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Mental Disorders and the Law

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Introduction

Questions regarding a criminal defendant's possible mental disorder may emerge at nearly any point in criminal justice proceedings: during arrest, preliminary hearings, trial, sentencing, incarceration, and release decision making. Often times, the law explicitly identifies the relevance of mental disorder. For example, legal doctrine addresses the ways in which mental disorder might impact a criminal defendant so severely that it precludes participating in trial (*Dusky v. United States* 1960) or culpability for a given offense (*United States v. Brawner* 1972). On the other hand, there is no comprehensive or integrated approach to mental disorder within the criminal justice process (Cohen 1996). Mental disorder may prove relevant to one legal question but not another, and different disorders—even different symptoms of the same disorder—may result in substantially different legal outcomes.

The attention the law gives to mental disorder is understandable when one considers the prevalence of mental illness among those who pass through the criminal justice system. For example, Justice Department statistics indicate that 35% of jail and

prison inmates suffer from a mental disorder, and a recent large-scale study of pre-trial arrestees in New York found that 22% had a moderately serious or serious mental illness (see Redding 2004).

However, mental disorder is not relevant only to questions of criminal law. Aspects of civil law address mental disorder when it causes concern that an individual may pose a danger to self or to others, even if no criminal law has been violated. Other psycho-legal questions in the civil context require determining, for example, whether mental disorder so impairs an individual that she cannot competently consent to medical treatment or execute a will. Following is an overview of the major classes of mental disorder and the ways in which they are salient to selected aspects of American criminal and civil law, focusing particularly on criminal law issues.

Overview of Mental Disorders Relevant in Legal Contexts

The *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth edition, (DSM-IV-TR; American Psychiatric Association 2000) serves as the standard diagnostic reference for mental health professionals. The manual catalogues the numerous syndromes that scholars have recognized, based upon research, as distinct and identifiable mental disorders. The manual also describes the diagnostic criteria for each disorder and related clinical information such as specific age and gender differences, typical course of the disorder, and prognosis. Thus, the DSM-IV-TR provides an official nomenclature for collecting clinical information, teaching, and communicating about mental disorders across a variety of contexts and disciplines.

For organizational and theoretical purposes, the DSM-IV-TR divides disorders according to type (e.g., Eating Disorders, Anxiety Disorders, Sexual and Gender Identity

Disorders, Mood Disorders, Personality Disorders). Although it is conceivable that nearly any disorder might become relevant in a particular legal question, certain classes of mental disorder emerge in legal contexts far more often than others. Legal professionals with even a basic knowledge of such disorders may be better able to serve their clients and identify when particular issues of law may be relevant (Redding 2004).

Schizophrenia and Other Psychotic Disorders:

Because they are among the most debilitating conditions, schizophrenia and other psychotic disorders often prove relevant to legal decisions. Psychosis itself is neither a specific mental disorder nor a formal diagnosis; rather, the term refers to particular symptoms that may be associated with several different disorders or even other factors (e.g., substance abuse). It refers broadly to a severe impairment in one's ability to distinguish reality from that which is not real. *Psychosis* may denote a group of severe symptoms including hallucinations (false sensory experiences such as seeing or hearing stimuli that are not present), delusions (false beliefs even despite clear evidence to the contrary), or grossly disorganized behavior.

Schizophrenia is the most commonly recognized of the psychotic disorders, and is characterized by symptoms such as hallucinations, delusions, disorganized statements, or grossly disorganized behavior. To meet diagnostic criteria, these symptoms must cause significant social or occupational impairment and persist, at least to some degree, for a period of six months or more (American Psychiatric Association 2000). There are several subtypes of schizophrenia: Paranoid (featuring prominent delusions and/or hallucinations), Disorganized (featuring disorganized speech and/or behavior, and flat or inappropriate emotions), and Catatonic (featuring severe physical oddities such as

immobile and mute behavior or odd purposeless movement). Schizophrenic individuals who may come into contact with the court include, for example: the patient who is so grossly disorganized and incoherent that she requires court-ordered treatment to attend to basic self-care and safety; or the delusional patient who believes he owns the local shopping mall and is repeatedly charged for trespassing on its premises and harassing its patrons.

Mood Disorders:

Mood Disorders are characterized by periods of substantial disturbance in emotion and activity level, and may feature episodes of depression (e.g., depressed mood and loss of pleasure, decreased energy and activity, changes in sleep or appetite), mania, or both. Mania, or a manic episode, is characterized by an unusually elevated mood that persists for at least one week and features symptoms such as inflated or grandiose self-esteem, decreased need for sleep, distractibility and over-activity, and excessive involvement in pleasurable, risky activities. Individuals experiencing a Major Depressive Episode may pose a risk to themselves (via suicidal behaviors or lack of self-care) to such an extent that legal intervention is necessary to ensure prompt and adequate treatment. Individuals experiencing a Manic Episode, on the other hand, might come into contact with the legal system due to criminal charges for risky or grandiose behavior (e.g., collecting money from investors in an impulsive and ill-conceived financial scheme, becoming aggressive due to increased irritability and impulsivity).

