⁰² With one mental health court reducing days of psychiatric hospitalization by ninety-eight percent,²⁰³ other aspects of the currently failing mental health system should imitate mental health courts' structure to bring about meaningful change.

In an involuntary commitment court, a judge would first decide whether an individual is subject to involuntary inpatient or outpatient commitment as set forth in the state's statute,²⁰⁴ which, assumedly, would be expanded to allow for commitment when an individual is causing "serious emotional injury" to the family.²⁰⁵ If clear and convincing evidence that the individual is in need of commitment exists, the individual would voluntarily choose to participate in the involuntary commitment court instead of proceeding with a traditional involuntary commitment proceeding.²⁰⁶ Severely-mentally-ill individuals would have an incentive to participate in

201. See generally Kirk Kimber, *Mental Health Courts—Idaho's Best Kept Secret*, 45 IDAHO L. REV. 249 (2008) (arguing that Idaho has ten essential elements that make mental health courts successful).

202. See Susan L. Pollet, *The Quiet Revolution in the Court System: Mental Health Courts*, 30 WESTCHESTER B.J. 35, 36 (2003) (explaining that although every mental health court has different conditions and sanctions, every mental health court has common themes).

203. Norma Jaeger, *Where We Have Been and Where We Are Going: A Review of Idaho's Drug and Mental Health Courts*, 48 ADVOCATE 26, 27 (2005) (reporting the success rate of the 7th District Mental Health Court in Bonneville County, Idaho). Similar success has been shown in family drug courts, where 97% of participants in the Pima County Family Drug Court entered into some form of treatment. José B. Ashford, *Treating Substance-Abusing Parents: A Study of the Pima County Family Drug Court Approach*, JUV. & FAM. CT. J., Fall 2004, at 27, 32.

204. In order to comport with due process, this first hearing would be a formal hearing. WINICK, *supra* note 39, at 142. This would improve current involuntary commitment hearings, which in practice often fail to be as formal as mandated by statute. *Id.*

205. See *supra* Section IV.A.

206. All mental health courts require that a person participate voluntarily. Allison D. Redlich, *Voluntary, but Knowingly and Intelligent? Comprehension in Mental Health Courts*, 11 PSYCHOL. PUB. POL'Y & L. 605, 605 (2005).

involuntary commitment court because they would have the opportunity to have their voices consistently heard by the judge in court.²⁰⁷ Because individuals are more likely to comply with legal proceedings when they feel they have been treated fairly,²⁰⁸ using a therapeutic jurisprudence model for this program would provide therapeutic benefits for the participant and encourage compliance with treatment orders.

The involuntary commitment court would be comprised of a judge, mental health professionals, and any interested family members.²⁰⁹ The involuntary commitment court would meet each week and would be structured into specific phases, with the frequency and intensity of the participants' review hearings varying according to their current phase of the program.²¹⁰ Similarly to mental health court, the involuntary commitment court would ensure treatment, offer rewards, and impose sanctions.²¹¹ Involuntary commitment courts would also allow families and other loved ones to track the progress of the severely-mentally-ill individual and voice any concerns they may have at each review hearing.

Involuntary commitment courts would also shift the sole burden of caring for the severely-mentally-ill individual away from the family.²¹² Outside of strictly monetary costs to society, the in-

207. Therapeutic jurisprudence allows individuals to give their voice to the tribunal, allowing individuals to feel validated when they feel the tribunal hears their voices. Michael L. Perlin, Professor, N.Y. Law Sch., Address at the Michigan State University College of Law Journal of Medicine and Law Symposium: The Criminalization of Mental Illness: Turning Patients into Inmates (Feb. 8, 2013).

208. Winick, *supra* note 10, at 44. Studies reveal that a hearing is beneficial when a patient feels it administers justice. *Id.* at 50.

209. Unlike mental health courts, the involuntary commitment court would not be criminal in nature, so a prosecutor or probation officer would be unnecessary. See Wolff, *supra* note 148, at 403.

210. Involuntary commitment courts would follow the same four treatment phases as many mental health courts. See *supra* Section I.D; OHIO MENTAL HEALTH COURTS, *supra* note 147, at 29–32.

211. See *supra* Subsection II.B.2.b.

212. Family members experience objective and subjective burden when dealing with a family member with a severe mental illness. Gabor I. Keitner, Christine E. Ryan & Alison Heru, *Families of People with Bipolar Disorder*, in FAMILIES AND MENTAL DISORDERS: FROM BURDEN TO EMPOWERMENT, *supra* note 185, at 71. Some examples of objective burdens include disruption to fami-

carceration of mentally ill individuals results in less obvious costs to society, including loss of productivity of both the individual and their family members who must care for them.²¹³ In order to remedy such burdens, mental health courts seek “to better assist [the offender] and family in the recovery process.”²¹⁴ Given the number of families faced with hopelessness and distress regarding a severely-mentally-ill family member who has not committed a crime, applying this same goal to involuntary commitment courts would alleviate at least a portion of the burden of looking after the severely-mentally-ill family member that now falls solely upon the family.²¹⁵ Because many families lack an understanding of mental illness, a support system of mental health professionals would also allow the family to gain a better understanding of their family member’s illness.²¹⁶

Involuntary commitment courts would also protect the dignity of severely-mentally-ill individuals who require involuntary commitment.²¹⁷ Stigmatization of mental health hospitalization has

ly life, financial problems, and reduced participation in social activities. *Id.* Examples of subjective burdens include worrying, distress, resentment, and insomnia. *Id.*

213. Amanda C. Pustilnik, *Prisons of the Mind: Social Value and Economic Inefficiency in the Criminal Justice Response to Mental Illness*, 96 J. CRIM. L. & CRIMINOLOGY 217, 231 (2005). Other indirect consequences of the incarceration of the mentally ill include worsening of the mental illness while in prison and reduced job opportunities and social status because of prior incarceration. *Id.* at 232 n.53.

214. GINGER LERNER-WREN, BROWARD’S MENTAL HEALTH COURT: AN INNOVATIVE APPROACH TO THE MENTALLY DISABLED IN THE CRIMINAL JUSTICE SYSTEM 3 (2000), available at http://contentdm.ncsconline.org/cdm4/item_viewer.php?CISOROOT=/spcts&CISOPTR=184&REC=1.

215. See Pete Earley, *A Father Grieves: No One Listened to the Parents*, PETEEARLEY.COM (Dec. 22, 2012), <http://www.petearley.com/2012/12/22/a-father-grieves-no-one-listened-to-the-parents/>. Earley narrates the frustrations of a father who was unable to gain meaningful treatment for his son even after his son threatened suicide and dug himself a grave. *Id.* With no other options, the parents attempted to get treatment for their son through his psychiatrist, but his son committed suicide eight days after release from one of multiple unsuccessful hospitalizations. *Id.*

216. Keitner, Ryan & Heru, *supra* note 212, at 81 (“[C]aring for an ill relative also entails a sense of reward and satisfaction.”).

217. Involuntary commitment courts would provide treatment, as opposed to punishment. Proud Usahacharoenporn, Note, *E.P. v. Alaska Psychiatric Insti-*

followed mentally ill patients since the onset of mental health treatment.²¹⁸ The Supreme Court even recognized the “stigma” of psychiatric hospitalization in *Addington v. Texas*, stating that this stigma has consequences on an individual that cannot be ignored.²¹⁹ Those affected with mental illnesses, especially severe mental illnesses, are often discriminated against for employment and housing, experience a loss of self-worth, and are sometimes unable to become a fully integrated member of society.²²⁰ Reintegration into society is also difficult after one has been hospitalized for a long period of time.²²¹

Although efforts have been made to reduce the stigma surrounding mental illness by increasing knowledge and awareness, the stigma, unfortunately, still prevails and prevents many from seeking needed treatment.²²² With stigma being “as painful as the disease itself,”²²³ an interdisciplinary involuntary commitment court would model mental health courts’ attempt to maintain the self-worth of participants and remove the stigma attached to their

tute: *The Evolution of Involuntary Civil Commitments from Treatment to Punishment*, 28 ALASKA L. REV. 189, 215 (2011) (arguing that commitment in *E.P. v. Alaska Psychiatric Institute*, 205 P.3d 1101 (Alaska 2009) was wrongful because the state granted a commitment to treat the individual’s drug problem, but the treatment facility did not provide substance abuse treatment).

218. JONES, *supra* note 37, at 113 (explaining that patients suffered from “spoiled identity” after hospitalization because the stigma of the hospitalization prevented them from easily marrying or gaining employment).

219. *Addington v. Texas*, 441 U.S. 418, 426 (1979) (“Involuntary commitment to a mental hospital . . . can engender adverse social consequences to the individual. Whether we label this phenomena ‘stigma’ or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual.”). The historical separation of mental health from physical health is one of the many factors that created the stigma attached to mental illness that persists today. U.S. DEP’T OF HEALTH & HUM. SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 6 (1999), available at <http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NBBHS>.

220. U.S. DEP’T OF HEALTH & HUMAN SERVICES, *supra* note 219, at 6.

221. *Lessard v. Schmidt*, 349 F. Supp. 1078, 1089 (E.D. Wis. 1972).

222. See U.S. DEP’T OF HEALTH & HUM. SERVS., *supra* note 219, at 8 (using as an example the public’s unwillingness to provide funding for mental health services).

223. CHANGE A MIND ABOUT MENTAL ILLNESS (BringChange2Mind 2009), available at <http://www.youtube.com/watch?v=WUaXFIANojQ>.

treatment.²²⁴ Additionally, because involuntary commitment courts would reevaluate the participant's process in a series of phases, involuntary commitment courts are likely to lessen the number and length of hospitalizations, which would also reduce the stigma associated with hospitalization.²²⁵

Involuntary commitment courts would combine the efforts of both involuntary inpatient commitment and involuntary outpatient commitment because the judge would have the ability to change the form of commitment as needed. This would eliminate the "revolving door" pattern of treatment that presently occurs.²²⁶ For example, in New York, a person who does not comply with an involuntary outpatient commitment treatment order may only be brought to a hospital for a period of seventy-two hours on an emergency basis.²²⁷ After seventy-two hours, if the individual con-

224. A graduate of one mental health court described her experience at her graduation by stating: "Thanks to mental health court, I have my self-respect back. I have my life back. And it's all because you guys never gave up on me." Jaeger, *supra* note 203, at 26. For an account of the stigma experienced by man suffering from bipolar disorder after being released from hospitalization, see SILVER LININGS PLAYBOOK (The Weinstein Co. 2012).

225. Jaeger, *supra* note 203, at 26. Community psychiatric hospitalization days have been reduced by 98% after the addition of a mental health probation officer to the mental health court in Bonneville County, Idaho. *Id.*

226. Johnston, *supra* note 146, at 561–62 (interviewing mental health court judges regarding recidivism of crime and treatment of mental health court participants' mental illnesses). The "revolving door" pattern is also highly prevalent amongst severely-mentally-ill individuals who are incarcerated. Shane Levesque, Note, *Closing the Door: Mental Illness, the Criminal Justice System, and the Need for a Uniform Mental Health Policy*, 34 NOVA L. REV. 711, 726 (2010). Because the severely mentally ill often do not have access to mental health care, housing, and programs that follow up on treatment, a 2004 study revealed that half of mentally ill prisoners and forty-two percent of mentally ill jail inmates had three or more incarcerations or probations. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, BUREAU OF JUSTICE STATISTICS: SPECIAL REPORT (rev ed. 2006), available at http://www.nami.org/Template.cfm?Section=Press_September_2006&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38175.

227. N.Y. MENTAL HYG. LAW § 9.60(n) (McKinney 2012) ("Such person may be retained for observation, care and treatment and further examination in the hospital for up to seventy-two hours to permit a physician to determine whether such person has a mental illness and is in need of involuntary care and

tinues to refuse treatment, he must be released and petitioned again for involuntary inpatient commitment.²²⁸ In an involuntary commitment court, the judge would be able to change the course of treatment from inpatient to outpatient without requiring another petition, thus eliminating this additional procedural step. The judge's ability to change the nature of the commitment would also ensure that treatment is of the appropriate restrictiveness depending on the participant's progress.²²⁹ Treating the "underlying pathology"²³⁰ of the illness with appropriately restrictive means would help to eliminate "revolving door" treatment.

