

Mental Health and the Law

Introduction

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The mentally ill face some vexing problems. Fortunately, many of these are ones where a body of interdisciplinary work can assist legal decisionmakers to protect more adequately the interests of the mentally ill, and those of society. This set of five articles prepared for the March 2004 Washington University School of Law conference on Mental Health and the Law brings this literature to bear on the gamut of issues raised in society's struggle to better address the pressing needs of the mentally ill.

Given the centrality of competence determinations to this field, it is appropriate that this set contains a pair of articles about competence. The set also devotes much-needed attention to ethical dilemmas posed by the representation of clients afflicted with mental health problems—filling an important hole in the mental health literature. Giving credence to Justice Brandies's observation that the states are laboratories of experimentation,¹ this set of articles also reviews innovative approaches to state regulation of mental health professionals and the provision of services, and highlights the promise of these approaches. Importantly, the authors candidly point out some of the failures of state law. Obviously, we should learn from our failures as well as our successes.

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1. *See* *New State Ice Co. v. Liebmann*, 285 U.S. 262, 310-11 (1932) (“To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

Perhaps most notably, these articles examine the intersection of the mental health system with legal systems, and highlight the costs of artificially parsing human problems—which for all of us are complex and messy—into neat little boxes labeled “juvenile justice” or “family and dependency” law. By unraveling the complex interplay between these systems, the authors advance considerably our understanding of the challenges facing the mentally ill in navigating them. The articles also suggest concrete ways in which legal education can instill a greater awareness of mental health issues. By doing so, the authors give hope that the next generation of attorneys, legal policymakers, and regulators will better respond to the needs of the mentally ill.

Lynda E. Frost and Adrienne E. Volenik—*The Ethical Perils of Representing the Juvenile Who May Be Incompetent*

Adrienne Volenik, Professor of Law and Director of the Mental Disabilities Law Clinic at T.C. Williams School of Law, University of Richmond, and Lynda Frost, an attorney in private practice and an Associate at the Institute of Law, Psychiatry, and Public Policy, University of Virginia, address ethical dilemmas faced by lawyers who represent juveniles who may not be competent to stand trial. The authors note that recent legislative changes increasing the penalties for juveniles found to be delinquent, have fueled the need to assess a client’s adjudicative competence. By using helpful hypotheticals followed by direct questions and answers, Professors Frost and Volenik present ethical issues that may arise and map out specific ways of deciding upon the most appropriate course of action.

The authors concentrate on the detailed Virginia juvenile competency standard passed in 1999 in answering the ethical dilemmas. In addition, they also incorporate the Model Rules of Professional Conduct and the ABA’s Criminal Justice Mental Health Standards. They give special attention to how the juvenile justice and adult criminal systems differ and the implications of this for the ethical quandaries an attorney may encounter. Professors Frost and Volenik also contrast the role of a guardian *ad litem* to that of a defense attorney and show how a guardian can resolve similar ethical issues.

Holly A. Hills, Deborah Rugs, and M. Scott Young—*The Impact of Substance Abuse Disorders on Women Involved in Dependency Court*

Professors Holly Hills, Deborah Rugs, and Scott Young, all colleagues in the Department of Mental Health Law and Policy at the Louis de la Parte Florida Mental Health Institute at the University of South Florida, present a cluster of issues that arise when the State seeks to adjudicate the children of a substance abusing women as “dependent.”

Beginning with the relationship between parental addiction and child abuse and neglect, the authors emphasize that treatment for substance abuse disorders is crucial to preserving families. Professors Hills, Rugs, and Young then present a typical scenario for a woman entering the dependency court process. They note that many elements of this process impede an effective transition into substance abuse treatment, the ability to stick-it-out in treatment, and the prompt and successful reunification of women with their children.

The authors then turn to innovative programs developed across the country, including family drug treatment courts and programs tailored specifically to mothers with substance abuse disorders. Highlighting data that indicate that treatment during pregnancy is more effective than at other times in a mother’s life and that women tend to stay in residential treatment facilities longer when they have their children with them, the authors argue that children should be included in treatment design and implementation.