Mental Retardation:

A diagnosis of Mental Retardation requires substantially below average intellectual functioning (an IQ score around 70 or below) along with related deficits in

adaptive functioning. Adaptive functioning refers primarily to daily living skills such as communication, self-care, home-living, social skills, and health and safety. Numerous factors may contribute to mental retardation including hereditary conditions, chromosomal aberrations, prenatal trauma, or extreme deprivation of nurturance and stimulation during infancy and childhood.

Personality Disorders:

Whereas most mental disorders are considered illnesses with specific symptoms, personality disorders more to be constellations of interpersonal behaviors that are so firmly ingrained that they cause substantial problems in daily living. “A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (American Psychiatric Association 2000: 685). Some personality disorders frequently manifest in harmful or criminal behavior, particularly the Antisocial, Narcissistic, and Borderline personality disorders. But unlike schizophrenia, personality disorders do not feature symptoms that alter one’s perception of reality (e.g., hallucinations, delusions). Thus, courts have been ambivalent towards the concept of personality disorder as presented by mental health professionals, and there is no clear-cut trend in legal decisions relating to personality disorders (for example, contrast *Foucha v. Louisian*, 1992 with *Kansas v. Hendricks* 1997).

Overview of Relevant Legal Issues:

Though there are numerous circumstances in which one’s mental disorder may become relevant to questions of law, certain legal questions (e.g., trial competence, legal

sanity) explicitly address the question of mental disorder, and in others (e.g., sentencing mitigation) mental disorder often becomes salient. However, it is not diagnosis per se that is most relevant to most legal issues. Rather, the law considers only whether or not one manifests deficits in certain functional capacities (e.g., ability to participate meaningfully in one's criminal trial; ability to attend to one's basic health, hygiene, and safety needs). A diagnosis is relevant only insofar as it relates to these deficits. There is never a one-to-one correspondence between a clinical diagnosis and a legal construct. Indeed, even the DSM-IV-TR acknowledges,

“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” (American Psychiatric Association 2000: xxxvii).

Competence to Stand Trial (Adjudicative Competence)

Western legal tradition has long held that it is inappropriate to try or convict a defendant who cannot understand or meaningfully participate in adjudicatory proceedings, including pretrial proceedings (Bonnie 1992). The Supreme Court of the United States explained that it is “fundamental to an adversary system of justice” (*Drope v. Missouri* 1975: 904) that an incompetent defendant not be subject to trial. The contemporary standard for trial competence (*Dusky v. United States* 1960), upon which all states have modeled their definitions, demands that a criminal defendant must have “sufficient present ability to consult with his lawyer with a reasonable degree of rational

understanding” and have “a rational as well as factual understanding of the proceedings against him” (402).

Typically, defense counsel requests that a judge order a clinical evaluation of trial competence when it appears that a defendant may be unable to meaningfully assist in mounting a defense. The clinician who conducts such an evaluation almost always interviews the defendant, and may also consult collateral information sources and review records, in an effort to determine whether the defendant has a mental disorder and whether the disorder impairs his or her ability to participate knowingly and meaningfully in the trial and to cooperate with counsel. In an effort to reduce subjectivity and increase reliability of clinician judgments, scholars have developed several structured measures of competence-related abilities (Grisso 2003). Optimally, clinicians conducting competence evaluations address all key psycholegal abilities and adequately explain to the court the reasoning that underlies their opinions (Skeem and Golding 1998). The determination of trial competence is a legal, rather than clinical decision, and the court is not obliged to concur with the evaluating clinician(s). Nonetheless, it appears that courts defers to the clinician’s decision in over 90% of cases (Zapf et al. 2004).

About 20% of defendants referred for competency evaluation are initially found incompetent (Hubbard, Zapf and Ronan 2003), although most are restored to competency and ultimately stand trial. Psychosis is the condition most associated with incompetence, with mental retardation also impairing competence in many cases. Evaluators do not reflexively equate psychosis with incompetence; only about half of psychotic defendants are found to be incompetent (Nicholson and Kugler 1991). But it is the functional deficits related to these diagnoses, rather than the diagnoses themselves, that preclude

participation in trial. There is no clinical condition that necessarily rules out (or in) trial competence.