Some may argue that involuntary outpatient commitment should not be incorporated into involuntary commitment courts because the less restrictive means of outpatient treatment are not as effective as involuntary inpatient commitment.²³¹ But with evidence of improvements in participation in mental health services

treatment in a hospital pursuant to the provisions of this article. Any continued involuntary retention in such hospital beyond the initial seventy-two hour period shall be in accordance with the provisions of this article relating to the involuntary admission and retention of a person."'). Current procedures for involuntary outpatient commitment fail to solve the entire problem because many statutes do not address the consequences for failing to comply with the treatment order. Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 88 (2009).

228. See N.Y. MENTAL HYG. LAW § 9.60(n).

229. Many state statutes make explicit reference to commitment to the least restrictive placement available. See, e.g., CONN. GEN. STAT. § 17a-498(c) (2012) (requiring the court to "make an order for his or her commitment, considering whether or not a less restrictive placement is available"); R.I. GEN. LAWS § 40.1-5-8 (2012) (requiring "that [after] all alternatives to certification have been investigated and deemed unsuitable, it shall issue an order committing the person to custody").

230. Johnston, *supra* note 146, at 561–62.

231. Watnik, *supra* note 127, at 1183. Another potential limitation of involuntary outpatient commitment is that many states allow for forced medication for outpatients, but fail to address forced medication for inpatients, who presumably are in greater need of treatment. Albert G. Besser, *Going Crazy on a Trip Through the Mental Health System*, 32 VT. B.J., Fall 2006, at 49, 50 (reviewing PETE EARLEY, *CRAZY: A FATHER'S SEARCH THROUGH AMERICA'S MENTAL HEALTH MADNESS* (2006)).

and decreases in harmful behaviors and homelessness,²³² involuntary outpatient commitment should be incorporated into involuntary commitment courts to provide structure and treatment for those who are not in need of the restrictiveness of involuntary inpatient commitment.

Additionally, including involuntary outpatient commitment would lessen the cost of incarceration and hospitalization to society.²³³ Involuntary commitment courts would create a global system of involuntary inpatient and outpatient commitment that would assist family members in obtaining treatment for a severely-mentally-ill loved one even if he is not in need of inpatient commitment.

One potential challenge of involuntary commitment courts is that some family members' opinions regarding treatment or the best interests of the severely-mentally-ill individual may conflict with other family members' opinions.²³⁴ But the family can be an important resource to the mentally ill adult and an emotional support system even if the entire family is not habituating together;²³⁵ therefore, the benefits that the family can bring to the severely-mentally-ill individual outweigh any difficulty that may arise from potential disagreements amongst family members.

In addition, there is potential for abuse of the law that would allow a bizarre or eccentric person to be committed even if he were not mentally ill.²³⁶ However, the standard of proof, which

232. Paul S. Appelbaum, *Assessing Kendra's Law: Five Years of Outpatient Commitment in New York*, PSYCHIATRIC SERVICES, July 2005, at 792, available at <http://ps.psychiatryonline.org/data/Journals/PSS/3647/791.pdf>.

233. See Pustilnik, *supra* note 213, at 218.

234. Elaine B. Krasik, Note, *The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis*, 48 U. PITT. L. REV. 539, 552–54 (1987) (addressing the concerns that conflicts of interest cause in medical decision making for an incompetent adult, especially amongst family members).

235. JONES, *supra* note 37, at 156.

236. McKinney, Jr., *supra* note 28, at 38; see also Steve Cotton, *The Yin and Yang of Custody Investigations: Observations of a Custody Investigator*, 10 MICH. CHILD WELFARE L.J. 16, 18 (2006) (observing that in conservative areas “eccentric behavior is often characterized as mental illness”). One court stated that the state has a stronger interest in committing those who are criminally insane because individuals who are civilly committed “may be guilty of nothing

involuntary commitment courts still would be required to follow, provides protection against wrongful commitment by requiring clear and convincing evidence that involuntary commitment is needed.²³⁷

Those who are skeptical of involuntary commitment courts may also argue that these courts would shift the public's idea of judges as impartial and unbiased adjudicators to judges who are invested in the successes and failures of those they are adjudicating.²³⁸ But because involuntary commitment is neither criminal nor civil in nature,²³⁹ this problem-solving court would not need to be strictly within the bounds of current criminal and civil problem-solving courts.²⁴⁰ Although an involuntary commitment court judge would take on an active role in the proceedings as mental health court judges do, the concern regarding the public's perception of judges would not apply to involuntary commitment courts because the judge is not acting as an adjudicator of criminal cases.²⁴¹ Furthermore, conducting involuntary commitment hearings in an adversarial manner has negative effects on severely-mentally-ill individuals, which could be lessened by the participation of a

more than unusual or bizarre behavior." *Birl v. Wallis*, 619 F. Supp. 481, 492 (M.D. Ala. 1985).

237. See *supra* Subsection II.B.1.b.

238. Allegra M. McLeod, *Decarceration Courts: Possibilities and Perils of a Shifting Criminal Law*, 100 GEO. L.J. 1587, 1669 (2012); see Timothy Casey, *When Good Intentions Are Not Enough: Problem-Solving Courts and the Impending Crisis of Legitimacy*, 57 SMU L. REV. 1459, 1499 (2004) (arguing that problem-solving courts' lack of neutrality causes lessened legitimacy because traditional courts' legitimacy rests upon the court being disinterested in the outcome).

239. Civil commitment has been referred to as the "no man's land" between civil and criminal law. Elaine M. Dahl, Note, *Taking Liberties: Analysis of In re Mental Health of K.G.F.*, 64 MONT. L. REV. 295, 297 (2003) (quoting Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 58 (1982)).

240. BLACK'S LAW DICTIONARY 410 (9th ed. 2009) (explaining that in criminal cases problem-solving courts aim to provide treatment rather than imprisonment, while in civil cases problem-solving courts attempt to make use of mediation or counseling rather than litigation).

241. See Dahl, *supra* note 239.

judge as an authoritative figure who still works collaboratively with the other players in the involuntary commitment court.²⁴²

There is no doubt that implementing involuntary commitment courts would be expensive, but these expenses are necessary now to prevent even more costly measures in the future.²⁴³ Those opposed to problem-solving courts argue that creating a specialized court for each area of law in need of reform would be far too costly.²⁴⁴ However, having the same judge who presides over mental health courts also preside over involuntary commitment courts could reduce the costs of implementation of involuntary commitment courts.²⁴⁵ Additionally, it is likely that many of the same mental health professionals would be involved in both mental health courts and involuntary commitment courts, which would also reduce costs.²⁴⁶

Moreover, although other areas of law are in need of reform, both mental health care and mental health laws are pressing issues in today's society that need specialized attention.²⁴⁷ In 2012, President Obama addressed mental health care and gun control in his speech following the shootings in Newtown, Connecticut by stating, "We're going to need to work on making access to mental health at least as easy as access to a gun."²⁴⁸ While mental health courts have been particularly effective in reducing rates of recidivism and violence,²⁴⁹ they have also been shown to reduce the cost

242. See Joel Haycock et al., *Mediating the Gap: Thinking About Alternatives to the Current Practice of Civil Commitment*, 20 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 265, 275–76 (1994) (arguing that severely-mentally-ill individuals may not be as compliant with staff and may be less honest regarding their illness during adversarial hearings).

243. "'We say a better system would cost too much,' says Marvin Swartz, a researcher at Duke University who has studied mental health systems for the past two decades. 'But we're spending more money ignoring the problem than we would have to spend to address it.'" Interlandi, *supra* note 1, at 27.

244. McLeod, *supra* note 238, at 1669.

245. See Johnston, *supra* note 146.

246. See *supra* Subsection II.B.2.b.

247. President Barack Obama, Speech on Gun Control (Dec. 19, 2012) (transcript available at http://bostinno.com/2012/12/19/president-obamasspeech-on-gun-control-and-reform-transcript-video/#ss__275884_274062_0__ss).

248. *Id.*

249. Anne Harper & Michael J. Finkle, *Mental Health Courts: Judicial Leadership and Effective Court Intervention*, JUDGES' J., Spring 2012, at 4, 5.

of mentally ill individuals to the government and society, including the costs of the court system, emergency room visits, and the criminal justice system.²⁵⁰ The current mental health system and the laws that support it are failing, and now is the time to implement more initiatives that have demonstrated success, such as mental health courts.

Family members of those suffering from severe mental illnesses have been largely ignored throughout history.²⁵¹ It is unjust to continue to fail to address the family as a unit during involuntary commitment.²⁵² The family's ultimate goal is almost always to achieve stabilization of the mental illness and maximize the family's well-being, not to wrongfully commit the family member.²⁵³ Although much of the traditional literature regarding the effects of severe mental illness on a family focuses on the struggles of life with a severely-mentally-ill family member, caring for a mentally ill family member can also be a gratifying experience for the entire family.²⁵⁴ Involuntary commitment courts would properly balance concerns for the family and the severely-mentally-ill individual and could even possibly lessen the thirty to forty percent of men-

250. *Id.*

251. JONES, *supra* note 37, at 11. The mental health system has, however, blamed family members for "causing" patients' mental illnesses. Keitner, Ryan & Heru, *supra* note 212, at 73.

252. *See* McKinney, Jr., *supra* note 28, at 45 ("Although no one would argue that merely having a mental illness should be grounds for losing rights to liberty and choice, there does seem to be a need for a middle ground somewhere in the equation.").

253. *See* GROB, *supra* note 34, at 81 (noting that even before due process concerns regarding commitment came into light, family members normally committed a family member due to extreme behavior such as "violent, suicidal, and occasionally homicidal acts, hallucinations, excitement, agitation, delusions, and deep depression"). Additionally, protection of the family member does not stop after the commitment is ordered. *See* Youngberg v. Romeo, 457 U.S. 307, 315 (1982). All "substantive liberty interests [u]nder the Fourteenth Amendment" remain intact, including the rights to safety and freedom from restraint. *Id.* at 319.

254. *See* Keitner, Ryan & Heru, *supra* note 212, at 70–71. Although family members often struggle living with a family member with a mental illness, families also report that these experiences improve family bonds, expand advocacy skills, and develop personal resilience. *Id.* at 71.

tally ill individuals in jails and prisons with no criminal charges against them.²⁵⁵

C. *Revised Standards and Involuntary Commitment Courts in Action*

To illustrate the hypothetical interplay between revised involuntary commitment standards and involuntary commitment courts, a daughter's account of her family's attempt to find treatment for her severely-mentally-ill father, published in the *New York Times Magazine* on June 24, 2012, will be used.²⁵⁶ Joseph Frank Interlandi, Sr. is a son, a brother, a husband, a father, a grandfather, and suffers from bipolar disorder.²⁵⁷ In 2005, Mr. Interlandi, a man with a vibrant personality, was diagnosed with bipolar disorder and committed on an inpatient basis to a New York state hospital, where he remained for one month.²⁵⁸ In August 2010, Mr. Interlandi's immediate family members noticed a familiar change in Mr. Interlandi's behavior, marked by paranoid behavior, suspicion of immediate family members, violent behavior toward his wife, and even threats of suicide.²⁵⁹ Still, suicide threats and violent behavior were inadequate to commit Mr. Interlandi involuntarily on an inpatient basis.²⁶⁰

255. See Pustilnik, *supra* note 213, at 219 (providing that "statistics show that between 30 and 40 percent of mentally ill individuals in the jails of certain states had no criminal charges pending against them, while jails report frequently holding people with mental illnesses simply because there is no other place to put them").

256. See Interlandi, *supra* note 1, at 24–30, 46–47.

257. *Id.* at 27–28.

258. *Id.* at 28. Mr. Interlandi was committed to the Senator Garrett W. Hagedorn Psychiatric Hospital, which closed on June 30, 2012. *Garrett W. Hagedorn Psychiatric Hospital Closure*, ST. N.J. DEP'T HUM. SERVICES, <http://www.state.nj.us/humanservices/dmhs/home/taskforc.html> (last visited Apr. 7, 2014).

259. Interlandi, *supra* note 1, at 26.

260. *Id.* Other examples of individuals unable to be committed in New Jersey include a man who believed aliens were on his roof, believed bugs were crawling out the walls, and refused to sit on any furniture; a man who refused to take psychiatric medication and mutilated his testicles; and a woman who would not eat because she believed that the Central Intelligence Agency was poisoning her. *Id.* at 26–27.

