William & Mary Law Review

Volume 66 (2024-2025)
Issue 1

Article 3

10-2024

A Rule Without a Reason: Determining the Capacity for Negligence of a Person with Mental Illness

Alex Geisinger
Drexel University School of Law

David DeMatteo
Drexel University School of Law

Kellie Wiltsie
Drexel University

Chelsea Jackson
Drexel University

A RULE WITHOUT A REASON: DETERMINING THE CAPACITY FOR NEGLIGENCE OF A PERSON WITH MENTAL ILLNESS*

ALEX GEISINGER,** DAVID DEMATTEO,*** KELLIE WILTSIE**** & CHELSEA JACKSON*****

ABSTRACT

Since the pandemic, the impacts of structural bias on racial minorities and other groups have become an even more compelling concern for legal commentators. One group that has received some attention in the effort to confront bias is the mentally ill. This attention has coincided with a rise in the willingness of individuals to talk about, and destigmatize, mental health issues in society. Yet, despite these efforts, along with a long and well-established body of scholarship that criticizes its treatment of mental illness, the civil law—particularly the law of tort—continues its entrenched refusal

---

* Professor DeMatteo, Ms. Wiltsie, and Ms. Jackson, along with the entire Drexel University Thomas R. Kline School of Law, dedicate this Article to the memory of our colleague and friend, Alex Geisinger, who passed away suddenly and unexpectedly before the publication of this Article. As an educator, litigator, and scholar, Alex believed in empowering people and strengthening the community, and those ideals are reflected in this Article.

** Professor of Law, Thomas R. Kline School of Law at Drexel University. The author is grateful to Sandra Benjamin, Ethan Jagielski, and Kevin Ricard for their research assistance. All mistakes are, of course, the author's alone.

*** Professor of Law at the Thomas R. Kline School of Law at Drexel University, a Professor of Psychology in the Department of Psychological and Brain Sciences at Drexel University, and Director of Drexel University's JD/PhD Program in Law and Psychology.

**** BS in Criminal Justice (2018) and a BS in National Security (2018) from the University of New Haven, an MS in Psychology (2022) from Drexel University, and a JD (2022) from the Thomas R. Kline School of Law at Drexel University. Ms. Wiltsie anticipates receiving a PhD in Clinical Psychology from Drexel University in June 2025.

***** BS in Psychology (2016) from Lafayette College, an MS in Investigative Forensic Psychology (2017) from the University of Liverpool, and a JD (2023) from the Thomas R. Kline School of Law at Drexel University. Ms. Jackson anticipates receiving a PhD in Clinical Psychology from Drexel University in June 2026.

to consider mental illness when determining the liability of individuals for harms they have caused. The law has lurched from one policy rationale to another in its efforts to avoid considering the impact of mental illness on liability. As evidenced by the Restatement (Third) of Torts, the only consistent basis for liability seems to be concerns over the law's administrability, with commentators continuing to suggest that the courts cannot adequately identify if and when a mental illness has impacted an individual's capacity to understand and act in accordance with the law.

Although many commentators have suggested that mental health professionals can adequately deal with concerns over administrability, none of them have explained how mental health practitioners actually do so. In this Article, we fill this gap. We first provide a sense of the legal landscape—describing the law of negligence's treatment of mental illness and the rather uncertain and constantly changing policy basis underlying it—before turning to the Restatement (Third) of Torts' almost complete reliance on administrability concerns as the basis for refusing to consider mental illness in addressing issues of liability. We then turn to a discussion of how these administrability concerns are unfounded by describing the process used by mental health professionals to analyze capacity in legal decision-making. Our goal is not only to make clear that the stated policy basis for liability is unsound, but also to provide lawyers, judges, and those concerned with the administration of justice with an understanding of the depth and reliability of the process that is used to analyze capacity when mental illness is at issue in a particular negligence case. When the process is delineated in its completeness and its safeguards brought to light, its rigor can hopefully decrease the influence of biases and misjudgments whose influence persists.

TABLE OF CONTENTS

INTRODUCTION

Since the pandemic, the impacts of implicit bias on racial minorities and other groups have become an even more compelling concern for legal commentators.[1] One group that has received some attention in the effort to confront bias is the mentally ill.[2] This attention has coincided with a rise in the willingness of individuals to talk about, and destigmatize, mental health issues in society.[3] Yet, despite these efforts, along with a long and well-established body of scholarship that criticizes its treatment of mental illness,[4]

1. A search of the term "implicit bias" for the last three years conducted on April 7, 2024, in Westlaw resulted in 2,781 articles. Westlaw *Secondary Sources Search*: "implicit bias," WESTLAW, https://1.next.westlaw.com/Browse/Home/SecondarySources?transitionType=Default&contextData=(sc.Default) [https://perma.cc/KKP4-ZT7L] (type term "implicit bias" in "Search Secondary Sources" box; then click search button; select "Date" filter; then choose "Last 3 years"; then click "Apply").

2. *See, e.g.*, Jamelia Morgan, *Disability's Fourth Amendment*, 122 COLUM. L. REV. 489, 495 (2022); Sara Emily Burke & Roseanna Sommers, *Reducing Prejudice Through Law: Evidence from Experimental Psychology*, 89 U. CHI. L. REV. 1369, 1414 (2022); Elizabeth F. Emens, *Mindful Debiasing: Meditation as a Tool to Address Disability Discrimination*, 53 CONN. L. REV. 835, 838 (2022); Richard A. Wise & Denitsa R. Mavrova Heinrich, *Toward a More Scientific Jurisprudence of Insanity*, 95 TEMP. L. REV. 45, 95 (2022); Jamelia N. Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401, 1436 (2021). For a discussion of bias content, see Maybell Romero, "*Ruined*," 111 GEO. L.J. 237, 276 (2022) ("Just as with addiction and substance use disorders, mental illness has been seriously and historically stigmatized, leading to poor outcomes and difficulties such as 'social isolation'; 'reduced employment, housing, and educational opportunities'; 'discrimination'; and more. Although it may be, unfortunately, unsurprising that most Americans have stigmatizing attitudes toward mental illness, even those who should know better, such as mental health clinicians and service providers, also exhibit this sort of stigmatization. Pop cultural representations of mental illness exacerbate the problem by essentializing those who have mental illness, stereotyping in three main ways: 'homicidal maniacs who need to be feared,' people with 'childlike perceptions of the world that should be marveled,' and people who are 'responsible for their illness because they have weak character.'" (internal footnotes omitted)).

3. *See* Romero, *supra* note 2, at 276; Kiera Lyons, Note, *The Neurodiversity Paradigm and Abolition of Psychiatric Incarceration*, 123 COLUM. L. REV. 1993, 1995 (2023).

4. *See* Kristin Harlow, Note, *Applying the Reasonable Person Standard to Psychosis: How Tort Law Unfairly Burdens Adults with Mental Illness*, 68 OHIO ST. L.J. 1733, 1751 (2007) ("[P]sychiatry is more advanced today than during the initial development of tort law. Effectively identifying defendants with a mental illness that impairs their capacity for understanding negligent action is an existing and effective part of the justice system. In fact, states have created detailed manuals providing processes for determining the mental status of defendants."); Gabrielle Lindquist, Comment, *Science or Status Quo? Disregard for a Defendant's Mental Illness in Tort Suits*, 95 WASH. L. REV. ONLINE 115, 117 (2020) ("[S]ubstantial legal scholarship calls for change and rebuts the justifications for continuing

the civil law—particularly the law of tort—continues its entrenched refusal to consider mental illness when determining the liability of individuals for harms they have caused, with related impacts on how people approach those with disabilities.[5] The law has lurched from one policy rationale to another in its efforts to avoid considering the role of mental illness on liability.[6] As evidenced by the Restatement (Third) of Torts, the only consistent basis for liability seems to be concerns over the law's administrability, with commentators continuing to suggest that the courts cannot adequately identify if and when a mental illness has impacted an individual's capacity to understand and act in accordance with the law.[7]

Although many commentators have suggested that mental health professionals can adequately deal with administrability concerns,[8] none of them have explained how mental health practitioners actually do so. In this Article, we fill this gap. Our goal is not only to make clear that the stated policy basis for liability is unsound but also to provide lawyers, judges, and those concerned with the administration of justice with an understanding of the depth and reliability of the process that is used to analyze capacity when mental illness is at issue in a particular negligence case. When the process is delineated in its completeness and its safeguards brought to light, its rigor can hopefully decrease the influence of biases and misjudgments whose influence persists.

The Article proceeds as follows. In Section I, we first provide a sense of the legal landscape: describing the law of negligence's general failure to consider a defendant's mental illness and the rather uncertain and constantly changing policy basis underlying it.

---

to disallow consideration of a tort defendant's mental illness.").

5. *See* Burke & Sommers, *supra* note 2, at 1369 ("[R]eport[ing] the results of a series of experiments that test the effect of inducing the belief that discrimination against a given group is legal (versus illegal) on interpersonal attitudes toward members of that group.... [F]ind[ing] that learning that discrimination is unlawful does not simply lead people to believe that an employer is more likely to face punishment for discriminatory behavior. It also leads some people to report less prejudicial attitudes and greater feelings of interpersonal warmth toward members of that group. Conversely, when people learn that the law tolerates discrimination against a group, it can license more prejudicial attitudes.").