Finally, the authors use key informant groups consisting of the caseworkers with the Department of Children and Family (DCF), consumers, attorneys or judges, and substance abuse counselors to diagram a child-friendly program. The authors provide critical information on: services needed by the women; barriers to treatment; the identification of substance abuse; communication between the court, DCF, and service providers; what areas work well and which could use improvement; and what keeps a woman motivated to stay in treatment. The answers developed in this field work support the growth of family drug court and the improvement of the relationship between the court, child welfare workers, and treatment providers.

Wenona Y. Whitfield—*Capacity, Competency, and Courts: The Illinois Experience*

Concentrating on Illinois, Wenona Whitfield Professor of Law, Southern Illinois University–Carbondale examines how courts determine whether to allow involuntary administration of psychotropic medication to civilly-committed mental health patients. Professor Whitfield also explores whether psychiatrists and lawyers can more effectively articulate the requirements for court-ordered involuntary medication. She begins her article with two assumptions: that “psychotropic medication works” and that involuntarily-committed persons are not automatically incapable of deciding whether to take psychotropic medication—an assumption that receives ample support in a 2001 study by the John T. and Catherine MacArthur Foundation.²

After surveying appellate court decisions in Illinois and several states’ statutory schemes, Professor Whitfield suggests that judges have little guidance in deciding questions of competency. She notes that while appellate decisions provide some guidance, they fail to explain in sufficient detail how trial judges should determine whether a patient has the capacity to make a reasoned decision concerning medication.

In concluding with a proposal for using administrative law judges to decide involuntary medication disputes, Professor Whitfield examines a study done by researchers at Choate Mental Health Center in Illinois showing that few patients refuse medication. Given the small number of cases actually requiring a judicial determination, together with the lack of expertise of judges, Professor Whitfield believes that a permanently assigned administrative law judge offers crucial benefits, such as the development of expertise, more consistency in opinions, and a reduction in cases decided on appeal.

2. Paul S. Appelbaum, M.D. & Thomas Grisso, Ph.D., Executive Summary, MacArthur Treatment Competence Study, Feb. 2001, *available at* http://macarthur.virginia.edu/treatment.html#N_1_ (last visited Sept. 11, 2003).

Richard Redding—*Why It Is Essential To Teach About Mental Health Issues In Criminal Law (And a Primer on How To Do It)*

Richard Redding, Professor of Law and Director, Program in Law, and Psychology, Villanova University School of Law, begins his article with an astounding, poignant statistic: with 16%—and perhaps as many as one-third—of prison inmates suffering from a serious mental illness, our nation's jails represent some of the largest mental hospitals in the U.S. Yet, despite the significant number of criminal defendants with mental disorders and the frequency with which attorneys encounter forensic mental health issues, students are woefully unprepared to represent the mentally ill. This is ironic since students are routinely taught criminal law doctrines rarely encountered in practice—such as mistake or duress.

Arguing that forensic mental health issues should be given greater coverage, Professor Redding recommends incorporating them into first year criminal law classes, as well as upper-level courses in criminal law and psychology. Professor Redding notes that teaching mental health issues may be done in a variety of ways, from an elaborate three week mini-course to simply inviting guest lecturers or using case studies of delusional clients who refuse to mount viable defenses.

Teaching these skills would better equip not only defense attorneys, but prosecutors as well. Prosecutors may probe for other deviant sexual behaviors beyond the charged offense, and may consciously strive to fashion more meaningful sentencing and parole options. Professor Redding's article is particularly noteworthy for its practical advice about how to neutralize a student's skepticism towards forensic mental health issues.

Matthew Howard, James Williams, Michael Vaughn, and Tonya Edmond—*Promises and Perils of a Psychopathology of Crime: The Troubling Case of Juvenile Psychopathy*

Professors Howard, Williams, Vaughn, and Edmond of the George Warren Brown School of Social Work at Washington University in St. Louis provide in this article a wonderful primer on the state of the art knowledge on adult and youth psychopathology.

Clearly, society has a vested interest in recognizing and derailing fledgling psychopaths early in their development. The authors present a chilling picture, based on a raft of studies, about the narcissistic and self-centered focus of many psychopaths. Psychopathic youth are not motivated by the welfare of others, often believe moral violations are acceptable as long as there is no contrary rule on point, are not focused on the guilt of various actors, and have only marginal capacity to feel empathy for others or to discern their emotional state.