After the Interlandi family spent many chaotic months unsuccessfully dealing with the illness on their own and searching for treatment for Mr. Interlandi, he was finally taken to Psychiatric Emergency Screening Services (PESS) after police noticed Mr. Interlandi acting strangely and disorientated after he fell in a convenience store.²⁶¹ Although his family was relieved that mental health professionals were finally intervening, the trip to PESS only resulted in a short two-to-three-week stay at a short-term psychiatric facility.²⁶² Upon receiving notice that Mr. Interlandi would be released from the hospital,²⁶³ the family disagreed upon whether they would allow Mr. Interlandi to come back to the home or whether they would secure a restraining order so that Mr. Interlandi would be unable to contact his family.²⁶⁴ The family ultimately chose to secure a restraining order, which placed them in a court system for victims of domestic violence, a system ill-equipped to handle mental health issues.²⁶⁵

After a failed involuntary commitment hearing, a violation of the restraining order resulting in jail time, five visits to the emergency room, and another visit to PESS, Mr. Interlandi's manic episode still had not subsided, and the family was exhausted.²⁶⁶ They worried that Mr. Interlandi would become a victim of a violent crime or accidental disaster, or worse, that he would never recover from his illness.²⁶⁷ Finally, after a third trip to PESS and a month and a half stay in jail for restraining order violations, Mr. Interlandi's mania began to subside on its own.²⁶⁸ Mr. Interlandi was released from jail on the condition that he meet with a proba-

261. *Id.* at 26.

262. *Id.* at 28.

263. *Id.*

264. *Id.* Jeneen Interlandi's brother was opposed to the restraining order, while Jeneen felt that it was the correct path to take because if Mr. Interlandi violated the restraining order he would be sent to jail. *Id.* Their mother was "genuinely frightened" of Mr. Interlandi's violent behavior. *Id.*

265. *See id.* The family was given brochures regarding divorce and safe houses, rather than assistance dealing with mental illness. *Id.* Jeneen wanted to explain that her "father was not really violent," but that he was in the midst of a bipolar episode, and the family needed to keep him safe. *Id.*

266. *Id.* at 27, 38.

267. *Id.* at 46.

268. *Id.*

tion officer every week and complete six months of therapy at the local community mental health center.²⁶⁹

If Mr. Interlandi lived in a state that revised the state involuntary commitment statute to allow for commitment when a severely-mentally-ill individual is causing “serious emotional injury” to family members²⁷⁰ and implemented an involuntary commitment court,²⁷¹ the Interlandi family’s experience would be much less chaotic and exhausting. When Mr. Interlandi began exhibiting signs of severe mental illness and became suspicious of his immediate family, the family would file a petition for involuntary commitment based on Mr. Interlandi causing “serious emotional injury” to family members.²⁷² Because of this expanded commitment standard, the family would not need to wait until Mr. Interlandi acted violently toward his wife and threatened suicide before they could file a petition.²⁷³

Assuming the court found by clear and convincing evidence that Mr. Interlandi was in need of commitment and that Mr. Interlandi voluntarily accepted admission into the involuntary commitment court, the court would then decide whether the commitment should be granted on an inpatient or outpatient basis.²⁷⁴ Each week after his commitment, Mr. Interlandi would return to the involuntary commitment court where the judge would listen to Mr. Interlandi himself, the mental health professionals working

269. *Id.* at 47. Jeneen Interlandi, *A Madman in Our Midst*, N.Y. TIMES MAG., July 8, 2012, at 6 (providing a correction to the article).

270. *See supra* Section IV.A.

271. *See supra* Section IV.B.

272. The Interlandi article does not describe in depth Mr. Interlandi’s actions when he was suspicious of his immediate family. Interlandi, *supra* note 1, at 26. This Note will assume that these actions meet Iowa’s standard of “serious emotional injury.” IOWA CODE § 229.1(16) (2012) (“An injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.”).

273. Interlandi, *supra* note 1, at 26.

274. Involuntary commitment courts would function the same as mental health courts, requiring a participant to voluntarily and knowingly accept participation in the court. *See* Redlick, *supra* note 206, at 605.

closely with Mr. Interlandi, and the Interlandi family.²⁷⁵ The testimony of all of the parties would better enable the judge to create an accurate plan for treatment based on the symptoms that Mr. Interlandi was exhibiting at that point in time.²⁷⁶ When Mr. Interlandi's mania subsided, Mr. Interlandi would progress through phases of the program that would continue to require him to report to the involuntary commitment court and encourage him to make plans to continue mental health treatment in the future.²⁷⁷

The involuntary commitment court would result in an initial proceeding with multiple review hearings, rather than the "five emergency room visits, four arrests, four court appearances, three trips to PESS and too many police confrontations to remember" that were a result of the current system.²⁷⁸ Additionally, in each phase of the involuntary commitment court, the Interlandi family would be presented with the opportunity to voice their concerns and opinions regarding Mr. Interlandi's treatment to those in charge of his treatment, instead of feeling as if speaking in court would constitute a "betrayal" to Mr. Interlandi.²⁷⁹ Working together in an involuntary commitment court, Mr. Interlandi would avoid serving time in jail, and the Interlandi family would have a feasible means of obtaining treatment for Mr. Interlandi.²⁸⁰ Finally, without

275. The family would replace the prosecutor and probation officer who are present in mental health courts. *See* Wolff, *supra* note 148, at 403.

276. For example, the Interlandi family would have been able to tell the judge that Mr. Interlandi was calling the home from the hospital screaming at the family and threatening them. Interlandi, *supra* note 1, at 28.

277. *See supra* Subsection II.B.2.b. This is similar to what Jeneen Interlandi thought should have happened. Interlandi, *supra* note 1, at 38 ("My father should have been hospitalized against his protestations until his mania subsided. Once it did, he should have been released under supervision and under the condition that he abstained from drinking, which can exacerbate the symptoms of bipolar syndrome, and adhere to a treatment plan involving some combination of talk therapy and medication. I imagined something like probation, but run by a mental health office instead of a criminal court.").

278. Interlandi, *supra* note 1, at 27.

279. *Id.* at 29. Jeneen Interlandi "could not get up the nerve" to go to her father's involuntary commitment proceeding. *Id.*

280. *Id.* at 38 (explaining that after hearing other families' stories, Jeneen Interlandi realized that for most families "hospitalizations and incarcerations quickly became indistinguishable").

extreme burden and exhaustion on the Interlandi family, the family could again laugh, apologize, and “let it go.”²⁸¹

V. CONCLUSION

Statistics show that almost two-thirds of people with a treatable mental illness fail to seek treatment.²⁸² The time is ripe for a change in our mental health system—a system that often makes unwanted treatment almost impossible without violence.²⁸³ But before real achievement can be made in the mental health arena, society as a whole must continue its focus on ending the stigma surrounding mental illness.²⁸⁴

Ending stigma is a very distant and ambitious goal given that research shows that former mental health patients are less accepted than convicted criminals.²⁸⁵ Steps can be taken in the right direction by increasing scientific knowledge about mental illness, communicating the effectiveness of mental health treatment to the public, and encouraging individuals living with untreated mental illness to seek treatment.²⁸⁶ Some community mental health organizations, for example, have posted billboards to spread awareness and educate about mental illness.²⁸⁷ These advertisements often depict people who appear “normal” and emphasize that mental illness truly can happen to anyone.²⁸⁸ The National Alliance on Mental Illness, with over 1,000 affiliates in local communities, also

281. *Id.* at 47.

282. U.S. DEP’T OF HEALTH & HUM. SERVS., *supra* note 219, at 8.

283. Increasing talk of the pressing issue of mental health reform began after the December 14, 2012 school shootings in Newtown, Connecticut. Joe Nocera, *Guns and Mental Illness*, N.Y. TIMES, Dec. 29, 2012, at A19. Some conservatives argue that mental illness is more to blame for mass shootings than gun control. *Id.*

284. U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 219, at 22.

285. Marsh, *supra* note 58, at 61. Research shows that mental illness is rated the second worst thing that can happen to an individual—after leprosy. *Id.*

286. *Id.*

287. See Angela J. Bass, *County Aims to Stop Mental Health Stigma*, HEALTHYCAL (Apr. 17, 2012), <http://www.healthycal.org/archives/8351>.

288. *Id.*

works to increase mental health awareness and lower stigma by hosting local walks to “stomp out stigma.”²⁸⁹

Nevertheless, even with efforts to end stigmatization of mental health, the burden on families to care for a severely-mentally-ill family member is great without policies and programs in place to support a family who cares for an individual in need of more restrictive treatment.²⁹⁰ This proposal addresses these issues and recommends a collaborative and therapeutic solution for the family as a unit.²⁹¹ First, states should ensure that an involuntary commitment standard exists that allows for commitment when a severely-mentally-ill individual is not dangerous but is causing “serious emotional injury” to the family.²⁹² Second, states should enact involuntary commitment courts that would ensure the best treatment for the severely-mentally-ill individual, ease the family’s burden of caring for a severely-mentally-ill family member, and empower the family to end the stigma of mental health treatment.²⁹³

Without changes in current laws, severely-mentally-ill individuals will continue to suffer.²⁹⁴ Meanwhile, family members will continue to struggle with the chaos and stress the severely-mentally-ill family member causes. Although they may suffer from constant anxiety about the safety and well-being of their loved one, they will maintain hope that treatment will be available soon, even after the family member is refused commitment time and time again.²⁹⁵

Although it would be impossible for revised commitment standards and involuntary commitment courts to remedy all of the problems within the mental health care system, family members

289. *NAMI Walks*, NAMI, <http://www.namiwalks.org> (last visited Apr. 7, 2014).

290. KOYANAGI, *supra* note 59, at 18.

291. *See supra* Sections IV.A-B.

292. *See supra* Section IV.A.

293. *See supra* Section IV.B.

294. Interlandi, *supra* note 1, at 46 (quoting Jennay Ghorwal, whose mother suffers from a chronic mental illness, saying, “What good are civil liberties if the person we’re protecting has zero quality of life?”).

295. *See Condon, supra* note 7 (reporting a story about parents who unsuccessfully attempted to get mental health treatment for their son for two years before he engaged in a shooting spree at his workplace).

must advocate for change in a system created by those unaware of the emotional strain and stress placed on families when they are repeatedly denied the necessary resources to treat severely-mentally-ill family members.²⁹⁶ After all: “We often do [not] know the impact of our actions when we speak out on behalf of persons with mental illnesses, fight stigma, or call for mental health reforms. We do [not] know how our words may affect someone else—even years after we have spoken them.”²⁹⁷

296. During interviews with civil rights attorneys, Pete Earley, journalist and parent of a son with a severe mental illness, asked if any of these attorneys zealously advocating for the rights of someone with a severe mental illness had anyone in their family with a severe mental illness. Not one did. EARLEY, *supra* note 62, at 148.

297. Pete Earley, *The Importance of Speaking Out!*, PETEEARLEY.COM (Feb. 2, 2010), <http://www.petearley.com/2010/02/02/the-importance-of-speaking-out/>.

“Furiosus Solo Furore Punitur”:¹ Should Mentally Ill Capital Offenders Be Categorically Exempt From The Death Penalty?

BY EMILY E. RANDOLPH*

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*Is this a dagger which I see before me,
The handle toward my hand?
Come, let me clutch thee.
I have thee not, and yet I see thee still.
Art thou not, fatal vision, sensible
To feeling as to sight? or art thou but
A dagger of the mind, a false creation,
Proceeding from the heat-oppressed brain?
I see thee yet, in form as palpable
As this which now I draw.²*

INTRODUCTION

Advancements in science, medicine, and technology suggest that disease, injury, and genetics may affect brain development and functioning.³ To a certain extent, technology such as computer tomography scanning (CT scans), functional magnetic resonance imaging (fMRI), positron emission tomography (PET scans), electroencephalography, and magnetoencephalography can be used to help identify brain dysfunction and, occasionally, diagnose mental illnesses.⁴ Reflective of these advancements in medicine is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), essentially the psychology and psychiatry community's "bible."⁵ The DSM-5 was released in 2012 and has catalogued more than 250 mental diseases or disorders.⁶

1. The Latin phrase "Furiosus solo furore punitur" translates to "A madman is punished by his madness alone," and is quoted by the majority opinion in *Ford v. Wainwright*, 477 U.S. 399, 409 (1986), referencing the idea that execution serves no purpose in cases of "madness" because "madness" is its own punishment.