6. *See infra* notes 22-25 and accompanying text (discussing the competing policy rationales).

7. *See infra* notes 35-43 and accompanying text.

8. *See, e.g.*, Lindquist, *supra* note 4, at 151-52 (discussing the limitations of administrability concerns).

Section I also focuses on the administrability concern central to the current rule and explains that, even as a matter of policy, reliance on such a policy provides tenuous support for the legal rule at best. The concluding part of Section I focuses on our main goal—to explain that administrability concerns are, in fact, an invalid basis upon which to rest the current treatment of mental illness in negligence. In Section II, we define "capacity to commit negligence" before turning in Section III to a discussion of the process used by mental health professionals to conduct forensic mental health assessments of justice-involved individuals. In Section IV, we discuss the ability of mental health professionals to analyze capacity and risk to demonstrate that concerns over administrability are simply misplaced. We end the Article with a brief conclusion.

I. THE RULE AND POLICIES REGARDING TREATMENT OF PERSONS WITH MENTAL ILLNESS IN TORT

A. The Rule and Its Early Policy Support

Since the inception of the common law of negligence, courts have generally held that those with mental illness should be judged based on the traditional reasonable person standard.[9] In other words, the general rule is that individuals with mental illness, unlike those with physical disability,[10] are not treated according to a standard that takes into account their mental illness.[11] The traditional rule has been subject to no small amount of criticism.[12] Much of this

9. *See* RESTATEMENT (SECOND) OF TORTS § 283B cmt. b (AM. L. INST. 1965) ("The rule stating that a mentally deficient adult is liable for his torts is an old one, dating back at least to 1616.").

10. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

11. *Id.* § 11(c) ("An actor's mental or emotional disability is not considered in determining whether conduct is negligent, unless the actor is a child.").

12. *See* Elizabeth J. Goldstein, *Asking the Impossible: The Negligence Liability of the Mentally Ill*, 12 J. CONTEMP. HEALTH L. & POL'Y 67, 67 (1995) ("Many commentators have severely criticized this rule."); *see also* John V. Jacobi, *Fakers, Nuts, and Federalism: Common Law in the Shadow of the ADA*, 33 U.C. DAVIS L. REV. 95, 104 (1999) ("[I]f insanity of a pronounced type exists, manifestly incapacitating the sufferer from complying with the rule which he has broken, good sense would require it to be admitted as an excuse." (quoting OLIVER WENDELL HOLMES, JR., THE COMMON LAW 95 (Little, Brown & Co. 1948) (1881))); Harlow, *supra* note 4, at 1734 ("One hundred twenty-six years later, the common law system

criticism stems from the recognition that negligence, as compared to strict liability, is a fault-based standard and that people with mental illness who do not have capacity to understand the risks they create or how to avoid them are not at fault for their actions.[13] Historically, however, courts have not been sympathetic to this argument, in part because of concerns about the ability to adequately determine the capacity of a person with mental illness.[14]

Interestingly, while the unwillingness to consider mental illness in determining a defendant's negligence has remained relatively intact,[15] some courts have been willing to consider capacity when a person with mental illness is a plaintiff subject to a claim for contributory negligence.[16] In those situations, several courts have allowed for consideration of the individual's capacity in analyzing whether they have breached the standard of care.[17] For example, in a wrongful death case stemming from the suicide of an individual receiving outpatient psychological care, the Iowa Supreme Court reasoned that whether a person suffering from mental illness lacks the capacity to be found negligent is a matter of fact.[18] The court followed the reasoning of the Illinois Supreme Court in *Hobart v. Shin*, stating that if an individual "is so mentally ill that he is incapable of being contributorily negligent, he would be entitled to have the jury so instructed."[19] Similarly, in *Dodson v. South Dakota Department of Human Services*, when a husband sued a hospital for medical malpractice after his wife committed suicide the day after

---

has yet to progress to the modern understanding of mental illness and fairness that Holmes set forth.").

13. *See* Goldstein, *supra* note 12, at 92; Harlow, *supra* note 4, at 1735-36.

14. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010); *see, e.g.*, Mem'l Hosp. of S. Bend, Inc. v. Scott, 300 N.E.2d 50, 56-58 (Ind. 1973).

15. There was a short point in time when support for the rule seemed to waver slightly. The RESTATEMENT (FIRST) OF TORTS contained an exception from the application of the reasonable person standard for "insane person[s]" in 1934 that was later removed in 1948. RESTATEMENT (FIRST) OF TORTS § 283 (AM. L. INST. 1934); *see* J.A. Bryant, Jr., Annotation, *Liability of Insane Person for His Own Negligence*, 49 A.L.R.3d 189, § 2 (1973).

16. *See, e.g.*, Snider v. Callahan, 250 F. Supp. 1022, 1022 (W.D. Mo. 1966); Stacy v. Jedco Constr., Inc., 457 S.E.2d 875, 878-79 (N.C. Ct. App. 1995); Feldman v. Howard, 214 N.E.2d 235, 237 (Ohio Ct. App. 1966), *rev'd on other grounds*, 226 N.E.2d 564, 567 (Ohio 1967).

17. *See Snider*, 250 F. Supp. at 1022-23; *Stacy*, 457 S.E.2d at 878-79; *Feldman*, 214 N.E.2d at 237.

18. Mulhern v. Cath. Health Initiatives, 799 N.W.2d 104, 112 (Iowa 2011).

19. *Id.* (quoting Hobart v. Shin, 705 N.E.2d 907, 911 (Ill. 1998)).

her discharge, the Supreme Court of South Dakota stated that the proper standard for judging the contributory negligence of a plaintiff suffering from mental illness is not that of the "objective reasonable-person standard."[20] Instead, the court found that an individual "should be held only to the exercise of such care as he or she was capable of exercising, that is, the standard of care of a person of like mental capacity under similar circumstances."[21]

The basis for treating a person with mental illness differently when that person is a plaintiff or defendant has never been well articulated.[22] Indeed, a number of courts that have treated mental illness differently when the party is a plaintiff seem to rely partly on a general concern that an individual's mental illness impacts capacity,[23] a factor that is equally relevant when the person is a defendant. It remains to be seen whether this distinct treatment of mental illness in contributory negligence continues. After all, claims

---

20. 703 N.W.2d 353, 355, 357 (S.D. 2005) (internal citations omitted).

21. *Id.* at 357.

22. Stephanie I. Splane, Note, *Tort Liability of the Mentally Ill in Negligence Actions*, 93 YALE L.J. 153, 157-58 (1983) ("No policy reasons for this distinction between primary and contributory negligence standards have ever been clearly articulated. Several factors, however, have been suggested. First, there is a vague supposition that the policy rationales supporting an objective standard in primary negligence cases have less force in cases of contributory negligence. Second, there seems to be less equitable discomfort in allowing mentally ill plaintiffs to recover since the mentally ill victim appears less threatening and more deserving of sympathy than a mentally ill tortfeasor who causes an injury. Third, the doctrine of contributory negligence is widely considered to be too harsh; this approach thus provides a means of avoiding some harsh results." (internal footnotes omitted)).

23. *See Dodson*, 703 N.W.2d at 357; *see, e.g.*, Maunz v. Perales, 76 P.3d 1027, 1035 (Kan. 2003) (holding that the mental capacity of the plaintiff should be taken into consideration when determining fault and the jury should use a capacity based standard, not a reasonable person standard); Arias v. State, 755 N.Y.S.2d 223, 232 (Ct. Cl. 2003) ("The standard of care which a mentally ill patient must exercise to protect himself ... is based upon the capacity of the patient and his perception of danger, considering the degree of his illness." (quoting Horton v. Niagara Falls Mem. Med. Ctr., 380 N.Y.S.2d 116, 121-22 (App. Div. 1976))); Hunt v. King Cnty., 481 P.2d 593, 600 (Wash. App. 1971) ("[I]t is a prerequisite ... that the patient [must] be capable of exercising the care of a reasonable [person]."); Champagne v. United States, 513 N.W.2d 75, 80 (N.D. 1994) ("If the patient's capacity for self care is so diminished by mental illness that it is lacking, we agree that an allocution of fault is not appropriate."); Fetzer v. Aberdeen Clinic, 204 N.W. 364, 366 (S.D. 1925) ("[T]he degree of care and diligence required is measured both by the mental incapacity of the patient and the dangers which the surroundings indicate may befall such patient in view of any peculiar mental traits exhibited by the patient."). *But see* Jankee v. Clark Cnty., 612 N.W.2d 297, 302 (Wis. 2000) (holding that a mentally ill patient who attempted to escape from a county health care center was bound to exercise the duty of ordinary care of a reasonable person).

about the lack of capacity are equally applicable when the person with mental illness is a defendant, and the general rule has long rejected any departure from the reasonable person standard in this context.[24] Recognizing this concern, the Restatement (Third) of Torts has suggested that the different treatment of mental illness in contributory negligence should be abandoned and the general rule of providing no exception to the reasonable person standard for those with mental illness should be applied in all areas of the negligence analysis.[25]

Other than contributory negligence, courts have been relatively uniform in their application of the general rule, with only a small number of courts allowing for a very narrow exception in the case of a mentally ill person's direct negligence when the mental illness occurs suddenly and without any previous knowledge.[26] The "sudden onset" cases, however, have been very limited and the standard has proven virtually impossible to meet.[27] As a result, the long-standing treatment of those with mental illness under the reasonable person standard has remained relatively intact and, except for uncertain recognition by some courts in the context of a contributory negligence claim, a mentally ill person's faultlessness continues to assert little, if any, sway in the analysis of their liability.[28]

B. The Move to Primary Reliance on Administrability

Despite relative stability in the application of the general rule, at least regarding a defendant's direct negligence, the majority of

---

24. *See* David E. Seidelson, *Reasonable Expectations and Subjective Standards in Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent*, 50 GEO. WASH. L. REV. 17, 17-18, 36 (1981).

25. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010) ("[Mental] disability is typically disregarded in considering whether the person has exercised reasonable care. This is the position taken by the Restatement Second of Torts § 283B, and the position is supported by a consistent line of modern cases.").

26. *See* Breunig v. Am. Fam. Ins. Co., 173 N.W.2d 619, 623 (Wis. 1970); Mackenzie Coupens, Comment, *Subjectivizing the Negligence Reasonable Person Standard for Persons with Mental Disabilities*, 100 DENV. L. REV. 281, 297 (2022); Seidelson, *supra* note 24, at 40.

27. For example, in *Breunig*, the Wisconsin Supreme Court found that the defendant previously indicated she felt "she had a ... relationship to God and was the chosen one to survive the end of the world." 173 N.W.2d at 625. This was enough for the court to find that "onset" was not sudden. *See id.*

28. *See* Seidelson, *supra* note 24, at 40; Splane, *supra* note 22, at 160.

policy rationales that underlie the rule have been anything but stable. At the outset, courts identified a variety of reasons to hold mentally ill defendants to the reasonable person standard. These reasons are outlined in the Restatement (Second) of Torts.[29] They include: (1) difficulties in distinguishing mental illness from other components of thought and temperament that would not engender a different standard of care;[30] (2) evidentiary concerns, including the fact that mental illness can be feigned;[31] (3) those suffering from mental illness who can pay for the harm they cause, should pay for the harm they cause;[32] and (4) incentivizing caretakers to look after their charges.[33]

Under the scrutiny of scholars and courts alike, the last two policy rationales regarding payment and incentivizing caretakers have now been rejected.[34] Following the insights of the cases and commentaries, the Restatement (Third) abandons these policy concerns as well; it focuses almost completely on what it describes as concerns regarding "administrability," along with some general statements about how, with deinstitutionalization of the mentally ill, "there is nothing especially harsh in at least holding such a person responsible for those harms that the person's clearly substandard conduct causes."[35] The Restatement (Third) further

29. RESTATEMENT (SECOND) OF TORTS § 283B (AM. L. INST. 1965).

30. *Id.* § 283B cmt. b(1) ("The difficulty of drawing any satisfactory line between mental deficiency and those variations of temperament, intellect, and emotional balance which cannot, as a practical matter, be taken into account in imposing liability for damage done.").

31. *Id.* § 283B cmt. b(2) ("The unsatisfactory character of the evidence of mental deficiency in many cases, together with the ease with which it can be feigned, the difficulties which the triers of fact must encounter in determining its existence, nature, degree, and effect; and some fear of introducing into the law of torts the confusion which has surrounded such a defense in the criminal law. Although this factor may be of decreasing importance with the continued development of medical and psychiatric science, it remains at the present time a major obstacle to any allowance for mental deficiency.").

32. *Id.* § 283B cmt. b(3) ("The feeling that if mental defectives are to live in the world they should pay for the damage they do, and that it is better that their wealth, if any, should be used to compensate innocent victims than that it should remain in their hands.").

33. *Id.* § 283B cmt. b(4) ("The belief that their liability will mean that those who have charge of them or their estates will be stimulated to look after them, keep them in order, and see that they do not do harm.").

34. For the policy rationales, see Harry J.F. Korrell, *The Liability of Mentally Disabled Tort Defendants*, 19 L. & PSYCH. REV. 1, 26-46 (1995).

35. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010). The disregard of more serious mental disorders is also based in part on administrative considerations. *See id.* ("The awkwardness experienced by the criminal-justice

provides some insight into the specifics of its concerns regarding administrability. The comment to the Restatement (Third) states:

> The disregard of more serious mental disorders is also based in part on administrative considerations. The awkwardness experienced by the criminal-justice system in attempting to litigate the insanity defense is at least instructive. Similarly, it can be difficult in many cases to ascertain what the causal connection is between even a serious mental disorder and conduct that appears to be unreasonable.[36]

The commentary does not elaborate on what it means by the "awkwardness" of litigating the insanity defense in criminal law. Presumably, the commentary alludes to standard critiques of the application of the insanity defense that we will discuss later in this Article.[37] The concerns of the Restatement (Third) regarding the difficulty of ascertaining "the causal connection ... between even a serious mental disorder and conduct that appears to be unreasonable" reflects traditional concerns that mental illness is hard to prove.[38] This suggests some concern that a person with a mental illness will attempt to blame their actions on mental illness when, in reality, the illness was not the basis for their behavior, or that someone may fabricate symptoms of mental illness or exaggerate existing symptoms of mental illness. Mental health professionals call this latter phenomenon "malingering," which is when a person feigns mental illness for secondary gain (for example, attempting to appear mentally ill to avoid culpability or liability).[39] As will be discussed, mental health professionals have developed effective

---

system in attempting to litigate the insanity defense is at least instructive. Similarly, it can be difficult in many cases to ascertain what the causal connection is between even a serious mental disorder and conduct that appears to be unreasonable. Furthermore, if a person is suffering from a mental disorder so serious as to make it likely that the person will engage in substandard conduct that threatens the safety of others, there can be doubts as to whether the person should be allowed to engage in the normal range of society's activities.").

36. *Id.*

37. *See infra* Section IV.B.

38. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

39. *Malinger*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/malinger [https://perma.cc/EDL5-JMG6].

methods of detecting malingering and can reliably opine on whether someone is feigning mental illness.[40]

As this discussion suggests, the policy support for treating those with mental illness under the traditional reasonable person standard is fraught with instability. Most of the original reasons for the rule have now been dismissed as invalid by the courts and the Restatement (Third), while the one remaining concern—administrability—along with some concerns regarding the policy of deinstitutionalization are left as the rule's remaining support.[41] Even the language of the comment to the Restatement (Third) seems to recognize the lack of gravity of these diminished rationales for holding a person with mental illness to the reasonable person standard.[42] To say "there is nothing especially harsh in at least holding ... a person responsible" is not to provide a definitive statement of support for such a position.[43] As courts continue to retreat from earlier rationalizations, and policy rationales continue to be undercut, we are left to consider whether the concerns of administrability, so circumspectly presented in the Restatement (Third), can provide the foundation for the rule.

In the next sections, we argue that administrability and related concerns cannot be the basis for the rule. In the following subsection, we turn to the inconsistency and irrationality of the legal arguments themselves, before turning to a discussion of whether the claim of inability to administer mental illness claims is itself supportable. Many scholars have taken issue with the administrability rationale, noting generally that the mental health field can deal with these concerns.[44] More recently, a survey of legal practitioners and psychologists highlighted the gap between the two professions on the issue, with psychologists generally indicating

40. *See infra* notes 119-30 and accompanying text.

41. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 (AM. L. INST. 2010); Harlow, *supra* note 4, at 1752-56; Okianer Christian Dark, *Tort Liability and the "Unquiet Mind": A Proposal to Incorporate Mental Disabilities into the Standard of Care*, 30 T. MARSHALL L. REV. 169, 185-86 (2004).

42. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

43. *Id.*

44. *See, e.g.*, Johnny Chriscoe & Lisa Lukasik, *Re-Examining Reasonableness: Negligence Liability in Adult Defendants with Cognitive Disabilities*, 6 ALA. C.R. & C.L. L. REV. 1, 29, 31-34 (2015); Dark, *supra* note 41, at 186.

that determining whether an individual is mentally ill can be done reliably, while lawyers felt the opposite.[45] As lawyers and forensic psychologists, we will bridge this divide by explaining the process and safeguards inherent in capacity determinations.

C. The Current Reliance on Administrability Concerns Is Unconvincing

The almost wholesale reliance on administrability concerns by the Restatement (Third) is especially concerning because analysis of a mentally ill person's negligence has been happening—successfully, it seems—for years. As discussed, despite their unwillingness to consider the mental illness of the defendant, a number of courts have found mental illness to be a consideration in claims of contributory negligence for some time now.[46] To prove contributory negligence, a defendant must prove a plaintiff acted negligently.[47] The defendant must even meet the same burden of proof in proving contributory negligence as a plaintiff would meet in proving negligence.[48] There is nothing to suggest that these courts cannot reliably incorporate determinations of capacity to analyze a plaintiff's breach. Indeed, to the contrary, it seems they are doing just that without encountering the kinds of difficulties in proof relied on by the Restatement (Third).

The Restatement (Third) relies in part on the claim that there should be no difference in the treatment of a mentally ill person in negligence based on whether the person is a plaintiff or defendant, and it argues that courts should abandon the analysis of capacity in

---

45. *See* Lindquist, *supra* note 4, at 132-33, 153.

46. *See supra* notes 15-26 and accompanying text.