Professors Howard, Williams, Vaughn, and Edmond perform a yeomen service in debunking many of the myths about youth offending that have arisen since John DiIulio's dire prediction that a "wave of super predators" would overrun society.³ For example, the authors review evidence that a small group of males with very high rates of anti-social behavior over their lives—who make up between five and eight percent of all youth offenders—commit a majority of the general and violent crimes. By contrast, the bulk of youth offenders begin offending at older ages, have lower rates of interpersonal violence, and stop offending in adolescence. Despite this, an increasing number of youth offenders in North America are assessed for psychopathy, a finding that often is dispositive of the outcome of their cases and which marks him or her for life.

This, then, raises questions about our ability to accurately diagnose such psychopathy, questions developed in great detail in the article. The authors fear that certain poorly validated instruments will be misused to identify psychopaths. For instance, although viewed by some as useful diagnostically, substance abuse and other factors that frequently occur in tandem with psychopathy have unclear causal connections, significantly undercutting their diagnostic value.

The article also devotes considerable attention to how juvenile psychopathology sometimes parallels adult psychopathology, but does not always do so. In fact, the authors argue that many of the suppositions about adult offending breakdown when looking at juveniles and call ultimately for more research on the similarities and differences between adolescent and adult psychopaths.

3. John Di'Ilio, *The Coming of the Super Predators*, WEEKLY STANDARD, Nov. 27, 1995, at 23.

Taken together, these articles illustrate convincingly how interdisciplinary scientific material can enhance and enrich our appreciation of the legal issues surrounding mental illness. Indeed, the insights offered in this set of articles are just a fraction of those that can be derived from the scientific literature.

In addition to issues arising in criminal prosecutions, questions frequently arise in dependency and termination of parental rights proceedings as to the safety of children living with a sex offender who has violated another child in his care.⁴ There, questions about the efficacy of court-ordered and voluntary treatment programs frequently come up when deciding whether to remove additional children from the household or take other steps to protect the victim's siblings.⁵ While the first two decades of studies about recidivism after treatment were all over the map,⁶ new research is emerging that

4. See, e.g., *In re Cindy B.*, 471 N.Y.S.2d 193, 195 (Fam. Ct. 1983) (refusing to find that siblings of oldest daughter, with whom father admitted to having sexual intercourse, were endangered, concluding that the state child protective services agency produced no evidence that the physical condition of the siblings was in imminent danger of becoming impaired); *In re Burchfield*, 555 N.E.2d 325, 333 (Oh. Ct. App. 1988) (concluding that a father's insertion of his finger into the vagina of his five-year-old daughter on two separate occasions provided sufficient evidence of unfitness of her siblings' environment because "in light of [the daughter's sexual abuse], it follows that so long as the father was in the home with [her siblings] the environment of these children was such as to warrant the state to assume guardianship"); *In re S.O.*, 649 N.E.2d 997, 998 (Ill. App. Ct. 1995) (concluding that father who had, on several occasions, rubbed his "privates" between his eldest daughter's legs, causing "white stuff" that he called "spit" to come out, was unfit to maintain parental rights of his three children because he failed to attend weekly counseling sessions). See generally Robin Fretwell Wilson, *The Cradle of Abuse: Evaluating the Danger Posed by a Sexually Predatory Parent to a Victim's Siblings*, 51 EMORY L.J. 241 (2002).

5. See, e.g., *In re M.B.*, 480 N.W.2d 160, 162 (Neb. 1992) (finding that the failure of a father who molested one child in his care "to seek treatment for his propensity toward sexual contact with minors" warranted state intervention on behalf of the remaining children); *In re M.F.*, 770 So. 2d 1189, 1194 n.13 (Fla. 2000) (directing lower courts to consider "any treatment received by the parent following the act," suggesting that treatment may materially diminish a child's risk); *In re S.O.*, 649 N.E.2d at 1000 (concluding that father who had sexually abused minor child was unfit to maintain parental rights of his three children since his unwillingness to resolve sexual problems placed the remaining children at risk).