2. WILLIAM SHAKESPEARE, *THE SECOND PART OF MACBETH*, act 1, sc. 1.

3. Mark E. Coon, *Drawing the Line at Atkins and Roper: The Case Against Additional Categorical Exemptions from Capital Punishment for Offenders with Conditions Affecting Brain Function*, 11 W.VA. L. REV. 1221, 1233 (Spring 2013) (citing Owen D. Jones et al., *Brain Imaging for Legal Thinkers: A Guide for the Perplexed*, 2009 STAN. TECH. L. REV. 5, 13–15 (2009)).

4. *Id.*

5. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL* (5th ed. 2013) [hereinafter DSM-5].

6. *Id.*

At the outset, it is important to note the distinctions drawn between the terms “insane” and “mentally ill.” Black’s Law Dictionary (Black’s) defines “insane” as meaning: “Mentally deranged; suffering from one or more delusions or false beliefs that (1) have no foundation in reason or reality, (2) are not credible to any reasonable person of sound mind, and (3) cannot be overcome in a sufferer’s mind by any amount of evidence or argument.”⁷ Black’s defines “mental illness” as “a disorder in thought or mood so substantial that it impairs judgment, behavior, perceptions of reality, or the ability to cope with the ordinary demands of life [A] [m]ental disease that is severe enough to necessitate care and treatment for the afflicted person’s own welfare or the welfare of others in the community.”⁸ One scholar has stated: “The lawyers refer to ‘insanity.’ This is a legal term only, and one that is not used by the psychiatrist; the latter prefers to speak of mental disorder, mental illness, or of psychosis or neurosis.”⁹ Even though the legal definition of “insanity” varies among jurisdictions, the general legal consensus of the word insanity is an individual who is “so out of touch with reality that they do not know right from wrong and cannot understand their punishment or purpose of it.”¹⁰ Conversely, mentally ill individuals frequently know, or are aware of, the difference between right and wrong and may also be in “touch with reality,” but still suffer from substantial mental limitations and challenges.

The National Institute of Mental Health has estimated that one in four adults, approximately 61.5 million Americans, experience some kind of mental illness in a given year.¹¹ Of those 61.5 million Americans, one in seventeen, or about 13.6 million, lives with a serious mental illness, such as schizophrenia, major depres-

7. BLACK’S LAW DICTIONARY (9th ed. 2009).

8. *Id.*

9. Winfred Overholser, *Psychiatry and the Law*, 38 MENTAL HYGIENE 243, 244 (1954).

10. DEATH PENALTY INFO. CTR., *Mental Illness and the Death Penalty*, <http://www.deathpenaltyinfo.org/mental-illness-and-death-penalty> (last visited Nov. 19, 2013).

11. Estimations are based off of the 2004 census. NATIONAL INSTITUTE OF MENTAL HEALTH, *The Numbers Count: Mental Disorders in America*, NIMH, <http://nimh.nih.gov/health/publications/the-numbers-count-mentaldisorders-in-america/index.shtml> (last visited Nov. 22, 2013).

sion, or bipolar disorder.¹² As may be anticipated from these numbers, a significant percentage of prison and jailhouse inmates in America suffer from severe mental illnesses, including reality-distorting illnesses like schizophrenia, bipolar disorder, and major depressive disorder.¹³ In the past thirty years, “. . . the number of people on death row with mental illness and other disabilities has steadily increased. Although precise statistics are not available, it is estimated that five to ten percent of people on death row have a serious mental illness.”¹⁴ This highlights a significant problem in our legal and penal system: despite safeguards supposedly in effect, severely mentally ill offenders are still sentenced to death.

A prohibition against the execution of the “insane” is a longstanding principle of English law: “For centuries, the English common law . . . has adhered to the view that it is improper and unlawful to execute a criminal who has lost his or her reason and descended into insanity.”¹⁵ In spite of the fact that American court decisions have repeatedly reaffirmed this common law rule, severely ill capital offenders are still sentenced to death.¹⁶ Varying theories have been promulgated as the reason for this common law prohibition. Among these theories are legal, moral, and theological justifications: an insane person may be unable to effectively defend

12. *Id.*

13. Doris J. James & Lauren E. Glaze, *Special Report: Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUST. STAT. (September 2006), http://www.nami.org/Template.cfm?Section=Press_September_2006&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38175 (last visited Oct. 13, 2013) (citing to a Special Report released in September 2006 by the Bureau of Justice Statistics estimated that approximately forty-five percent of inmates (70,200 inmates) in federal prisons, fifty-six percent in state prisons (705,600 inmates), and sixty-four percent in local jails (479,900 inmates) suffered from mental health problems. The findings were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.).

14. *State v. Ketterer*, 855 N.E.2d 48, 86 (2006) (citing NAT’L MENTAL HEALTH ASS’N, *Death Penalty & People with Mental Illnesses* (2006), <http://www.nmha.org/position/deathPenalty/deathpenalty.cfm>); see also NAT’L MENTAL HEALTH ASS’N, *Position Statement 54: Death Penalty & People with Mental Illnesses* (2010), <http://www.nmha.org/go/position-statements/54>.

15. John E. Theuman, *Annotation, Propriety of Carrying Out Death Sentences Against Mentally Ill Individuals*, 111 A.L.R. 5th 491 (2003).

16. *Id.*

himself or assist his counsel; the sentence would provide no deterrent value to future offenders; the sentence simply offends humanity; it is unfair to send a man to “meet his maker” when he is “not fit to prepare himself for it;” and because a prisoner who was of sound mind might be able to allege something in stay of judgment or execution.¹⁷ Although there is a lack of uniform rationale for the common law rule against the execution of the insane, it is clear that it exists.¹⁸ Despite the clear prohibition of the execution of “insane” persons, American courts and legislatures have long grappled with serious questions regarding mentally ill capital offenders, primarily: who is mentally ill and should those mentally ill capital offenders be spared the death penalty?

There is considerable case law attempting to determine what constitutes a person being labeled as “insane” or “mentally ill.” In *Ford v. Wainwright*, the United States Supreme Court (the Court) upheld the longstanding common law prohibition against the execution of the insane by finding that the Constitution prohibits an insane person’s execution under the Cruel and Unusual Punishments Clause of the Eighth Amendment.¹⁹ The Court, however, failed to state how to determine who is “insane” and instead, left the decision to the States. Much later, in *Panetti v. Quarterman*, the Court undertook its first direct interpretation of *Ford* and held that Panetti’s severe delusions, coupled with his inability to understand why he was to be executed, rendered him incompetent.²⁰ The Court reasoned that offenders must have sufficient mental capacity to be “aware of the punishment they are about to suffer and why they are about to suffer it.”²¹ In the interim between *Ford* and *Panetti*, the Court categorically barred the execution of “mentally retarded”²² capital offenders in *Atkins v. Virginia*.²³ *Atkins*, in es-

17. *Ford v. Wainwright*, 477 U.S. 399, 408 (1986) (referencing COOLEY ON BLACKSTONE, BOOK IV, 24, in *Musselwhite v. State*, 60 So. 2d 807 (1952)); see also 111 A.L.R. 5th 491 (2003).

18. *Id.*

19. *Ford*, 477 U.S. at 408; U.S. CONST. amend. VIII.

20. *Panetti v. Quarterman*, 551 U.S. 930 (2007).

21. *Id.* quoting *Ford*, 477 U.S. at 422 (Powell, J., concurring).

22. AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013) [hereinafter DSM-5]. The term “mental retardation” has been replaced with “intellectual disability” in the DSM-5. *Id.* The term has come into common use among medical, educational, and

sence, removed the “case-by-case” assessment for the intellectually disabled and rendered the death penalty an excessive punishment for *all* such offenders.²⁴ Finally, borrowing reasoning from *Atkins*, the Court held in *Roper v. Simmons* that juvenile offenders under the age of eighteen are categorically barred from the imposition of the death penalty because they are, as a group, less culpable than the typical adult offender.²⁵

Rather than continuing to use mental illness as a mitigating factor in determining sentencing of the capital offender, this Note argues that the Eighth Amendment’s protection from cruel and unusual punishments, which resulted in the Court’s categorical prohibition against the execution of the intellectually disabled, the “insane,” and youthful offenders, should be extended to cover capital offenders who suffer from debilitating mental illnesses.²⁶ More specifically, if a convicted offender has a medically diagnosed mental disorder as outlined by the DSM-5 or other similar standard for psychological evaluation, he or she should be exempt from the possibility of the imposition of death as a punishment. This exemption is not intended to cover any and all diagnoses outlined in the DSM-5, but rather to cover offenders with severe disorders, including disorders resulting in a significant incapacity to “appreciate the nature, consequences, or wrongfulness of criminal

other professionals, as well as the lay public and advocacy groups. Public Law 111-256, known as Rosa’s Law, replaces the term “mental retardation” with “intellectual disability.” Rosa’s Law. Pub. L. No. 111-256, 124 Stat. 2643, (October 5, 2010). [Hereinafter this paper will refer to it as such, regardless of the Court’s use of the term “mentally retarded.”]

23. *Atkins v. Virginia*, 536 U.S. 304 (2004).

24. American Bar Association, *Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, AM. BAR ASS’N, August 6, 2006, <http://www.americanbar.org/content/dam/aba/migrated/moratorium/policy/2000s/hundredtwentytwoa.authcheckdam.pdf> (last visited Nov. 21, 2013) [hereinafter *Recommendation and Report*].

25. *Roper v. Simmons*, 543 U.S. 551 (2005).

26. DSM-5, *supra* note 22. According to the DSM-5, an intellectual disability involves “impairments of general mental abilities that impact adaptive functioning in three” areas: conceptual, social, and practical. *Id.* These areas “determine how well an individual copes with everyday tasks.” *Id.* The DSM-5 does not require a specific age for an intellectual disability, however, the symptoms must start during the individual’s developmental period. *Id.*

conduct”; “exercise rational judgment in relation to the conduct at the time of the crime”; and to “conform one’s conduct to the requirements of law.”²⁷

Part I of this Note will discuss the Court’s holdings in *Atkins v. Virginia*, *Roper v. Simmons*, *Ford v. Wainwright*, and *Panetti v. Quarterman*.²⁸ Part I will also describe the lack of clarity from the Court in determining how the states should apply these rulings and their arguable lack of uniformity. Part II will address a possible solution to the problem: a categorical exemption for the mentally ill from the death penalty.²⁹

I. THE PROBLEM

Today, in order for the death penalty to be constitutionally permissible, its imposition on an offender must comply with the “evolving standards of decency that mark the progress of a maturing society”³⁰ and it must “be graduated and proportional to the offense.”³¹ Evidencing society’s evolving standards of decency, courts have found “discrete circumstances” where the Eighth Amendment restricts or prohibits the “reach of the death penalty.”³²

Specific groups of offenders may not be constitutionally sentenced to death. Those groups are considered categorically exempt from the ultimate punishment. The first categorical exemption discussed in this paper is for offenders with an intellectual disability.³³ The second categorical exemption is for youthful of-

27. *Recommendation and Report, supra* note 24, at 7–9.

28. *Panetti v. Quarterman*, 551 U.S. 930 (2007); *Roper v. Simmons*, 543 U.S. 551 (2005); *Atkins v. Virginia*, 536 U.S. 304 (2004); *Ford v. Wainwright*, 477 U.S. 399 (1986).

29. This Note will not address exemptions for individuals with traumatic brain injuries; however, such injuries raise similar constitutional and moral concerns as those for individuals suffering from mental illnesses.

30. *Trop v. Dulles*, 356 U.S. 86, 100–01 (1958).

31. *Kennedy v. Louisiana*, 554 U.S. 407, 418 (2008); *see also Weems v. United States*, 217 U.S. 349, 373 (1910).

32. Lyn Entzeroth, *The Challenge and Dilemma of Charting a Course to Constitutionally Protect the Severely Mentally Ill Capital Defendant from the Death Penalty*, 44 AKRON L. REV. 529, 543 (2011).