47. RESTATEMENT (SECOND) OF TORTS § 464 cmt. a (AM. L. INST. 1965) ("The rule [for contributory negligence] is essentially the same as that stated in § 283 as to the standard of conduct required of the actor for the protection of others. The standard of conduct which determines the negligence of a defendant and the contributory negligence of a plaintiff is thus the same.").

48. RESTATEMENT (THIRD) OF TORTS: APPORTIONMENT OF LIAB. § 4 (AM. L. INST. 2000) ("The defendant has the burden to prove plaintiff's negligence, and may use any of the methods a plaintiff may use to prove defendant's negligence.... [T]he defendant also has the burden to prove that the plaintiff's negligence, if any, was a legal cause of the plaintiff's damages."); 65A C.J.S. *Negligence* § 786 (2024) ("Generally, the burden of establishing contributory negligence rests on the defendant.").

contributory negligence.[49] However, it concedes in recognizing that juries, aided by testimony from experts, will be called on to consider the relative impact of the mentally ill party relative to all other parties in the case:

> Moreover, even though the plaintiff's mental disability is ignored in considering whether the plaintiff is contributorily negligent at all, under Restatement Third, Torts: Apportionment of Liability § 8, Comment *c*, that disability can be considered in the course of the more open-ended process of apportioning percentages of responsibility between the plaintiff and the defendant. Accordingly, the plaintiff whose contributory negligence is in part explainable in terms of mental disability can be expected to receive an award that is larger than the awards received by other plaintiffs who engage in seemingly similar acts of contributory negligence. Indeed, if the evidence shows that the plaintiff is largely unable to appreciate risks or largely unable to control conduct in light of risk, the jury is likely to assign to the plaintiff only a small share of the overall responsibility.[50]

Thus, the Restatement (Third), despite concerns about administrability, expects courts to do exactly what the Restatement suggests cannot be done in the case of mental illness—to consider the impact of an individual's mental illness on their behavior; except the Restatement suggests it should be done in the context of weighing responsibility rather than determining liability.[51] To weigh one's responsibility requires considering many of the same factors the Restatement suggests make administrability difficult.[52] Implicit in the Restatement's (Third) reasoning is that juries can and will consider how a person's mental illness impacts the ability to

---

49. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010) ("The shift in tort doctrine from contributory negligence as a full defense to comparative responsibility as a partial defense weakens whatever arguments that otherwise might favor a dual standard that would treat the mentally disabled plaintiff more leniently than the mentally disabled defendant. Under comparative responsibility, that plaintiff, even if found contributorily negligent, may well encounter only a limited reduction in the award the plaintiff receives from the defendant found guilty of negligence.").

50. *Id.*

51. *See id.*

52. *Id.* § 11 cmt. a, cmt. e.

"appreciate risks" or do something to avoid it[53]—the exact same things that need to be done in analyzing breach. It is absurd to rely on a claim that factors like capacity cannot be properly measured as the basis for invalidating a reasonable mental illness rule while relying on the analysis of such factors to claim the current rule of mental illness in contributory negligence should not be valid.

The Restatement's (Third) general suggestion that "there is nothing especially harsh in at least holding such a person responsible for those harms that the person's clearly substandard conduct causes"[54] also applies faulty logic. To claim that "there is nothing especially harsh" in creating liability for "clearly substandard conduct" is to simply assume that the conduct is substandard. The Restatement (Third) simply assumes that the reasonable person standard applies in reaching this conclusion.[55] Yet, *the issue to be considered is whether individuals with mental illness should be held to a different standard*. It is only after determining what the appropriate standard is that one can determine whether an individual's behavior violates it.

One cannot have one's cake and eat it too. Mental illness either is or is not determinable in negligence. Moreover, if mental illness is not determinable, one would expect similar concerns to be raised in any of the many areas where courts consider a defendant's capacity that we discuss above.[56] But, of course, they do not. In those situations, courts allow for determinations of capacity as a matter of course. All of these factors together suggest a rule without a reason; or, at least, a stated reason.[57] In such a case, it is hard to

53. *See id.* § 11 cmt. e.

54. *Id.* ("The disregard of more serious mental disorders is also based in part on administrative considerations. The awkwardness experienced by the criminal-justice system in attempting to litigate the insanity defense is at least instructive. Similarly, it can be difficult in many cases to ascertain what the causal connection is between even a serious mental disorder and conduct that appears to be unreasonable. Furthermore, if a person is suffering from a mental disorder so serious as to make it likely that the person will engage in substandard conduct that threatens the safety of others, there can be doubts as to whether the person should be allowed to engage in the normal range of society's activities. While modern society has tended to resolve these doubts in favor of deinstitutionalization, there is nothing especially harsh in at least holding such a person responsible for those harms that the person's clearly substandard conduct causes.").

55. *See id.*

56. *See supra* notes 49-54 and accompanying text.

57. The double maxim from prominent legal scholar Karl Llewellyn seems apt: "[T]he rule

ignore claims that the rule on mental illness in negligence is based not on valid policy reasons, but on an outdated view of people with mental illness as dangerous and unpredictable.[58]

II. CAPACITY CONCERNS IN CONSIDERING THE NEGLIGENCE OF A MENTALLY ILL PERSON

Our goal in this and the following sections is to discuss specifically how forensic mental health professionals can reliably analyze the various issues surrounding capacity and malingering. To begin, however, we must first describe what we mean when we refer to "capacity to commit negligence."

To understand how forensic mental health professionals can reliably deal with the Restatement's (Third) administrability concerns, we must begin by considering exactly what mental health professionals need to determine when analyzing the capacity of a person with mental illness to engage in negligent action. Negligence law has long made exceptions to the traditional objective reasonable person standard for assessing whether particular defendants have acted reasonably.[59] Specifically, it recognizes exceptions to the objective test based on the reduced capacity of children and of individuals with physical disabilities.[60] Children are expected to conform their actions with other children of similar age, experience, and intelligence.[61] Additionally, children are acknowledged by the law to "not have the same capacity to perceive, appreciate, and avoid dangerous situations which is possessed by the ordinary, prudent adult."[62] Similarly, individuals with physical disabilities are expected to behave as a reasonable person with that disability would.[63]

---

follows where its reason leads; where the reason stops, there stops the rule." KARL N. LLEWELLYN, THE BRAMBLE BUSH: THE CLASSIC LECTURES ON THE LAW AND LAW SCHOOL 174 (11th prtg. 2008) (emphasis omitted).

58. Jeffrey Borenstein, *Stigma, Prejudice and Discrimination Against People with Mental Illness*, AM. PSYCHIATRIC ASS'N (Aug. 2020), https://www.psychiatry.org/patients-families/stigma-and-discrimination [https://perma.cc/XH3Y-BNRS].

59. Chriscoe & Lukasik, *supra* note 44, at 32-34.

60. *Id.* at 45-46.

61. *Id.* at 14.

62. Korrell, *supra* note 34, at 23-24; *see* Dorais v. Paquin, 304 A.2d 369, 370-71 (N.H. 1973).

63. Chriscoe & Lukasik, *supra* note 44, at 16.

An examination of these existing exceptions indicates that "[l]iability attaches only to those actors who [both] fail to conform their conduct and *are capable of conforming their conduct*."[64] This renders the objective test one with "individual capacity side constraints."[65] These exceptions also acknowledge that not every person possesses the ordinary capacity to avoid doing harm to their neighbors.[66]

Although the specific question of what capacity is will be decided judicially, we provide some sense of what we think capacity to act negligently is and how it will be defined. As one might imagine, because there is no reasonable person with a mental illness standard, courts have had little reason to consider specifically what the capacity to commit negligence is. However, an analysis of the law of negligence and other areas of tort suggests that the key considerations will be whether a person has the capacity to understand the risk they are creating and the behaviors necessary to avoid those risks.[67]

These are the concerns that animate the reasonableness discussion in the Restatement (Third). The Restatement (Third) frequently references appreciation of risk as the basic concern of reasonableness[68] and specifically references it in discussing concerns relevant to the problems of mental illness.[69] Risk, in turn, is generally conceived of as the ability to identify the types of harms that could result from one's actions and the magnitude of those harms.[70] In addition to recognizing risks, the Restatement (Third)

64. Korrell, *supra* note 34, at 22.

65. *Id.*

66. OLIVER WENDELL HOLMES JR., THE COMMON LAW 109 (1881).

67. Early American courts and legal historians generally agree that inherent in an "insane" individual's disability is a lack of capacity. These authors posit that some individuals with mental illness lack the capacity to appreciate the risk they pose to society, and that they may also lack awareness of how their disorder impacts their behavior. Similarly, these individuals lack the capacity to weigh the pros and cons of given courses of conduct responsive to the risk being created. *See* James Goudkamp & Melody Ihuoma, *A Tour of the Tort of Negligence*, 32 J. PRO. NEGL. 137, 141-44 (2016).

68. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 7(a), § 12; *see also id.* § 3 cmt. a ("*Terminology.* Conduct that displays reasonable care is the same as conduct that is reasonable, conduct that shows 'ordinary care,' conduct that avoids creating an 'unreasonable risk of harm.'").

69. *Id.* § 11 cmt. e ("Indeed, if the evidence shows that the plaintiff is largely unable to appreciate risks or largely unable to control conduct in light of risk, the jury is likely to assign to the plaintiff only a small share of the overall responsibility.").