6. Compare Henry Giarretto, *A Comprehensive Child Sexual Abuse Treatment Program*, 6 CHILD ABUSE & NEGLECT 263, 264 (1982) (finding a recidivism rate of less than 1% for children returned to their families following a California treatment program), with ARNON BENTOVIM ET AL., CHILD SEXUAL ABUSE WITHIN THE FAMILY: ASSESSMENT AND TREATMENT 265 (1988) (reporting in a study of 120 families treated in England that 16% later experienced sexual abuse, but noting that for 15% of participating families, researchers could not rule out whether sexual abuse occurred again).

shows that treatment may indeed mitigate the risk of recidivism over time in certain circumstances.⁷

This interdisciplinary evidence also permits us to challenge the boundaries of our traditional understanding of mental health issues in other ways as well. Thus, while a refined understanding of the relationship between child abuse and later psychopathy might be significant in reducing juvenile crime, as Professors Howard, Williams, Vaughn, and Edmond note, a better understanding of this relationship might also tell us where to concentrate and target our preventative and remedial efforts. In fact, a slew of studies on the effects of abuse over time already highlights for us where mental health services may be most needed. We know, for example, that abused and neglected children who are asymptomatic as kids may experience “sleeper effects” well into adulthood, requiring therapy and other services.⁸

Just as social science highlights the risk of mental strain to the victims of abuse, it also points out the risk of abuse to the mentally disabled. Mental disabilities not only make one vulnerable to later social offending, they make the disabled prime targets of abuse.

During childhood, mentally retarded children are four times more likely to experience neglect, physical abuse, emotional abuse, or sexual abuse than non-disabled children.⁹ And the mentally retarded are not alone in drawing predators. Children with behavioral disorders are seven times more likely than non-disabled children to endure neglect, physical abuse or emotional abuse; and five and one-half times more likely to experience sexual abuse.¹⁰

Children with other handicaps are also victimized at staggeringly high rates. Vision impaired children, for instance, experience unwanted intercourse in far greater numbers than sighted children.

7. See, e.g., Lea H. Studer et al., *Phoenix: An In-hospital Treatment Program for Sex Offenders*, 23 J. OFFENDER REHAB. 91, 95 (1996) (finding that 3.3% of the sex offenders who completed the program had criminal convictions or charges brought against them for post-treatment sexual offenses, significantly less than those who failed to complete the program, 10%).

8. Joseph H. Beitchman et al., *A Review of the Long-Term Effects of Child Sexual Abuse*, 16 CHILD ABUSE & NEGLECT 101, 102 (1992).

9. PM Sullivan, *Maltreatment and Disabilities: A Population-Based Epidemiological Study*, 24(10) CHILD ABUSE & NEGLECT 1257, 1266, tbl. 4 (2000).

10. *Id.*

Twenty-two percent of blind girls in one study reported such abuse, compared to eight percent of sighted girls.¹¹ Deaf youth and other handicapped children are also victimized in droves.¹² One meta-analysis of fourteen studies found that disabled children are as much as 8.5 times more likely to be preyed upon than non-disabled children.¹³

This increased risk comes both from within the family and outside it. Sullivan reports that a significant portion of offenders who prey on the disabled are immediate family members.¹⁴ Sobsey and colleagues argue nonetheless that “much of the excess risk . . . comes from the service system, not the family.”¹⁵ Their research has shown that the risk of incest is only slightly higher for disabled children, while the risk of abuse from outside the family is “much higher,” with most victims experiencing chronic abuse.¹⁶

11. Marit Hoem Kvarn, *Sexual Abuse of Children with Disabilities*, Report 2003 (Save the Children, Norway, 2003). See also A Welbourne et al., *A Comparison of the Sexual Learning Experiences of Unusually Visually Impaired and Sighted Women*, J. VISUAL IMPAIRMENT 256 (June 1983).

12. See Sullivan, *supra* note 9, at 1261-62 (finding in an entire school-based population, as opposed to a sample, that 31% of disabled children were maltreated, making them 3.4 times more likely to experience abuse than non-disabled peers); D. Sobsey & S. Manell, *Sexual Abuse Patterns of Children With Disabilities*, 2 INT'L J. CHILDREN'S RIGHTS 96 (1994); PM Sullivan et al., *Sexual Abuse of Deaf Youth*, in AMERICAN ANNALS OF THE DEAF 256 (Oct. 1987) (reporting that four pioneering small-scale studies of children in residential schools for the deaf found that 54% of deaf boys and 50% of deaf girls reported sexual abuse). See generally Edward Goldson, *Maltreatment Among Children With Disabilities*, 13 INFANTS & YOUNG CHILDREN 44 (2001).