33. *Atkins v. Virginia*, 536 U.S. 304, 304 (2004).

fenders.³⁴ The third is the partial exemption laid out by the court for insane or mentally ill offenders.³⁵

A. *The Supreme Court's Categorical Exemptions*

In *Atkins* and *Roper*, the Court found that the intrinsic characteristics of two groups of offenders made the death penalty an excessive punishment if imposed.³⁶ The result was an exemption for the intellectually disabled³⁷ followed by an exemption for juvenile offenders under the age of eighteen.³⁸ The Court based both of its rulings on the idea that those two groups, intellectually disabled offenders and youthful offenders, have lesser culpability than the average offender and that the social purposes of the death penalty, deterrence and retribution, are not served by applying it to these groups of offenders.

1. The Intellectually Disabled Offender Exemption

Daryl Atkins was convicted of capital murder in Virginia.³⁹ During the sentencing phase of his trial, a defense expert witness testified that Atkins was “mildly mentally retarded.”⁴⁰ Atkins was

34. *Roper v. Simmons*, 543 U.S. 551, 551 (2005).

35. *Panetti v. Quarterman*, 551 U.S. 930, (2007); *Ford v. Wainwright*, 477 U.S. 399 (1986).

36. Entzeroth, *supra* note 32, at 548.

37. *Atkins*, 536 U.S. at 304.

38. *Roper*, 543 U.S. at 551.

39. Atkins and an accomplice kidnapped, robbed, and murdered a man after spending the day drinking alcohol and smoking marijuana. *Atkins*, 536 U.S. at 307.

40. The defense's witness was a forensic psychologist who based his conclusion on interviews with people who knew Atkins, a review of school and court records, and the administration of the Wechsler Adult Intelligence Scales test (a standard intelligence test). A score of 100 on the WAIS-III is considered average intelligence. The cutoff for intellectual disability is generally an IQ of 70 to 75 or lower. Atkins scored a 59. *Id.* at 308–09 & n.5. The State's rebuttal expert testified that Atkins was at least of average intelligence and possibly suffered from antisocial personality disorder. *Id.* at 309. Antisocial personality disorder is a mental health condition in which a person has a long-term, often criminal, behavior of manipulating, exploiting, or violating the rights of others.

sentenced to death.⁴¹ On appeal, the Court held that the execution of the intellectually disabled is cruel and unusual punishment under the Eighth Amendment.⁴²

In light of the Court's narrowing jurisprudence seeking to "ensure that only the most deserving of execution are put to death," the Court held that "an exclusion for the mentally retarded is appropriate."⁴³ After review of several authorities outlining the characteristics and impairments of an intellectually disabled individual, the Court found that because of these impairments, intellectually disabled offenders, as a rule, were less culpable than the average offender.⁴⁴ Although intellectually disabled offenders' "deficiencies do not warrant an exemption from criminal sanctions," their deficiencies do diminish their personal culpability.⁴⁵ At its core, the *Atkins* decision removed the case-by-case assessment of capital punishment for the intellectually disabled and rendered the death penalty excessive for all such offenders.

The Court specified that two primary social purposes of the death penalty, retribution and deterrence, are not served by executing the intellectually disabled.⁴⁶ Unless the imposition of the death penalty on an offender reasonably furthers one of these goals, it is the "purposeless and needless imposition of pain and suffering" and thus constitutionally impermissible under the Eighth Amendment.⁴⁷ Regarding retribution and society's "interest in seeing that the offender gets his just deserts," the *Atkins* court stated that ". . . the severity of the appropriate punishment necessarily

See MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/00921.htm> (last visited Oct. 12, 2013).

41. *Atkins v. Virginia*, 536 U.S. 304, 310 (2004). At sentencing, the prosecution presented evidence of Atkins' sixteen prior violent felony convictions, which included abduction, attempted armed robbery, armed robbery, and maiming. *Id.* at 339 (Scalia, J., dissenting).

42. *Atkins*, 536 U.S. at 321.

43. *Id.* at 319.

44. *Id.* at 316.

45. *Id.* at 318.

46. *Id.* at 318–20.

47. *Id.* at 318 (quoting *Enmund v. Florida*, 458 U.S. 782, 798 (1982)).

depends on the culpability of the offender.”⁴⁸ The same cognitive and behavioral impairments that diminish an intellectually disabled offender’s culpability make retribution or community vengeance less defensible—“if the culpability of the average murder[er] is insufficient to justify the most extreme sanction available . . . the lesser culpability of the mentally retarded offender surely does not merit that form of retribution.”⁴⁹ Deterrence, on the other hand, is based upon the idea that the “increased severity of the punishment” will discourage future offenders from “carrying out murderous conduct.”⁵⁰ In other words, deterrence relates to society’s “interest in preventing capital crimes by prospective offenders.”⁵¹ The cognitive and behavioral impairments of the intellectually disabled, which render such an offender less morally culpable, also decrease the likelihood that they can process the possibility of execution as a penalty and control their conduct accordingly.⁵²

As further support for their decision, the Court stated that the movement of state legislatures to statutorily ban the execution of the intellectually disabled offender was direct evidence of the evolving standards of human decency.⁵³ At the time of *Atkins*, nineteen states either statutorily banned or were in the process of passing legislation to ban, the execution of the intellectually disabled.⁵⁴ The Court explained that because a large number of States had prohibited the execution of the intellectually disabled, it was

48. *Id.* at 319.

49. *Id.* at 319–20; *see also* *Godfrey v. Georgia*, 446 U.S. 420, 433 (1980).

50. *Atkins*, 536 U.S. at 320.

51. *Id.* at 319.

52. “. . . it seems likely that capital punishment can serve as a deterrent only when murder is the result of premeditation and deliberation. Exempting the mentally retarded from that punishment will not affect the cold calculus that precedes the decision of other potential murderers.” *Id.* at 320 (quoting *Enmund*, 458 U.S. at 799; *Gregg v. Georgia*, 428 U.S. 186 (1976) (internal quotations and citations omitted)).

53. *Atkins*, 536 U.S. at 314–16.

54. Between 1989 and 2001, Georgia, Maryland, Kentucky, Tennessee, New Mexico, Arkansas, Colorado, Washington, Indiana, Kansas, Nebraska, South Dakota, Arizona, Connecticut, Florida, Missouri, and North Carolina had statutorily banned the execution of the intellectually disabled. Texas and Virginia both had legislation pending that had passed through at least one house. *Id.* at 314–15.

clear that our society viewed “[intellectually disabled] offenders as categorically less culpable than the average criminal.”⁵⁵

“[T]o the extent there is serious disagreement about the execution of [intellectually disabled] offenders” among the states the disagreement centers on “determining which offenders are in fact [disabled].”⁵⁶ The clinical definition of “mental retardation” requires subaverage intellectual functioning and significant limitations in adaptive skills, including communication, self-care, and self-direction.⁵⁷ The Court stated: “Mentally retarded persons frequently *know the difference between right and wrong and are competent to stand trial*. Because of their impairments . . . they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand reactions of others.”⁵⁸

Finally, intellectually disabled offenders’ limitations render it more likely that the death penalty will be improperly imposed.⁵⁹ Offenders’ inherent characteristics increase the likelihood that they will give false confessions,⁶⁰ and lessen their ability to show persuasive mitigating evidence in the face of strong prosecutorial aggravating factors.⁶¹ Intellectually disabled offenders are usually “poor witnesses” and their “demeanor may create an unwarranted impression of lack of remorse for their crimes” resulting in an inability to give “meaningful assistance to their counsel.”⁶² Addition-

55. *Id.* at 316.

56. *Id.* at 317.

57. *Id.* at 318.

58. *Id.* (referencing J. McGee & F. Menolascino, *The Evaluation of Defendants with Mental Retardation in the Criminal Justice System*, in THE CRIMINAL JUSTICE SYSTEM AND MENTAL RETARDATION, 55, 58–60; Appelbaum & Appelbaum, *Criminal-Justice Related Competencies in Defendants with Mental Retardation*, 14 J. PSYCHIATRY & L. 483, 487–89 (Winter 1994) (emphasis added)).

59. *Atkins*, 536 U.S. at 320–21.

60. *Id.* at 320 (referencing Everington & Fulero, *Competence to Confess: Measuring Understanding and Suggestibility of Defendants with Mental Retardation*, 37 MENTAL RETARDATION 212, 212–13, 535 (1999) (There has been at least one death row exoneration of an intellectually disabled person who unwittingly confessed to a crime that he did not commit)).

61. *Id.* (quoting *Lockett v. Ohio*, 438 U.S. 587, 605 (1978)).

62. *Id.* at 320–21.

ally, reliance on intellectual disability as a mitigating factor is a double-edged sword.⁶³ Instead of diminishing the offender's culpability, a jury may view an offender's intellectual disability as enhancing the aggravating factor of future dangerousness.⁶⁴

2. *Roper v. Simmons*: The Youthful Offender Exemption

In a premeditated plan, Simmons, a seventeen year old, burglarized a woman's home and then murdered her.⁶⁵ He confessed to the crime, was tried as an adult, and was convicted.⁶⁶ During sentencing, the trial judge instructed jurors they could consider Simmons' age as a *mitigating factor*, however, Simmons was sentenced to death.⁶⁷ After Simmons' appeal proceedings had "run their course," the Court decided *Atkins*, and thus prohibited the execution of the intellectually disabled.⁶⁸ In light of the *Atkins* decision, Simmons appealed again, arguing that "the reasoning of *Atkins* established that the Constitution prohibits the execution of a juvenile who was under eighteen when the crime was committed."⁶⁹ The Court agreed and Simmons' death penalty sentence was set aside.⁷⁰ In *Roper v. Simmons*, borrowing reasoning from its *Atkins* decision, the Court held that the death penalty cannot be constitutionally imposed on an offender who committed a capital crime when he was under the age of eighteen.⁷¹

The Court stated that "the reasons why juveniles are not trusted with the privileges and responsibilities of an adult also explain why their irresponsible conduct is not as morally reprehensible as that of an adult."⁷² Juveniles, in general, lack maturity and

63. *Id.* at 321.

64. *Id.*

65. *Roper v. Simmons*, 543 U.S. 551, 557 (2005).

66. *Id.*

67. *Id.* at 558.

68. *Id.* at 559.

69. *Id.*

70. *Id.* at 560.

71. *Id.* at 551.

72. *Id.* at 561 (quoting *Thompson v. Oklahoma*, 487 U.S. 815, 835 (1988) (holding that the evolving standards of decency do not permit the execution of any offender under the age of sixteen at the time of the crime)).

an underdeveloped sense of responsibility.⁷³ These inherent “deficiencies” result in juveniles’ “impetuous and ill-considered actions and decisions.”⁷⁴

As it found in *Atkins*, the Court discussed the primary social purposes of the death penalty, retribution and deterrence, and their application to juvenile offenders.⁷⁵ The two primary social purposes of the death penalty are not served by executing juveniles because “[r]etribution is not proportional if the law’s most severe penalty is imposed on one whose culpability or blameworthiness is diminished.”⁷⁶ Additionally, it is unlikely that the death penalty would have a significant deterrent effect on youthful offenders because “[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent.”⁷⁷ The Court concluded with the idea that the inherent differences between average adults and juveniles renders the youthful offender’s conduct less “morally reprehensible” than the same conduct done by an adult.⁷⁸

B. *Insanity or Mental Illness Qualified Exemption*

Before both *Atkins* and *Roper*, the Court had the opportunity to determine whether or not a mentally ill offender can be sentenced to death under the Constitution. As discussed above, history and common law have shown that the insane are generally viewed as less culpable and less deserving of the death penalty than the average capital offender for a variety of reasons.⁷⁹ The first case discussed is *Ford v. Wainwright*, which involved an offender who was sane at the time of his sentence but subsequently lost touch

73. *Id.* at 569.

74. *Id.* (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993)); *see also* *Eddings v. Oklahoma*, 455 U.S. 104, 115–16 (1981) (“Even the normal 16-year-old customarily lacks the maturity of an adult.” “[Y]outh is . . . a time and condition of life when a person may be most susceptible to influence and to psychological damage”).

75. *Roper*, 543 U.S. at 571–72.

76. *Id.*; *see also* *Thompson*, 487 U.S. at 837.

77. *Id.*

78. *Id.* at 570.