70. *Id.* § 3 cmt. e ("The balancing approach rests on and expresses a simple idea. Conduct

also explains that negligence requires a person to understand the types of behaviors they can take to avoid those risks and their relative magnitude.[71] Legal theory supports the view that capacity in negligence should be defined in terms of ability to understand risk and the types of actions necessary to avoid it.[72] One scholar has summarized the various sources and means of support in a recent article.[73] Both components of reasonableness, he notes, find support from a variety of sources:

> According to Ague, a "lunatic" should not be responsible in negligence where he lacks the capacity "to realise the risk of injury to another person which his act may involve." Goudkamp and Ihuoma echo this sentiment in their contention that persons who are "sufficiently" mentally disordered lack the ability to "weigh up pros and cons of given courses of conduct." It is true that the capacity to realise risk is undoubtedly an implicit trait of the "reasonable man."[74]

This scholar also discusses the interpretation of "capacity":

> The interpretation of "capacity" as "capacity to act differently" has enjoyed scholarly and judicial support. Korrell incorporated this interpretation into his "test" for excusing an insane person's liability in tort law. Perry also claimed that a person's capacity "to avoid the result ... is what gives rise to moral responsibility for harm".... Honoré also placed the notion of the capacity "to act otherwise" at the heart of his general theory of outcome responsibility. He said that the "capacity to act otherwise" referred to

---

is negligent if its disadvantages outweigh its advantages, while conduct is not negligent if its advantages outweigh its disadvantages. The disadvantage in question is the magnitude of risk that the conduct occasions; as noted, the phrase 'magnitude of the risk' includes both the foreseeable likelihood of harm and the foreseeable severity of harm that might ensue. The 'advantages' of the conduct relate to the burden of risk prevention that is avoided when the actor declines to incorporate some precaution. The actor's conduct is hence negligent if the magnitude of the risk outweighs the burden of risk prevention.").

71. *See, e.g.*, *id.* § 3 Reporters' Note ("Those are alternative means of expressing the idea that it is a risk for which an actor who created it is negligent or a risk that requires reasonable care by the responsible actor to avoid negligence.").

72. *See* John Fanning, *Mental Capacity as a Concept in Negligence: Against an Insanity Defense*, 24 PSYCHIATRY, PSYCH. & L. 694, 697, 702-03 (2017).

73. *See id.* at 701-02.

74. *Id.* (internal footnotes omitted).

> a "general ability to perform the sort of action that would in the instant case have led to a different outcome."[75]

Similarly, although not involving defendants accused of negligence, early American cases involving defamation, libel, and slander are informative to understanding the definition of capacity in tort law.[76] These cases frequently held an insane defendant not liable, reasoning that "while an insane person is generally held liable for his torts, if an essential ingredient to the tort is intent, malice or a certain state of mind, then he cannot be held liable for such a tort."[77] Although dealing with this different standard, the courts focused on both understanding the circumstances and being able to take precautions. A quote from Justice Holmes is illustrative:

> There is no doubt that in many cases a man may be insane, and yet perfectly capable of taking the precautions, and of being influenced by the motives, which the circumstances demand. But if insanity of a pronounced type exists, manifestly incapacitating the sufferer from complying with the rule which he has broken, good sense would require it to be admitted as an excuse.[78]

It is precisely the second type of man which, as a result of mental illness, lacks capacity both to appreciate the risk he poses to society and to conform his conduct to avoid this risk.[79]

Thus, when assessing capacity, a mental health professional would need to determine whether the mental illness impacted a person's ability to understand the risk they were creating at the time of their negligent action and/or the reasonable behaviors (in the context of their mental illness) to avoid the risk. However, the Restatement (Third) continues to express concern that such determinations of capacity cannot be readily administered.[80] Such

---

75. *Id.* (internal footnotes omitted).

76. *See, e.g.*, Wilson v. Walt, 25 P.2d 343, 344 (Kan. 1933); Irvine v. Gibson, 77 S.W. 1106, 1107-08 (Ky. 1904); Ullrich v. N.Y. Press Co., 50 N.Y.S. 788, 790 (Sup. Ct. 1898); Bryant v. Jackson, 25 Tenn. (5 Hum.) 199, 203-04 (1845).

77. Robert M. Ague, Jr., *The Liability of Insane Persons in Tort Actions*, 60 DICK. L. REV. 211, 218 (1956).

78. HOLMES, JR., *supra* note 66, at 109.

79. *See id.*

80. *See* discussion *supra* Section I.C.

administration has long occurred within other contexts, including the insanity defense and personal injury, and is readily applicable to the context of capacity in negligence law.

III. THE RELIABILITY OF FORENSIC MENTAL HEALTH ASSESSMENT (FMHA)

In this section, we explain that mental health professionals can reliably determine a mentally ill individual's capacity to act negligently and whether that person is malingering—that is, whether the person is attempting to avoid liability by feigning mental illness.[81] Put simply, we explain that the law's skepticism regarding the administrability of a reasonable person with a mental illness standard is unfounded, and we demonstrate how an individual's capacity to analyze risk can be reliably determined given the processes now used by mental health professionals.[82] Given that the persistent concern in the legal field is that there is no way to demonstrate a relationship between a defendant's mental illness, capacity, and alleged liability, we aim to demonstrate that these links can be evidenced through psychological evaluation that follows foundational principles of forensic mental health assessment.

Capacity of a person with mental illness can be formally assessed through a mental health evaluation. Within the legal system, questions regarding mental health capacities have long been addressed through the process of forensic mental health assessment (FMHA).[83] FMHA involves a psychological evaluation by a mental health professional, typically a psychologist or psychiatrist, as part of the legal decision-making process.[84] These evaluations address a specific legal question, such as competence to stand trial, insanity, workplace disability, or psychological damages, and the forensic mental

81. KIRK HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT 165-66, 178 (2001).

82. *See infra* notes 105-15 and accompanying text.

83. *See* Kirk Heilbrun, Geoffrey R. Marczyk, David DeMatteo, Eric A. Zillmer, Justin Harris & Tiffany Jennings, *Principles of Forensic Mental Health Assessment: Implications for Neuropsychological Assessment in Forensic Contexts*, 10 ASSESSMENT 329, 330 (2003).

84. *See id.*

health professional assists the trier of fact using both clinical and scientific data.[85]

According to the American Psychological Association's *Specialty Guidelines for Forensic Psychology*, which provide foundational and sometimes mandatory guidance for forensic mental health professionals throughout the United States, a mental health professional who conducts FMHA should have "a fundamental and reasonable level of knowledge and understanding of the legal ... standards, laws, rules, and precedents that govern their participation in legal proceedings and that guide the impact of their services on service recipients."[86] FMHA can be useful to attorneys in representing their clients in a variety of ways, and FMHA can be applicable in a wide variety of legal contexts, including criminal, civil, family, and administrative law.[87] An expert can opine about past and current clinical functioning as well as other psycho-legal considerations, including, for example, malingering. A minimally proficient expert should be able to assess how a person's mental health capacity contributes to their ability to control their behavior; this is relevant, for example, to determine whether an individual can refrain from causing harm to others. Whether an expert should opine about the ultimate legal question, such as whether someone behaved negligently and is therefore liable, continues to be of great debate within the mental health field, although such "ultimate issue" testimony is permitted by the Federal Rules of Evidence in almost every legal context.[88] If an expert chooses or is not permitted to answer the ultimate legal question, lawyers can fill this gap through effective direct examination so that a factfinder may draw conclusions from the expert's testimony as it applies to the legal questions of capacity and responsibility. In other words, experts do not need to determine that a person acted negligently to articulate conclusions related to

85. *See* HEILBRUN, *supra* note 81, at 29.

86. Am. Psych. Ass'n, *Specialty Guidelines for Forensic Psychology*, 68 AM. PSYCH. 7, 9 (2013).

87. FORENSIC MENTAL HEALTH ASSESSMENT: A CASEBOOK 1 (Kirk Heilbrun, David DeMatteo, Stephanie Brooks Holliday & Casey LaDuke eds., 2d ed. 2014).

88. *See* FED. R. EVID. 704; *see also* KIRK HEILBRUN, THOMAS GRISSO & ALAN M. GOLDSTEIN, FOUNDATIONS OF FORENSIC MENTAL HEALTH ASSESSMENT 50-52 (2009).

capacity to appreciate risk and reasonable behavior within the context of their mental illness.[89]

A. The Evaluation Process

Although the procedures of FMHA vary depending on the legal question, there are several standard components. FMHAs are focused on a legal standard—for example, competence to stand trial and insanity—so they differ from traditional mental health assessments conducted in clinical/therapeutic contexts. Below, we (a) distinguish FMHA from traditional clinical assessments, and (b) outline the evaluation process for the purpose of illustrating the methodical uniformity of FMHAs, which partially addresses administrability concerns.

1. Informed Consent

A mental health professional retained by a party (defense, prosecution, or plaintiff) must obtain informed consent from the examinee before proceeding because the examinee has a right to refuse to participate.[90] However, when the FMHA is court ordered, the examinee's participation is not voluntary and therefore informed consent is not needed.[91] Although informed consent is not necessary when the evaluation is court ordered (because the examinee has no legal right to refuse being evaluated), the examinee must still be informed about the basic parameters of the evaluation, including who requested the evaluation, the purpose of the evaluation, how the results will be used, limits on confidentiality, and the possibility of testimony.[92]

---

89. *See* FED. R. EVID. 704(b).