Legal Sanity or Criminal Responsibility

One of the most controversial and complex questions in criminal law relates to legal sanity, also referred to as criminal responsibility or mental state at the time of the offense. Western legal tradition has generally held that those who are unaware of the meaning of their illegal acts should not be held criminally responsible for them. Consequently, for over a century, legislators have developed and modified legal standards of insanity. Currently, most states use either a standard based upon the M'Naghten rule or the American Law Institute (ALI) standard (*United States v. Brawner* 1972). Both require the presence of some mental disorder, and require that this disorder impair a defendant's ability to know or appreciate the legal or moral wrongfulness of his behavior. The ALI standard also allows for a "volitional prong," the possibility that the defendant knew the wrongfulness of his behavior but could not conform it to the requirements of the law.

Whereas competence to stand trial requires assessment of one's present abilities, an evaluation of legal sanity requires inferences about one's mental state at an earlier point in time. Thus, clinical evaluation of legal sanity requires not only an interview with the defendant, but an exhaustive review of criminal (e.g., arrest reports, prior offenses) and mental health records (e.g., psychiatric hospitalizations), as well as other collateral information (e.g., interviews with arresting officers and family members) that may shed light on a defendant's clinical status at the time of the offense (Melton et al. 1997). The defendant's diagnostic presentation is the variable most strongly associated with a

judgment of legal (in) sanity, although there is no one-to-one relationship between any particular diagnosis and a legal judgment of “Not Guilty by Reason of Insanity” (NGRI). Defendants whom clinicians opine to be psychotic (often schizophrenic) at the time of the offense are most likely to be found legally insane, whereas certain diagnostic categories (e.g., personality disorders), are almost never related to a finding of insanity (Cochrane, Grisso and Frederick 2001; Warren et al 2004).

The public often misunderstands the insanity defense, overestimating the use and success of the insanity defense and mistakenly assuming that those found NGRI are released upon acquittal (Silver, Cirincione and Steadman 1994). Similarly, the public often assumes the insanity defense is employed most often in murder cases, that defendants who plead insanity are usually malingering (faking) mental illness, and that insanity defense cases devolve into a battle of expert witnesses who disagree regarding the presence of mental illness. Research clearly contradicts each of these “myths” (Perlin 1996)

Other criminal law issues also frequently warrant an evaluation of mental disorder. For example, regarding capital sentencing, the U.S. Supreme Court has ruled that juries must consider mitigating circumstances (*Penry v. Lynaugh* 1989), which often include some form of mental disorder, and that Mental Retardation precludes a defendant from receiving the death penalty (*Atkins v. Virginia* 2002)

Civil Commitment

All states have civil commitment laws allowing for involuntary hospitalization of mentally disordered individuals. Yet mental disorder and a clear need for treatment are not, by themselves, sufficient to warrant involuntary hospitalization (*O’Conner v.*

Donaldson 1975). Rather, civil commitment is only appropriate for those whose mental disorder leaves them so impaired as to be 1) a danger to themselves or others, or 2) unable to adequately care for themselves; they must need treatment that is unavailable in any settings less restrictive than a psychiatric hospital.

Clinicians involved in the civil commitment process are often required not only to identify a patient's mental disorder and necessary treatment, but to offer a prediction of dangerousness, or an assessment of risk. Originally, researchers maintained that mental illness was not associated with violence and that clinical predictions of dangerousness were wrong more often than not (*Monahan* 1984). However, more recent research, which tends to emphasize "risk assessment" rather than "predicting dangerousness," is far less pessimistic. Generally, clinicians perform significantly better than chance when they consider information that research has identified as relevant to violence risk and when they offer predictions for a limited frame of time and circumstances (*Borum* 1996). The current consensus among scholars is that mental disorder does indeed bear a modest, but reliable, relationship to violent behavior (*Monahan* 1992) and that the risk for violence among the mentally disordered increases with 1) active symptoms of psychosis, and particularly with 2) active substance abuse.

A second form of civil commitment has received increasing attention in recent years. Many states adopted Sexually Violent Predator (SVP) statutes in the 1980s and 1990s to protect the public from repeat sexual offenders. The typical SVP statute allows for civil commitment of sexual offenders even after they have served their prison sentences, if there is evidence that they are dangerous by virtue of being prone to continued sexual offending, suffer from a "mental abnormality," and lack volitional

control (*Kansas v. Hendricks 1997*). Like other civil commitment procedures, adversarial court proceedings are used to determine proof of mental disorder and likelihood of future dangerousness (Janus and Meehl 1997). Contrary to many other legal standards for mental disorder, however, SVP statutes often include personality disorders as a qualifying class of mental disorder.

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