Of course, it is sometimes difficult to know in which direction the causal arrow runs. See PK Jaudes & LJ Diamond, *The Handicapped Child and Child Abuse*, 9 CHILD ABUSE & NEGLECT 341 (1983) (noting the complex relationship between abuse and handicaps, with some abuse causing handicaps, while other abuse occurs to a handicapped child, and finding in a group of 162 children with cerebral palsy that over one-third of those abused or neglected were abused after discovery of the handicap); E Ryerson, *Sexual Abuse and Self-Protection for Mentally Disabled Youth* (SIECUS Report XIII, 1994).

13. Manjula Govindshenoy & N. Spencer, *A Systematic Review of the Literature on the Abuse of Disabled Children Presented to the IXth International Society for Protection Child Abuse & Neglect European Conference on Child Abuse and Neglect: Promoting Interdisciplinary Approaches to Child Protection*, Warsaw, Poland, Aug. 29-31, 2003, at 79 (abstract on file with author).

14. Sullivan, *supra* note 9, at 1270.

15. Sobsey & Manell, *supra* note 12, at 98.

16. *Id.*

These abusive experiences are costly to the victims in unexpected ways. Disabled children who are abused miss more school.¹⁷ They also receive lower standardized test scores than their non-abused, but disabled counterparts.¹⁸

Researchers ascribe this additional risk to a number of characteristics of the disabled that together create an acute vulnerability. Disabled children and adults occupy a subordinate position, are conditioned to comply with authority, fear threats and are susceptible to bribes, are very naïve about sexual norms, may be unable to distinguish sexual abuse from basic assistance with hygiene (like bathing), crave affection, and are often told by the offender that the sexual activity is “special.”¹⁹

Reducing the risk to the mentally disabled may require different strategies for children living at home than for those living in residential facilities. For the latter, lower resident to caretaker ratios in residential facilities, background checks of caretakers, taking care not to depersonalize the disabled, greater parental involvement, unannounced observation of caretakers, periodic confidential interviews with residents, self-protection education about exploitation and abuse, and avoiding the impulse to give authority to some residents over others—which fosters a system in which the strongest, most brutal sometimes prey on the weaker and younger—may all be warranted and useful.²⁰ For a child or adult at risk of being victimized in the home, a “medical home”—together with ongoing support and monitoring of families with disabled children—may be an important start.²¹

While it is natural to wish for more resources and services, we can also be smarter about the way we leverage existing resources. When abuse is discovered, better methods are needed for “correctly judging future risks to the children” and, when necessary, removing victims

17. Sullivan, *supra* note 9, at 1268.

18. *Id.*

19. See Sullivan et al., *supra* note 12, at 257; Ryerson, *supra* note 12, at 6. See also Margaret Brinig & F.H. Buckley, *Parental Rights and the Ugly Duckling*, 1 J.L. & FAM. STUD. 41 (1999).

20. Sullivan et al., *supra* note 12, at 259, 260; Ryerson, *supra* note 12, at 6.

21. See Goldson, *supra* note 12, at 44.

from the offender's grasp.²² Likewise, state agencies should note disabilities when investigating allegations of abuse, something they do not now routinely do despite the relationship between disability and abuse.²³ Finally, given the fact that many abused, disabled kids under-perform educationally, school personnel can act as a first line of defense, "be[ing] alert for signs of maltreatment among disabled children who were not achieving as well as expected."²⁴

Clearly, we have a great deal of work to do to protect the mentally ill from others, from the "system," and from themselves.²⁵ Only by working across disciplines do we have any hope of getting this done.

22. See Jaudes & Diamond, *supra* note 12, at 344.

23. Sullivan, *supra* note 9, at 1258.

24. *Id.* at 1271.

25. See Sobsey & Manell, *supra* note 12, at 98 (reporting that older disabled children between 13 and 20 years of age were most often abused by disabled peers).