90. Heilbrun et al., *supra* note 83, at 338.

91. *See* Karen C. Kalmbach & Phillip M. Lyons, *Ethical Issues in Conducting Forensic Evaluations*, 2 APPLIED PSYCH. CRIM. JUST. 261, 263-64 (2006).

92. *See* DAVID DEMATTEO, JAYMES FAIRFAX-COLUMBO & ALISHA DESAI, BECOMING A FORENSIC PSYCHOLOGIST 12 (2019) (describing the process of providing informed consent in FMHA).

2. The Legal Issue

The evaluator should focus on the specific legal issue before the court. Unlike a traditional clinical assessment, which focuses on assessing and treating the person's mental illness, FMHAs are focused on specific legal questions,[93] such as whether the examinee is competent to stand trial or was insane at the time of the offense. In a negligence case, an evaluator could be retained to assess how the examinee's specific mental health capacity relates to or influences their ability to appreciate and understand the risk stemming from their actions that led to the negligence claim.[94]

3. The Evaluator's Role

The mental health professional conducting the evaluation is an objective third party not setting out to "help" the examinee or hold bias in favor of a particular party or outcome; rather, the mental health professional should be objective and loyal to the evaluation data.[95] In this regard, not every evaluation will ultimately be helpful to the examinee's case, and it is important for the evaluator to explain this to the examinee (and examinee's attorney) and notify the examinee that the attorney would not use the findings of the evaluation if the findings would not benefit the case (unless the evaluation is court ordered, in which case a report must be filed with the court).

4. Who Is the Client and Who Controls the Evaluation

In a clinical setting, the person being evaluated is the client. However, in a forensic context, the examinee is not the mental health professional's client; rather, the evaluator's client is the attorney who hired the evaluator or the court that appointed the evaluator. As the client, the attorney determines whether the evaluation and subsequent report are helpful to their client's case,

93. *See id.* at 15 (Table 1.1) (highlighting that FMHAs focus on a legal question).
94. *See id.*
95. *See* HEILBRUN, *supr*a note 81, at 36, 44.

and whether to ask the evaluator to testify in later court proceedings.[96]

5. Limits to Confidentiality

The evaluator should explain to the examinee how the results of the evaluation will be used. For example, the evaluator should explain that the retaining lawyer determines if a forensic report based on the FMHA will be written (typically based on the evaluator's oral summary of the evaluation results) and that, if a report is written, it will be provided to opposing counsel and the court. The evaluator should also explain that they may be asked to testify about the evaluation at a deposition, hearing, or trial.[97]

Although FMHAs can (and should) vary based on the type of evaluation, type of examinee, and other factors, common components of an FMHA include: informed consent (if necessary), a comprehensive biopsychosocial interview of the examinee (focusing on the domains of family, education, social functioning, medical history, mental health history, substance use history, and legal history), a clinical interview focused on current mental health functioning, psychological testing, a review of relevant records, and collateral interviews with knowledgeable third parties—such as family members, treating professionals, and employers—to gather additional information.[98]

The role of testing in the context of FMHA deserves comment. First, the testing completed must be relevant to the specific legal question at hand, which means that any measures used in the evaluation should be specifically targeted at assessing behaviors and capacities that are relevant to the legal question.[99] In the negligence context, an evaluator would administer testing that narrowly

96. *See id.* at 10 (clarifying that the client in FMHA is not the examinee but rather the retaining attorney or appointing court).

97. *See* DEMATTEO ET AL., *supra* note 92, at 11-12 (discussing the importance and components of informed consent in FMHA).

98. *See id.* at 17 (listing the sources of information in FMHA).

99. *See* GARY B. MELTON, JOHN PETRILA, NORMAN G. POYTHRESS, CHRISTOPHER SLOBOGIN, RANDY K. OTTO, DOUGLAS MOSSMAN & LOIS O. CONDIE, PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 49 (4th ed. 2018) (noting that tests used in FMHA should yield data that are relevant to the legal inquiry).

focuses on the individual's specific mental health capacity as it relates to their ability to understand and appreciate risk of harm to others. Second, testing results should be supported and verified through other sources of information, such as collateral records and third-party interviews.[100] Collateral records may include previous mental health history and treatment. Though present-state psychological testing can provide helpful information in the evaluation process, collateral information may serve as stronger evidence when evaluating or reconstructing a person's mental state at an earlier time (such as at the time of the negligent act), particularly when an individual is experiencing interfering symptoms of serious mental illness that make their self-reporting less reliable.[101] Third, if tests are used, they should have well-established psychometric properties, including validity and reliability, with the type of person being examined; for example, a test that was not developed using data from males should not be used with males, or a test developed for one specific purpose should not be used for other purposes unless there is convincing research supporting its alternate use.[102]

The role of psychiatric diagnoses in the context of FMHA also deserves comment. First, focusing exclusively on the examinee's diagnosis is typically not helpful; the focus should be on clinical symptoms and their relationship to the functional legal capacities.[103] For example, concluding that someone is not competent to stand trial because they have a diagnosis of schizophrenia is an example of weak *ipso facto* reasoning. Given the extreme variability in symptom presentation and symptom severity among people with the same diagnosis, the focus should be on whether the person's specific and observable symptoms interfere with relevant functional legal capacities.[104] Second, accuracy in diagnosing psychiatric illnesses is

100. *See* HEILBRUN, *supra* note 81, at 99 (noting that FMHAs should incorporate data from multiple sources).

101. *See* DEMATTEO ET AL., *supra* note 92, at 13 (discussing the importance and role of collateral interviews in the context of FMHA).

102. *See* Am. Psych. Ass'n, *supra* note 86, at 15 (discussing the importance of selecting appropriate tests in the context of FMHA).

103. *See* CHRISTOPHER SLOBOGIN, THOMAS L. HAFEMEISTER & DOUGLAS MOSSMAN, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 514 (7th ed. 2020) (discussing the limitations associated with psychiatric diagnoses in FMHAs).

104. *See, e.g.*, Isaac R. Galatzer-Levy & Richard A. Bryant, *636,120 Ways to Have Posttraumatic Stress Disorder*, 8 PERSPECTIVES ON PSYCH. SCI. 651, 656 (noting there are

heavily dependent on the skill of the evaluator and the type of disorder in question. The reliability of diagnosing improves when using diagnostic criteria outlined in the DSM-5-TR,[105] clear identification and definitions of psychiatric symptoms, and with structured interviewing processes. With these practices in place, the inter-rater reliability of psychiatric diagnoses, or the rate at which two evaluators are to arrive at the same diagnosis, can be quite high.[106]

It is important to note that FMHAs can focus on past, present, or future behavior. An example of an FMHA that focuses on past behavior is an evaluation to assess whether a criminal defendant was insane, which focuses on the defendant's mental state at the time of the offense.[107] This type of retrospective-focused evaluation would be used to assess someone's capacity in a negligence context. An evaluation of a defendant's competence to stand trial is an example of a present-focused FMHA because the focus is on the defendant's present abilities (to understand the proceedings and assist counsel).[108] Future-focused evaluations, such as assessing someone's propensity for violence, are conducted in several civil and criminal contexts, including civil commitment and criminal sentencing.[109]

This process of FMHA has occurred thousands of times within both state and federal courts in both criminal and civil contexts. A likely very conservative estimate is that mental health professionals

---

636,120 symptom combinations that lead to a diagnosis of Posttraumatic Stress Disorder).

105. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2022).

106. *See generally* Ahmed Aboraya, Eric Rankin, Cheryl France, Ahmed El-Missiry & Collin John, *The Reliability of Psychiatric Diagnosis Revisited: The Clinician's Guide to Improve the Reliability of Psychiatric Diagnosis*, PSYCHIATRY (Jan. 2006) (discussing ways to improve the reliability of psychiatric diagnoses); Jeremy Matuszak & Melissa Piasecki, *Inter-Rater Reliability in Psychiatric Diagnosis: Collateral Data Improves the Reliability of Diagnoses*, 29 PSYCHIATRIC TIMES 7, 12 (2012) (discussing the importance of collateral data in improving the reliability of psychiatric diagnoses).

107. *See generally* IRA K. PACKER, EVALUATION OF CRIMINAL RESPONSIBILITY (2009) (discussing evaluations of a defendant's mental state at the time of the offense).

108. *See* PATRICIA A. ZAPF & RONALD ROESCH, EVALUATION OF COMPETENCE TO STAND TRIAL 7 (2009) (noting competence to stand trial evaluations focus on the defendant's present functioning).