79. *Atkins v. Virginia*, 536 U.S. 304 (2002).

with reality.⁸⁰ The second case is *Panetti v. Quarterman* where the Court elaborates on the application of the insanity or mental illness qualified exemption.⁸¹ The result of these two opinions is a qualified exemption, rendering a mentally ill defendant ineligible for the death penalty only if he fails to understand the reason why he is to be executed.⁸²

In 1974, Alvin Ford was convicted of murder and sentenced to death.⁸³ Eight years later, Ford developed severe delusions which led him to sincerely believe that he could not be executed because “he owned the prisons and could control the Governor through mind waves.”⁸⁴ Ford’s delusions rendered him unable to draw a connection between the homicide for which he had been convicted and his impending death sentence.⁸⁵ Under Florida law, Ford was found competent to be executed.⁸⁶ The Court granted certiorari to determine “whether the Constitution places a substantive restriction on the State’s power to take the life of an insane prisoner.”⁸⁷

The Court decided that the Eighth Amendment prohibits the execution of the insane as cruel and unusual punishment.⁸⁸ In discussing the common law reasoning behind their decision, the Court stated that various support ranges from a lack of retributive or deterrent value to religious reasons, to insanity as punishment itself: “*furiosus solo furore punitur*.”⁸⁹ Whether the reason for the

80. Ford v. Wainwright, 477 U.S. 399 (1986).

81. Panetti v. Quarterman, 551 U.S. 930 (2007).

82. *Id.* at 959.

83. Ford v. Wainwright, 477 U.S. 399, 401 (1986).

84. *Id.* at 403.

85. *Id.* “After 14 months of evaluation, taped conversations between Ford and his attorneys, letters written by Ford, interviews with Ford’s acquaintances, and various medical records, [the psychiatrist] concluded in 1983 that Ford suffered from ‘a severe, uncontrollable, mental disease which closely resembles Paranoid Schizophrenia With Suicide Potential—a major mental disorder . . . severe enough to substantially affect Mr. Ford’s present ability to assist in the defense of his life.’” *Id.* at 402–03.

86. Ford v. Wainwright, 477 U.S. 399, 404 (1986).

87. *Id.* at 405.

88. *Id.* at 410.

89. “One explanation [for the common law restriction] is that the execution of an insane person simply offends humanity; another, that it provides no example to others and thus contributes nothing to whatever deterrence value is

common law restriction is to protect the “condemned” who lack the “comfort of understanding” or “society itself from the barbarity of . . . mindless vengeance,” the restriction is enforced by the Eighth Amendment.⁹⁰

Essentially, the result of the Court’s decision in *Ford* was prohibiting the execution of the insane; however, the Court did not decide how to determine which individuals are included in their prohibition.⁹¹ *Ford* leaves that decision to the states.⁹² In *Panetti*, the Court expressly adopts language from Justice Powell’s *Ford* concurrence as the appropriate standard for the mentally ill partial exemption.⁹³

In 1992, Scott Panetti committed a capital murder.⁹⁴ Before trial, the District Court ordered a psychiatric evaluation, which revealed that Panetti suffered from serious mental illness.⁹⁵ Panetti had been hospitalized several times for mental health reasons, prescribed anti-psychotic medications, and his wife filed a protective order because of his psychotic behavior.⁹⁶ Despite clear indications of severe mental illness, Panetti was found competent to waive counsel, be tried, convicted, and sentenced to death.⁹⁷ The Court granted certiorari to determine “whether the Eighth Amendment permits the execution of a prisoner whose mental illness deprives him of the mental capacity to understand that he is being executed as a punishment for a crime.”⁹⁸ The Court reversed his sentence on the ground that Panetti’s delusions, when paired with his failure to

intended to be served by capital punishment. Other commentators postulate religious underpinnings: that it is uncharitable to dispatch an offender “into another world, when he is not of a capacity to fit himself for it.” *Id.* It is also said that execution serves no purpose in these cases because madness is its own punishment: *furiosus solo furore puniter.*” *Id.* at 407–08 (referencing 4 WILLIAM BLACKSTONE, COMMENTARIES *24–25 (internal citations omitted)).

90. *Id.* at 409–10.

91. *Ford*, 477 U.S. at 416.

92. *Id.* at 416.

93. *Panetti v. Quarterman*, 551 U.S. 930, 949 (2007).

94. Panetti broke into his in-laws home, murdered them, and proceeded to take his wife and daughter hostage for the night. *Panetti*, 551 U.S. at 935–36.

95. The evaluation revealed that Panetti suffered from delusions, hallucinations and possibly fragmented personality disorder. *Id.* at 936.

96. *Id.*

97. *Id.* at 935–36.

98. *Id.* at 954 (internal quotations omitted).

understand why he was to be executed, rendered him incompetent.⁹⁹ As in *Ford*, the *Panetti* Court addressed the lack of retributive or deterrent value in executing an insane prisoner: “. . . we may seriously question the retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life”¹⁰⁰ Additionally, a mentally ill defendant’s distorted mental state calls into question society’s vindication that may come from his execution:

The potential for a prisoner’s recognition of the severity of the offense and the objective of community vindication are called in question [. . .] if the prisoner’s mental state is so distorted by a mental illness that his awareness of crime and punishment has little or no relation to the understanding of those concepts as a whole.¹⁰¹

Panetti claimed that he understood that the State was to execute him for the murders he committed; however, he truly believed that the State’s given reason was a lie and, in actuality, he was being executed to “stop him from preaching.”¹⁰² The Court found that the standard applied by the Court of Appeals, whether *Panetti* was aware of his impending execution and aware of the State’s reason why, was far too broad in its application:¹⁰³ “A prisoner’s *awareness* of the State’s rationale for an execution is not the same as a *rational* understanding of it.”¹⁰⁴ The Court ultimately adopted Justice Powell’s standard from his concurrence in *Ford* which determines competency by asking whether offenders subject to execution are aware of the punishment they are about to receive and why they are about to receive it.¹⁰⁵

99. *Panetti*, 551 U.S. at 961–62.

100. *Id.* (quoting *Ford v. Wainwright*, 477 U.S. 399, 409–10 (1986)).

101. *Id.* at 958–59.

102. *Id.*

103. *Id.* at 957 (quoting *Ford v. Wainwright*, 477 U.S. 399, 405 (1986) (internal quotations omitted)).

104. *Id.* at 959 (emphasis added).

105. *Ford v. Wainwright*, 477 U.S. 399, 422 (1986).

C. *The Lack of Uniform Reasoning*

From these four cases, it is clear that there is inconsistency in the Court's opinions and reasoning regarding the types of characteristics rendering an offender inherently less culpable and warranting a full categorical exemption from execution.

In *Atkins*, the Court found that the execution of intellectually disabled criminals was cruel and unusual punishment prohibited by the Eighth Amendment and granted such offenders a complete exemption from the death penalty.¹⁰⁶ Intellectually disabled offenders "who meet the law's requirements for criminal responsibility should be tried and punished when they commit crimes," but "[b]ecause of their disabilities in areas of reasoning, judgment, and control of their impulses . . . do not act with the level of moral culpability that characterizes the most serious adult criminal conduct."¹⁰⁷ Further, "their impairments can jeopardize the reliability and fairness of capital proceedings against" them.¹⁰⁸ The Court's primary line of reasoning for this ban was because an intellectually disabled defendant's cognitive impairments, limitations, and disabilities render him less morally and legally culpable for his actions.¹⁰⁹ At their core, those attributes can be described as significant cognitive limitations not shared by the general population. The execution of the intellectually disabled does not further societal purposes because it would not satisfy retribution or deterrence.

Atkins acts as a wide-reaching categorical safety net from the death penalty for a specific group of people. It does not matter if the intellectually disabled offender knows the crime he committed, why he committed it, whether it was exquisitely executed or especially brutal,¹¹⁰ whether it was right or wrong, why he is being punished, or if he has a "rational" understanding of that punishment. A determination of whether such an offender understands the State's reasoning in wishing to execute him is unnecessary. He or she is exempt solely due to meeting the requirements of a specific mental disability as determined by a medical or mental health pro-

106. *Atkins*, 536 U.S. at 319.

107. *Id.* at 306.

108. *Id.*

109. *Id.* at 318.

110. *Id.* at 350 (Scalia, J., dissenting).

fessional. Because of an inherent characteristic, offenders with an intellectual disability are fully and categorically exempt from our country's most severe punishment, regardless of the severity of their crime or their awareness of its illegality. There is no specific range of IQ specified in *Atkins* as being necessary for an individual to satisfy the Court's intellectual disability test. There are simply a number of factors that are analyzed and applied to satisfy a diagnosis.¹¹¹

Similarly, in *Roper*, the Court imposes a complete categorical exemption from the death penalty for offenders who committed their crime under the age of eighteen because they lack the maturity and sense of moral responsibility of the normal adult offender, while possessing a susceptibility to outside pressures and influences and "transitory" personality traits.¹¹² In other words, because youthful offenders have yet to celebrate their eighteenth birthday, he or she could not possibly control his or her murderous impulses, and thus are exempted from death. If the seventeen year-old offender in *Roper* had committed his crime a day after he turned eighteen, under the Court's logic, over-night he would have developed the logical reasoning, impulse control, and cognitive abilities of a normal adult offender and would be eligible for the death penalty. Certainly, a seventeen-year-old with average intelligence who has sufficient cognitive abilities to commit a carefully executed and brutal murder would comprehend "why he has been singled out and stripped of his fundamental right to life."¹¹³ This black-letter categorical exemption is even more arbitrary than *Atkins*: an individual is assumed to lack certain characteristics because of their age. This is not to say that States or the Federal Government should execute offenders under the age of eighteen, but rather to highlight the capricious nature of the Court's cut-off. The Court just as easily could have chosen age twenty, or twenty-one, or twenty-five. How is it determined that a nineteen year old, also still a "teenager," is more culpable than a seventeen year old? The essential point remains the same, rather than looking at the character-

111. *Atkins v. Virginia*, 536 U.S. 304 (2004).

112. *Roper*, 543 U.S. at 569–70.

113. *Ford*, 477 U.S. at 409 (referencing *The Eighth Amendment and the Execution of the Presently Incompetent*, 32 STAN. L. REV. 765, 777, n.58 (1980)).

istics of a specific individual, the Court is ruling that an entire group of offenders lack certain attributes, which render them less culpable than the “average adult offender,” both morally and legally, for his actions.

Under *Ford* and *Panetti*, the prohibition of the execution of the insane expands to include individuals who fail to understand the reason that the State has sentenced them to death. Although never expressly stated by the Court in either case, the opinions indicate that mentally ill offenders suffer from limitations not shared by the general adult population. In *Ford*, the Court fails to extend a categorical exemption to cover mentally ill offenders, simply holding that it is unconstitutional to execute an insane individual.¹¹⁴ Like in *Atkins* and *Roper*, the *Ford* Court found that the deterrence and retributive goals of the death penalty remain unsatisfied by imposing it upon an insane individual.¹¹⁵ “*Panetti* attempted to define the standard for determining when an offender is competent to be executed, a requirement the court established [. . .] in *Ford*.”¹¹⁶ The Court stated from Justice Powell’s *Ford* concurrence,¹¹⁷ that an offender may not be executed if he simply knows that he is to be executed, but rather must rationally comprehend the State’s reason for his execution: “A prisoner’s awareness of the State’s rationale for an execution is not the same as a rational understanding of it.”¹¹⁸ Despite this clarification, the Court leaves for the States the ultimate responsibility to determine who of the mentally ill are fit to be sentenced to death under the Constitution and who should be spared the ultimate punishment.

The Court’s partial and qualified exemption for mentally ill offenders is insufficient in light of their reasoning in *Atkins* and *Roper*. Many, if not most, mentally ill offenders have cognitive, behavioral, and adaptive impairments strikingly similar to the impairments of the intellectually disabled described in *Atkins* and lack the rational thinking processes necessitated by the Court’s decision in *Roper*. Disorders like schizophrenia, psychotic disor-

114. *Ford*, 477 U.S. at 409–10.

115. *Id.* at 409.

116. Christopher Slobogin, *The Supreme Court’s Recent Criminal Mental Health Cases*, 22 CRIM. JUST. 8, 14 (Fall 2007).

117. *Ford*, 477 U.S. at 422.