109. *See generally* KIRK HEILBRUN, EVALUATION FOR RISK OF VIOLENCE IN ADULTS (2009) (discussing the future-focused nature of violence risk assessments in various legal contexts).

are involved in approximately one million cases per year.[110] From child custody cases to capital sentencing, FMHA encompasses a broad range of legal issues, yet different types of FMHA all have shared features as explained above. Negligence, in terms of the FMHA process, should not be treated any differently within the civil courtroom. In numerous contexts, mental health professionals are asked to articulate a link between an individual's mental health functioning and a specific legal-capacity question using scientific data, clinical judgment, and testing methods that have been rigorously peer reviewed and demonstrated to be reliable and valid.[111]

In specifically addressing the Restatement's (Third) concerns, forensic evaluators can rely on several methods to ensure the evaluation process is reliable. First, evaluators should practice in accordance with the *Specialty Guidelines for Forensic Psychology*.[112] These guidelines, which are formal policy of the American Psychological Association (a national membership organization for psychologists), delineate how evaluators can conduct their work both ethically and in accordance with principles that promote a high level of quality in forensic practice.[113] The guidelines are intended to be aspirational (in other words, not mandatory or enforceable),[114] although they carry the force of law (and are therefore enforceable) in states that have adopted the *Specialty Guidelines* into state law. Pennsylvania, for example, has adopted the *Specialty Guidelines* (and other guidelines from the American Psychological Association) into state law.[115] Evaluators who conduct forensic work eschewing

110. *See* MELTON ET AL., *supra* note 99, at 575 (providing an estimate of the number of FMHAs conducted each year in the late 1980s).

111. Reliability and validity are the cornerstones of quality science. Reliability refers to the consistency of a measure, and validity refers to the accuracy of a measure. It is important in the administration of FMHA that measures have been demonstrated to produce the same results under similar conditions, and that they are representative of what they are intended to measure. *See* DAVID L. FAIGMAN, EDWARD K. CHENG, JENNIFER L. MNOOKIN, ERIN E. MURPHY, JOSEPH SANDERS & CHRISTOPHER SLOBOGIN, MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 1:16 n.2-3 and accompanying text (2022-2023 ed. 2022) (discussing the importance of validity and reliability in psychological testing).

112. *See* Am. Psych. Ass'n, *supra* note 86, at 7 (providing guidelines for conducting FMHAs).

113. *See id.*

114. *See id.* at 8 ("Guidelines are aspirational in intent.").

115. *See* 49 PA. CODE § 41.61 (1998).

these guidelines risk scrutiny regarding the validity and reliability of their work. The admissibility of expert testimony, in part, relies on a determination of the reliability of the scientific procedures used to obtain the expert evidence.[116]

B. Addressing Malingering in FMHA

In the FMHA context, it is important to consider an individual's motivations in participating in the assessment. The FMHA can potentially benefit the examinee by, for example, lending support to a not guilty verdict in a criminal context or reducing the likelihood of a finding of liability in the civil context. As such, the mental health professional must make efforts to evaluate malingering, which is the intentional falsification of a mental health condition for the purpose of gaining secondary benefits, such as appearing to be less culpable to a court of law.[117] To conclude that an examinee is malingering, the evaluator must determine that the individual is exhibiting "goal-directed behavior designed to achieve a readily identifiable external incentive."[118] Incorrectly identifying the absence or presence of malingering can have detrimental consequences. Misclassifying malingering when an individual's presentation is genuine can prevent an individual who is truly mentally ill from receiving appropriate care. Conversely, failing to identify malingering can derail efforts of justice, diverting malingerers out of the legal system into behavioral health care where personal stakes are often lower and the environment is more comfortable.[119]

---

116. *See* Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 594-95 (1993) (discussing reliability as one criterion for the admissibility of proffered expert evidence).

117. Malingering is one aspect of the broader category of response style. Response style, which is how the examinee is approaching the evaluation, includes both faking bad (malingering) and faking good (presenting in a favorable manner). *See* HEILBRUN, *supra* note 81, at 165, 184.

118. HANDBOOK OF FORENSIC NEUROPSYCHOLOGY 138 (Arthur MacNeill Horton, Jr. & Lawrence C. Hartlage eds., 1st ed. 2003).

119. *See* Jeffrey J. Walczyk, Nate Sewell & Meghan B. DiBenedetto, *A Review of Approaches to Detecting Malingering in Forensic Contexts and Promising Cognitive Load-Inducing Lie Detection Techniques*, 9 FRONTIERS IN PSYCHIATRY 1, 2 (2018).

Malingering should not be determined from a single source or solely from the evaluator's clinical judgment, but ideally is recognized through multiple sources of data.[120] The evaluator can make this determination from several sources of information.[121] They can elicit self-report information from the examinee and compare that with information obtained from collateral sources, such as records or third-party interviews.[122] There are also specific assessment measures, such as the Minnesota Multiphasic Personality Inventory (MMPI), that can provide reliable data as to whether a person is over-exaggerating psychopathology symptoms. The MMPI is a standardized test often used in forensic contexts to elicit information about personality and psychopathology.[123] It has been validated and normed across many groups of people, and it has several iterations (the MMPI-3 was most recently released in 2020).[124] The measure includes a variety of scales that are specifically designed to detect content responsive faking, such as "faking good," where an examinee responds in a manner to appear mentally healthier than they are, or "faking bad," which suggests malingering.[125] The measure can even detect when a respondent is randomly selecting answers, which indicates that the examinee answered the questions without regard to item content, and alert the evaluator to whether the resulting MMPI profile is invalid.[126] Furthermore, there are measures designed specifically to detect malingering. The Structured Interview of Reported Symptoms, 2nd edition (SIRS-2), detects response styles that may be associated with malingering and

120. *See* HANDBOOK OF FORENSIC NEUROPSYCHOLOGY, *supra* note 118, at 138-39; *see also* HEILBRUN, *supra* note 81, at 176 (discussing the role of testing in assessing an examinee's response style).

121. *See generally* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION (Richard Rogers & Scott D. Bender eds., 4th ed. 2018).

122. *See* HEILBRUN, *supra* note 81, at 167 (discussing the role of collateral interviews in assessing an examinee's response style).

123. *See* Yossef S. Ben-Porath, Kirk Heilbrun & Madelena Rizzo, *Using the MMPI-3 in Legal Settings*, 104 J. PERSONALITY ASSESSMENT 162, 164-65 (2022) (discussing the MMPI-3's use in forensic contexts).

124. *See id.* at 162-63 (explaining the history and evolution of the MMPI).

125. YOSSEF S. BEN-PORATH & MARTIN SELLBOM, INTERPRETING THE MMPI-3 73 (2023) (discussing "fake bad" and "fake good" interpretations of the MMPI).

126. Claudia K. Reeves, Tiffany A. Brown & Martin Sellbom, *An Examination of the MMPI-3 Validity Scales in Detecting Overreporting of Psychological Problems*, 34 PSYCH. ASSESSMENT 517, 517 (2022).

other forms of feigning.[127] The Miller Forensic Assessment of Symptoms Test (M-Fast) is a screening interview designed to assess the likelihood that an individual is feigning psychiatric illness.[128] The Test of Memory Malingering (TOMM) discriminates between true memory impairment and malingering.[129] All of these measures were developed to assess deliberate distortions in the self-report of mental health or cognitive symptoms.

An evaluator can also identify signs of malingering through clinical judgment, such as looking for symptoms that are inconsistent with what is known about the diagnosis. Incongruencies in severity and pattern of the observed behavior can be an indication (but not necessarily dispositive) that someone is malingering.[130] In the same way that the evaluator could articulate to a court whether the person's capacity is consistent with that of the reasonably mentally ill person for a given diagnosis, the evaluator can determine if the symptomology observed is consistent with accepted diagnostic criteria [DSM-5-TR][131] or commonly recognized symptom presentations for a particular disorder. In the following section, we discuss how evidence specific to a person can be combined with known data about a group of people to inform an evaluator about psycho-legal capacities and potential causal connections.

IV. DETERMINING CAPACITY AND RISKS IN FMHA

Current justifications for maintenance of the status quo in tort law come from several arguments. Naysayers of the reasonable mentally ill person standard argue that it would be difficult for factfinders to "draw the line."[132] There is concern that the factfinder would not be able to determine whether a defendant's mental illness

127. *See generally* RICHARD ROGERS, KENNETH W. SEWELL & NATHAN D. GILLARD, STRUCTURED INTERVIEW OF REPORTED SYMPTOMS 3-6 (2d ed. 2010).

128. *See generally* HOLLY A. MILLER, M-FAST: MILLER FORENSIC ASSESSMENT OF SYMPTOMS TEST; PROFESSIONAL MANUAL (Psychological Assessment Resources, Inc. 2001).

129. *See generally* TOM N. TOMBAUGH, TEST OF MEMORY MALINGERING (TOMM) 1 (1996).

130. Thomas J. Guilmette, *The Role of Clinical Judgment in Symptom Validity Assessment*, *in* MILD TRAUMATIC BRAIN INJURY: SYMPTOM VALIDITY ASSESSMENT AND MALINGERING 31, 31-33 (Dominic A. Carone & Shane S. Bush eds., 2013).

131. *See, e.g.*, AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed.; text revision 2022).

132. Lindquist, *supra* note 4, at 118.

was the proximate cause of the alleged conduct.[133] However, this argument should hold little weight because factfinders are tasked with such a determination in many current legal contexts.