118. *Panetti v. Quarterman*, 551 U.S. at 959.

ders, mania, major depressive disorder, and dissociative disorders are all typically associated with extremely disorganized thinking, hallucinations, and disruption of perception or memory of one's environment.¹¹⁹ As the Court stated in both *Atkins* and *Roper*, although those youthful and intellectually disabled offenders can differentiate right from wrong, their inherent mental limitations render them substantially less culpable for their criminal actions.¹²⁰ The same case can be made for mentally ill individuals. Often, a person suffering from a mental illness is aware of the difference between right and wrong, good and evil, or lawful and unlawful behavior; however, mentally ill individuals suffer from cognitive issues that interfere with their rational thinking and decision making processes. Because of the similarities shared between the intellectually disabled and mentally ill, those offenders are inherently less culpable.

If an intellectually disabled or youthful offender commits a capital crime and is convicted, he or she cannot be sentenced with the death penalty, even if he understands that the punishment is for the capital murder he committed.¹²¹ Why, then, is the exemption laid out for the mentally ill a qualified one? The Court has stated that an offender being aware of his or her impending execution is not equivalent to a rational understanding of that impending punishment.¹²² Why may a mentally ill individual be executed if he or she has a "rational" understanding of his sentence, but youthful and intellectually disabled offenders may not? Mentally ill offenders suffer from cognitive limitations similar to the limitations the Court outlines in *Atkins* and *Roper*, which ultimately renders those two groups less morally culpable. The qualified exemption leaves a large group of people with a diagnosable illness affecting their cognitive abilities subject to our nation's most extreme punishment: a punishment that is only to be implemented against the coldest and most calculating of individuals.

119. *Recommendation and Report*, *supra* note 24, at 7.

120. *Atkins*, 536 U.S. at 318; *Roper*, 543 U.S. at 569–70.

121. *Roper*, 543 U.S. at 551.

122. *Panetti v. Quarterman*, 551 U.S. 930, 959 (2007).

II. A SOLUTION: A CATEGORICAL EXEMPTION FOR THE MENTALLY ILL

The Court has repeatedly stated that “capital punishment must be limited to those offenders who commit a narrow category of the most serious crimes and whose *extreme culpability* makes them the most deserving of execution.”¹²³ This idea is intended to guarantee not only that the “worst of the worst” offenders will be sentenced to death, but also to narrow the group of offenders eligible for death.¹²⁴ In furtherance of that goal, the Supreme Court and state legislatures have struggled with two significant questions regarding the death penalty: first, who falls within the narrow category that may be sentenced to death, and secondly, what characteristics constitute the “extreme culpability” deserving of execution?¹²⁵ In answering these two questions, the Supreme Court has carved out the exemptions discussed above for *all* youthful offenders and *all* intellectually disabled offenders; however, the exemption for mentally ill offenders is a qualified exemption. Only mentally ill or insane offenders who do not comprehend the reason *why* they are to be executed are exempted from the death penalty.

The Court’s categorical exemption from the death penalty for offenders with an intellectual disability and youthful offenders should be extended to cover individuals suffering from a mental illness where the offender demonstrates a “substantial mental limitation not shared by the general population.”¹²⁶ Offenders should not be sentenced to death if, at the time of the commission of their offense, offenders suffer from a severe mental illness or disorder which significantly affects their ability to conform their conduct to rule of law or society, to appreciate the wrongfulness or consequences of their conduct, or to exercise rational judgment.¹²⁷ An offender that has been diagnosed with a mental illness that is viewed by mental health professionals as severe and that frequently results in behavioral and cognitive issues, should automatically

123. *Kennedy v. Louisiana*, 554 U.S. 407, 420 (2008) (emphasis added) (quoting *Roper v. Simmons*, 543 U.S. 551, 568 (2005); *Atkins v. Virginia*, 536 U.S. 304, 319 (2002) (internal quotations omitted)).

124. *Kennedy*, 554 U.S. at 420.

125. Entzeroth, *supra* note 32, at 530.

126. *Atkins*, 536 U.S. at 310.

127. *Recommendation and Reports*, *supra* note 24, at 1.

be exempted from the possibility of the death penalty as a sentence.

A. *Intellectual Disability and Mental Illness Have Similar Characteristics*

As the basis of their exemption for the intellectually disabled from the death penalty, the *Atkins* Court found that the intellectually disabled offender's "cognitive and behavioral impairments," such as diminished abilities to process and understand information, learn from experience, engage in logical reasoning, or control impulses, in turn make it "less likely they can process the information of the possibility of execution as a penalty" and "control their conduct based on that information."¹²⁸ In his article *Supreme Court Decision Raises New Ethical Questions for Psychiatry*, Alan A. Stone, former president of the American Psychological Association, stated that "From a biopsychosocial perspective, primary mental retardation and significant Axis I disorders have similar etiological characteristics," and "the mentally ill suffer from many of the same limitations that . . . diminish [an intellectually disabled individual's] personal culpability."¹²⁹ This statement means that the same factors that the Court uses to justify the death penalty exemption for intellectually disabled and youthful offenders are also found in severely mentally ill individuals.

In discussing an extension of the exemption found in *Atkins*, it is important to note the definition of intellectual disability used by the Court in making their determination. The American Psychiatric Association defines an intellectual disability as:

. . . significantly subaverage general intellectual functioning . . . accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social /interpersonal skills, use of community resources, self-

128. *Atkins*, 536 U.S. at 320.

129. Alan A. Stone, *Supreme Court Decision Raises New Ethical Questions for Psychiatry*, PSYCHIATRIC TIMES, Sept. 1, 2002, available at <http://www.psychiatristimes.com/forensic-psychiatry/supreme-court-decision-raises-new-ethical-questions-psychiatry>.

direction, functional academic skills, work, leisure, health, and safety The onset must occur before age 18 years “Mild” mental retardation is typically used to describe people with an IQ level of 50-55 to approximately 70.¹³⁰

From this definition, one can see compelling similarities between the intellectually disabled and the mentally ill. Compare, for example, the symptoms of schizophrenia to those of an intellectually disabled person. Schizophrenia, classified as an Axis I disorder, is described as a mental disorder that lasts for a minimum of six months and includes two or more of the following “positive symptoms:” delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.¹³¹ Aside from the more commonly known positive symptoms, many schizophrenics also suffer “negative symptoms,” which may appear with or without positive symptoms.¹³² Negative symptoms include loss of interest in everyday activities, appearing to lack emotion, reduced ability to plan or carry out activities, neglect of personal hygiene, social withdrawal, or loss of motivation. Additionally, schizophrenics may suffer from cognitive symptoms involving problems with thought processes. The cognitive symptoms associated with schizophrenia are often the most debilitating because they interfere with the individual’s ability to perform routine daily tasks and may include problems making sense of information, difficulty paying attention, and memory problems.¹³³ In *Panetti*, one expert witness testified:

. . . when somebody is schizophrenic . . . you have a situation where . . . the logical integration and reality connection of their thoughts are disrupted, so the stimulus comes

130. *Id.* See also DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (2000) [hereinafter DSM-4].

131. Stone, *supra* note 129. See also W. Edward Craighead & Charles B. Nemeroff, *Schizophrenia: Definition of Disorder*, in THE CORSINI ENCYCLOPEDIA OF PSYCHOLOGY AND BEHAVIORAL SCIENCE (3d ed. 2001).

132. Mayo Clinic Staff, *Disease and Conditions: Schizophrenia*, MAYO CLINIC, <http://www.mayoclinic.com/health/schizophrenia/DS00196/DSECTION=symptoms>.

133. *Id.*

in, and instead of being analyzed and processed in a rational, logical, linear sort of way, it gets scrambled up and it comes out in a tangential, circumstantial, symbolic . . . not really relevant kind of way.¹³⁴

Aside from the more severe symptoms of schizophrenia, like hallucinations and the requirement of a low IQ score required for an intellectual disability, the only notable differences between intellectual disability and schizophrenia appears to be the requirement of an intellectual disability to manifest before age eighteen.

If, as the Court stated in *Atkins*, the basis for the prohibition against the execution of the intellectually disabled and youthful offenders stems from the offender's diminished capacities to understand and process information, communicate, learn from mistakes and experience, engage in logical reasoning, control impulses, and understand the reactions of others, it logically follows that mentally ill offenders who suffer from these same diminished capacities should also be categorically exempted from the death penalty.¹³⁵ The reasoning used by the court in *Atkins* to justify the exemption for the intellectually disabled is easily extrapolated to apply to individuals with mental illness.

B. *Evolving Standards of Human Decency*

As the Court reiterated in *Atkins*, "The basic concept underlying the Eighth Amendment is nothing less than the dignity of man The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."¹³⁶ Evidencing these evolving standards, the American Psychiatric Association, the American Psychological Association, the National Alliance for the Mentally Ill (NAMI), and even the American Bar Association (ABA) are in support of a death penalty exemption for offenders with severe mental illnesses.¹³⁷ As the Court

134. *Panetti v. Quarterman*, 551 U.S. 930, 955 (2007).

135. *Overstreet v. State*, 877 N.E.2d 144, 175 (Ind. 2007).

136. *Atkins v. Virginia*, 536 U.S. 304, 311–12 (2002) (quoting *Trop v. Dulles*, 356 U.S. 86, 100–01 (1958)).

137. Entzeroth, *supra* note 32, at 531 (referencing *Recommendation and Report on the Death Penalty and Persons with Mental Disabilities*, 30 MENTAL & PHYSICAL DISABILITY L. REP. 668 (2006)); Ronald J. Tabak, *Executing Peo-*

stated in *Atkins*, “[n]ot all people who claim to be [intellectually disabled] will be so impaired as to fall within the range of [intellectually disabled] offenders about whom there is a national consensus,”¹³⁸ not all people who claim to be mentally ill will suffer from impairments so great as to fall within the range of mentally ill offenders about whom there is a “national consensus.” This standard is reflected in the ABA’s Recommendation.

The ABA has adopted the stance that offenders should not be given the death penalty who at the time of their offense were suffering from a severe mental illness that significantly impaired their capacity to “appreciate the nature, consequences, or wrongfulness of their conduct,” “exercise rational judgment in relation to conduct,” or “conform their conduct to the requirements of law.”¹³⁹ To illustrate the reasons for its recommended exemption, the ABA provides compelling examples of the type of offenders the *Recommendation* is intended to cover. Take, for example, a hypothetical offender “who experiences delusional beliefs that electric power lines are implanting demonic curses, and thus comes to believe that he or she must blow up a city’s power station”¹⁴⁰ Although the hypothetical offender may understand that it was morally wrong to destroy property and that it was against the law, he or she may nevertheless fail to understand that the consequences of his or her actions would harm society, possibly kill individuals, and may in fact have viewed his or her behavior as necessary to

ple with Mental Disabilities: How We Can Mitigate an Aggravating Situation, 25 ST. LOUIS U. PUB. L. REV. 283 (2006) (discussing the then-proposed ABA recommendation, reasons for the recommendation, and examples of executions of severely mentally ill capital offenders); Ronald J. Tabak, *Overview of Task Force Proposal on Mental Disability and the Death Penalty*, 54 CATH. U. L. REV. 1123 (2005) (discussing background and development of task force and recommendation to provide death penalty exemptions based on mental illness or disability); Christopher Slobogin, *Mental Disorder as an Exemption from the Death Penalty: The ABA-IRR Task Force Recommendations*, 54 CATH. U. L. REV. 1133 (2005) (discussing recommendations and potential controversies of recommendations); John Parry, *The Death Penalty and Persons with Mental Disabilities: A Lethal Dose of Stigma, Sanism, Fear of Violence, and Faulty Predictions of Dangerousness*, 29 MENTAL & PHYSICAL DISABILITY L. REP. 667 (2005) (discussing the critical need filled by ABA recommendation).

138. *Atkins*, 536 U.S. at 317.

139. *Recommendation and Reports*, *supra* note 24, at 1.

140. *Id.* at 8.

protect society.¹⁴¹ The ABA Recommendation also discusses the highly publicized case of Andrea Yates who murdered her five children.¹⁴² The jury believed that her delusions existed at the time of the offense and, although she appreciated the wrongfulness of her acts, she was spared the death penalty.¹⁴³ The ABA's final example is of an offender suffering from a "mood disorder with psychotic tendencies."¹⁴⁴ Although that individual may understand the difference between right and wrong, he may feel "impervious to punishment" because of his delusions of grandiosity caused by his mental illness.¹⁴⁵

While the recommendations from the American Psychiatric Association, American Psychological Association, and the NAMI should come as no shock, there appears to be a movement among the States indicating positive changes in death penalty legislation to exempt the mentally ill from execution. In *Ford*, the Court stated: "[W]e leave to the State the task of developing appropriate ways to enforce the constitutional restriction [against the execution of the mentally ill] It may be that some high threshold showing on behalf of the prisoner will be found a necessary means to control the number of nonmeritorious or repetitive claims of insanity."¹⁴⁶ In light of *Ford*, a number of States are contemplating possible legislation exempting the mentally ill from the death penalty and investigating the constitutionality of imposing the death penalty on that group. In 2010, Connecticut was the only state that had the death penalty but also categorically banned the execution of an individual who is mentally ill at the time he commits the offense.¹⁴⁷ In 2012, Connecticut abolished the death penalty entirely. Several states, however, have pending legislation that, if passed,

141. *Id.*

142. *Recommendation and Reports, supra* note 24, at 9; *see also* Deborah W. Denno, *Who is Andrea Yates? Short Story About Insanity*, 10 DUKE J. GENDER L. & POL'Y 37 (2003).

143. *Id.*

144. *Recommendation and Reports, supra* note 24, at 9

145. *Id.* (referencing AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR]).

146. *Ford v. Wainwright*, 477 U.S. 399, 416 (1986).

147. CONN. GEN. STAT. § 53a-46a (2010)

would provide an exemption from capital punishment for mentally ill offenders.¹⁴⁸

One state with pending legislation is Indiana. Indiana established a commission specifically to examine the death penalty and its imposition on the mentally ill.¹⁴⁹ The commission, known as the “Bowser Commission” issued a report recommending an exemption for the severely mentally ill from the death penalty.¹⁵⁰ A bill was then introduced to the legislators exempting individuals with “severe mental illnesses” from the death penalty, defining “severe mental illness” as major depression, bipolar disorder, delusional disorder, schizophrenia, and schizoaffective disorder.¹⁵¹

Other states have also started to examine this issue. For example, Tennessee also appointed a commission to study the death penalty and to determine whether the current laws provide adequate protection for the intellectually disabled and mentally ill; what criteria should be used in judging an individual’s level of mental illness; whether there is a disproportionate number of people on death row with mental illness; and whether or not people with mental illness should be executed.¹⁵²

North Carolina introduced significant legislation that would provide a death penalty exemption for the mentally ill.¹⁵³ North Carolina’s bill mirrors the language of the ABA *Recommendation* and defines severe mental illness as “any mental disability or defect that significantly impairs a person’s capacity” to “appreciate the nature, consequences, or wrongfulness of the person’s conduct in the criminal offense,” “exercise rational judgment in relation to the criminal offense,” or “conform the person’s conduct to the requirements of the law in connection with the criminal offense.”¹⁵⁴

Although all death penalty States currently allow an offender to present mitigating evidence of his mental illness,¹⁵⁵ pend-

148. Entzeroth, *supra* note 32, at 564.

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.* at 555; see also William Redick, *Is Tennessee Going to Fix its Death Penalty?*, 45 TENN. B.J. 12 (Sept. 2009).

153. Capital Procedure/Severe Mental Disability, S.B. 309, Gen. Assemb. (N.C. 2009).

154. *Id.*

155. Entzeroth, *supra* note 32, at 567.

ing state legislation indicates a small, but significant step in the right direction to protect mentally ill offenders from execution. Indiana has begun to delineate specific diagnoses exempted from the death penalty,¹⁵⁶ North Carolina's exemption is extended to those with *any* mental disability that satisfies the statutory requirements,¹⁵⁷ and Tennessee has appointed a commission to study the death penalty.¹⁵⁸ Despite the fact that no State court has ruled in favor of a categorical exemption for the mentally ill, many courts have often found that a defendant's mental illness renders the death penalty a disproportionate punishment for their offense.¹⁵⁹ Unfortunately, in some cases, even when mental illness is presented as a mitigating factor, juries have imposed death sentences on severely mentally ill offenders.¹⁶⁰

Despite the positive direction in some State courts, others are moving in the opposite direction. In one Missouri case, the death penalty was found an appropriate sentence even though the convicted offender had a severe mental illness.¹⁶¹ The Missouri Supreme Court also declined the expansion of *Atkins* to exempt capital offenders who are mentally ill.¹⁶² In Florida, the state supreme court refused to find the death penalty a disproportionate sentence where a defendant, with extensive history of mental illness, plead guilty and sought the death penalty.¹⁶³ Another Florida case, *Gill v. State*, found that the death penalty was not disproport-

156. *Id.* at 564.

157. Capital Procedure/Severe Mental Disability, S.B. 309, Gen. Assemb. (N.C. 2009).

158. Entzeroth, *supra* note 32, at 555. See also Redick, *supra* note 152.

159. See *State v. Thompson*, No. E2005-01790-CCA-R3-DD, 2007 WL 1217233, *36 (Tenn. Crim. App. Apr. 25, 2007) (finding that the death penalty was disproportionate where defendant had a lengthy history of mental illness and no criminal history in his adult life); *State v. Roque*, 141, P.3d 368, 405-06 (2006) (death sentence disproportionate based on defendant's mental illness and intellectual disability); *Cooper v. State*, 739 So.2d 82, 86 (Fla. 1999) (death sentence disproportionate for an eighteen-year-old with no criminal record diagnosed with paranoid schizophrenia); *Hayes v. State*, 739 P.2d 497, 503-04 (Nev. 1987) (death penalty disproportionate when offender was delusional at the time he committed murder).

160. Entzeroth, *supra* note 32, at 573.

161. *State v. Johnson*, 207 S.W.3d 24, 50-51 (Mo. 2006).

162. *Id.*

163. *Rodgers v. State*, 3 So.3d 1127 (Fla. 2009).

tionate, despite the defendant's mental illness, because of the "magnitude of aggravating factors."¹⁶⁴

C. Questions, Controversies, and Concerns

Detractors of a death penalty exemption for the mentally ill have many objections. One objection to an exemption for the mentally ill is that people with mental illness are more "at fault" for their condition than intellectually disabled people because their conditions are often treatable with medication or therapy.¹⁶⁵ This argument, however, does not hold up against mental health and medical professional knowledge about mental illness. First and foremost, most mental illnesses stem from a genetic predisposition rather than from any "fault" of the sufferer.¹⁶⁶ Although it is true that substance abuse or environmental factors may act as catalysts in some cases, generally most mental illness stems from an individual's genetic make-up.¹⁶⁷ Furthermore, many individuals with severe mental illness are incapable of recognizing the benefits of medication.¹⁶⁸ Those who do understand medication's benefits may resist taking it because of the often serious and unwanted temporary and long-term side effects, or they may simply lack the funds to pay for expensive medications and therapy.¹⁶⁹

A common question asked by detractors is: Mentally ill offenders are already allowed to use evidence of their mental illness as a mitigating factor in capital sentencing, why is that insufficient? As is the case for offenders with an intellectual disability, mental illness is often a double-edged sword for the offender.¹⁷⁰ On the one hand, it may lessen the offender's culpability. On the other hand, some jurors may view mental illness as evidence of future

164. Gill v. State, 14 So. 3d 946, 964–65 (Fla. 2009).

165. Slobogin, *supra* note 137, at 1147 (referencing Christopher Slobogin, *What Atkins Could Mean for People with Mental Illness*, 33 N.M. L. REV. 293, 309–11 (2003)).

166. *Id.*

167. *Id.*

168. *Id.* at 1447–48 (quoting Robert Pear, *Few Seek to Treat Mental Disorders Common, U.S. Says; Many Not Treated*, N.Y. TIMES, Dec. 13, 1999, at A1).

169. *Id.*

170. *Atkins v. Virginia*, 536 U.S. at 321 (2002).

dangerous or other aggravating factors.¹⁷¹ The fact that there are currently mentally ill offenders on death row is direct evidence of such a result.¹⁷² As was stated above in the Missouri and Florida, even though the mentally ill defendants were allowed to present evidence of their illness as mitigating factors, these offenders were still sentenced to death.¹⁷³

Others may argue that an exemption for the mentally ill would effectively abolish the death penalty because of the prevalence of mental illness in capital offenders. This argument is not reflective of the actual result of such an exemption. As of April 3, 2013, there were 3,108 individuals on death row.¹⁷⁴ Although precise numbers are not available, current statistics estimate that five to ten percent of individuals on death row suffer from a severe mental illness.¹⁷⁵ That statistic means that approximately 155 to 310 of prisoners that are currently incarcerated on death row would be eligible for the proposed exemption from the death penalty. Thus, the exemption proposed by this note does not equate to a capital offender walking free on the streets or the abolition of the death penalty, but rather would provide, at most, 300 offenders with inherent lesser culpability from the most severe punishment our society has.

What about individuals feigning mental illness to escape execution? Isn't the diagnosis of mental illness inherently difficult? While an individual feigning mental illness to receive a lesser sentence is possible, mental disorders are generally no more prone to misdiagnosis than is intellectual disability.¹⁷⁶ The types of assess-

171. Tabak, *supra* note 137, at 1153–58.

172. Death Penalty Information Center, *Facts about the Death Penalty*, (January 6, 2012), DEATH PENALTY INFORMATION CTR., available at <http://www.deathpenaltyinfo.org/documents/FactSheet.pdf> [hereinafter *Facts about the Death Penalty*].

173. *Rodgers v. State*, 3 So.3d 1127, 1127 (Fla. 2009); *Gill v. State*, 14 So. 3d 946, 964–65 (Fla. 2009); *State v. Johnson*, 207 S.W.3d 24, 50–51 (Mo. 2006).

174. *Facts about the Death Penalty*, *supra* note 172.

175. The Mental Health America Board of Directors approved this policy on March 5, 2011. See Mental Health America, *Position Statement 54: Death Penalty and Mental Illness*, NMHA, <http://www.nmha.org/positions/death-penalty#edn6>. It is required to be reviewed by the Mental Health America Public Policy Committee, and currently is set to expire December 31, 2016. *Id.*

176. Slobogin, *supra* note 165, at 1148.

ments that would need to be done to identify mental illness are “virtually identical to the evaluations carried out every day in the criminal justice system in connection with the insanity defense.”¹⁷⁷ The goal for a capital sentencing exemption is to determine when an offender’s mental illness leads to *diminished* culpability, not the complete absence of culpability (as is the case with the insanity defense).¹⁷⁸ By exempting the mentally ill offender from execution, he or she is not walking free on the streets and escaping punishment for his or her actions, but rather is punished in accordance with his or her personal legal and moral culpability.

Detractors have also argued that an extension of *Atkins* to the mentally ill would stigmatize a class of citizen that is already subject to discrimination.¹⁷⁹ The death penalty exemption for youthful and intellectually disabled offenders is not intended to be and should not be viewed as a stigmatization of a class of individuals. Similarly, neither should an exemption for the mentally ill because an exemption would be based on the same reasoning and logic provided by the Court for youthful and intellectually disabled offenders. Rather than stigmatize or discriminate against mentally ill offenders, a categorical exemption would serve as a way to protect a category of vulnerable citizens from a punishment unequal to their personal culpability.

CONCLUSION

The death penalty is currently legal in thirty-two states, the federal government, and the military.¹⁸⁰ As of April 3, 2013 there were 3,108 individuals on “Death Row” and it is estimated that five to ten percent of those inmates suffer from some form of mental illness or disorder.¹⁸¹ This seems to indicate that the use of mental illness as a mitigating factor in capital sentencing is insufficient. As society, science, and medicine have furthered our

177. *Id.* at 1149.

178. *Id.* at 1149–50.

179. Mark E. Coon, *Drawing the Line at Atkins and Roper: The Case Against Additional Categorical Exemptions from Capital Punishment for Offenders with Conditions Affecting Brain Function*, 11 W. VA. L. REV. 1221, 1233 (2013).

180. *Facts about the Death Penalty*, *supra* note 172.

181. *Id.*

knowledge of mental illnesses' symptoms, causes, and treatment, so too should society's treatment of such individuals evolve. The goal of an exemption for the mentally ill offender is not to remove all responsibility for a mentally ill offender's wrongful actions, but rather to reflect the proposition that individuals who suffer from significant limitations not shared by the general adult population should be treated differently. Clearly, society views individuals with cognitive limitations as less deserving of the death penalty, as evidenced by the complete exemptions for the intellectually disabled and juvenile offenders. This view should be extended to cover mentally ill offenders.

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