An illustrative example exists in the civil context. A jury considers whether a defendant's tortious actions inflicted emotional distress on a plaintiff. This involves the consideration of the plaintiff's mental state, including whether a reasonable person in the plaintiff's situation would have a similar disposition.[134] Evidence presented by the plaintiff's attorney could include expert testimony that addresses the existence of a diagnosed mental illness, and then the jury would be tasked with determining whether the defendant's actions caused or contributed to the development of the plaintiff's mental health symptoms. The factfinder does *not* have to decide whether the mental illness exists. If they find the expert testimony to be credible, the factfinder would evaluate the facts under the applicable law as they would in any other context. In short, the legal community is effectively ignoring the existence of psychological expertise on these issues when that expertise could shed light on what role mental illness should play in negligence culpability. It makes little sense to think the factfinder capable of considering the mental illness of the plaintiff, such as in the eggshell doctrine,[135] while simultaneously concluding the factfinder cannot do the same when it is the mental illness of the defendant they must consider.

Administrability concerns continue to plague the legal field, as well as questions of a mental health professional's ability to know that a mentally ill individual behaves and functions in the same way as the reasonable person with mental illness. This consideration is at the forefront of FMHA. Under the principles that guide FMHA, case-specific evidence should be used in assessing clinical

133. *See id.*

134. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 46 cmt. j (AM. L. INST. 2012).

135. The eggshell doctrine, also known as the "take[ ] the victim as found" rule in civil law, holds that a defendant is liable for the full extent of harm caused to a plaintiff, even if the plaintiff's pre-existing health condition or vulnerability made them more susceptible to the injury. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 31 cmt. a (AM. L. INST. 2010). In other words, the defendant is responsible for the consequences of their actions, regardless of the plaintiff's unusual fragility or condition. *See generally* Vosburg v. Putney, 50 N.W. 403 (1891) (landmark case formulating this doctrine).

condition, functional abilities, and causal connection.[136] There are two broad sources of information—idiographic and nomothetic. Idiographic information focuses on the individual being evaluated and requires considering that person in an individualized manner.[137] In the context of FMHA, idiographic data are typically derived from extensive interviews that elicit information or data specific to the person being evaluated.[138]

By contrast, nomothetic information is mainly concerned with data derived from a particular group of people, such as the normative group for a psychological test, and it can also be used to assess clinical condition, functional abilities, and causal connection.[139] For example, a person's psychological test results are interpreted by comparing their results to the normative data, which are derived from the group of people upon whom the test was developed.[140] The normative data provide an indication of what results are considered "normal" (or high, low, etc.). As such, the examinee's test results are interpreted based on how they compare to the normative group. This type of approach typically utilizes quantitative data.[141] However, overreliance on nomothetic data can lead to a failure to consider how case-specific data impact the psycho-legal question.[142] Both of these approaches—idiographic and nomothetic—are important sources of relevant information in the FMHA context. A mental health professional is tasked with using scientific reasoning to assess the "causal connection between clinical condition and functional abilities."[143] This is important particularly when "employing case-specific information and interpreting it."[144]

Relying exclusively or disproportionately on either source of data—idiographic or nomothetic—weakens the validity and reliability of FMHA. FMHA should consider idiographic (case-specific)

136. FORENSIC MENTAL HEALTH ASSESSMENT, *supra* note 87, at 6.
137. *Id.*
138. *Id.* at 18-19.
139. *Id.* at 10.
140. *Id.* at 6.
141. *See* David DeMatteo, Ashley Batastini, Elizabeth Foster & Elizabeth Hunt, *Individualizing Risk Assessment: Balancing Idiographic and Nomothetic Data*, 10 J. FORENSIC PSYCH. PRAC. 360, 361 (2010).
142. *See id.*
143. FORENSIC MENTAL HEALTH ASSESSMENT, *supra* note 87, at 7.
144. *Id.* at 18.

data in the context of nomothetic (group-derived) data. For example, administering properly developed psychological tests that have firm evidence of being valid and reliable provides an effective approach for comparing the individual being evaluated to the group of people on whom the psychological test was developed. To be clear, this is an empirically supported approach that promotes an objective and valid assessment of the individual being evaluated. Such an approach is consistent with the admissibility standard for expert testimony, derived from *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[145] that is used in all federal courts and most state courts.[146]

The evaluation should be based on information and techniques that have been shown to be both reliable and valid because that permits the evaluator to highlight specific characteristics of the individual being assessed in light of the legal question at hand. This approach could be used when assessing capacity under a negligence claim. Idiographic data, such as extensive interviewing, could be used to describe a variety of domains relevant to an individual's capacity within the negligence framework, and more specifically the reasonably mentally ill person standard. Though the "reasonable person" is a hypothetical person, the legal concept is most comparable to the functional use of nomothetic data in the forensic context. The reasonable person is derived from how the average person in the particular context may think, feel, and act, similar to how the data collected from a group of individuals can be thought to pertain to a similar measure of behavior and characteristics.

A. Restatement (Third) Concerns Regarding Causation

As previously noted, the comment to the Restatement (Third) states that "it can be difficult in many cases to ascertain what the causal connection is between even a serious mental disorder and conduct that appears to be unreasonable."[147] The evaluation procedures outlined above provide a structure for addressing the Restatement's (Third) concern regarding establishing causation. In the

145. 509 U.S. 579, 592-96 (1993).

146. *See* SLOBOGIN ET AL., *supra* note 103, at 530.

147. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

negligence context, the FMHA must specifically consider the capacities relevant to whether an individual at the time of the negligent act could both understand and appreciate the risk their actions pose to others. This capacity in the negligence context will be entirely dependent on the specific mental health symptoms of the individual, as mental health capacity does not present the same among disorders or individuals. For most mental health disorders, capacity is fluid in its severity, frequency, and presentation. The mental health professional must demonstrate the relationship between any clinical symptoms and the specific legal capacity, but also must establish how that deficit in capacity caused the harm to another individual.[148] In making this determination, the mental health professional would consider how the average mentally ill person in the particular context in question would behave, which requires consideration of the nomothetic data known for individuals with a specific mental health disorder.[149]

B. Lessons from FMHA in Criminal Contexts

The Restatement (Third) provides, in support of its claim that an exception to the reasonable person standard based on mental health is not administrable, a reference to what it describes as the "awkwardness" of determinations of capacity in criminal law. Specifically, the Restatement states that the "awkwardness experienced by the criminal-justice system in attempting to litigate the insanity defense is at least instructive."[150] The specific nature of the "awkwardness" being referenced is not entirely clear, so we will focus on how insanity is currently treated in criminal law in an attempt to disabuse general claims that the way insanity is treated in criminal law provides a basis for denying its use in the context of negligence.

There are several examples from criminal law that demonstrate the ability of mental health professionals to determine capacity. The evaluation of a defendant's mental state at the time of the offense

148. *See, e.g.*, FORENSIC MENTAL HEALTH ASSESSMENT, *supra* note 87, at 66, 76-77 (providing an example of a case report discussing a defendant's mental state at the time of the offense and analyzing whether he met the legal definition of insanity).

149. *See supra* notes 138-43 and accompanying text.

150. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

is a fairly common referral question. This psycho-legal question relates to a defendant's criminal responsibility for criminal behavior.[151] For example, an FMHA may focus on whether a criminal defendant had the mental capacity, or *mens rea*, to formulate the element of intent that is required for first-degree murder, or whether the defendant was insane at the time of the offense; although there are four different insanity tests used in the United States, they typically involve considering whether the defendant's mental illness interfered with their capacity to understand right from wrong or to conform their conduct to the requirements of the law.[152]

Although a direct parallel cannot be made between the criminal context and the civil context (because, for example, there is no insanity defense to a negligence claim as there is in the criminal court system),[153] parallels can be made between certain considerations in a criminal context (for insanity) and that of an evaluation conducted in a civil context (for negligence). In both contexts, a mental health professional is considering the mental capacity of a defendant in the past when the alleged act occurred and forming an opinion on whether that capacity contributed to the relevant legal issue. In both contexts, best practice standards in the field of FMHA provide a framework and structure for making that determination in a valid and reliable manner. Mental health professionals are frequently asked to opine on a causal connection between an individual's mental state and criminal behavior, and their testimony is routinely admitted in criminal courts. As such, there is no valid basis for concluding that similar evaluations could not be conducted in negligence contexts, and we respectfully disagree that the criminal justice system experiences "awkwardness" in "attempting to litigate the insanity defense."[154]

---

151. *See* FORENSIC MENTAL HEALTH ASSESSMENT, *supra* note 87, at 57.

152. *See* David DeMatteo, Daniel A. Krauss, Sarah Fishel & Kellie Wiltsie, *The United States Supreme Court's Enduring Misunderstanding of Insanity*, 52 N.M. L. REV. 34, 38-41 (2022).

153. Fanning, *supra* note 72, at 694.

154. RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL AND EMOTIONAL HARM § 11 cmt. e (AM. L. INST. 2010).

CONCLUSION

Throughout this Article, we have described what we call "a rule without a reason." As we explained, the rule that mental illness impacting a person's capacity to understand risk should not be considered when determining tort liability has had many different bases. None of these bases have survived. The last one—a cornerstone of much of the law's willingness to ignore mental illness—is that the law cannot administer claims of mental illness reliably. In this Article, we have suggested that this reason cannot stand either.

It is perhaps more telling that we describe the rule as "a rule in search of a reason." One would naturally ask, given this description, whether this is—or should be—the logic of the law. Of course, it is not. To determine what the rule should be and then search for reasons to support it is the opposite of the type of thoughtful, reasoned rulemaking we expect of the law. And although correlation is not causation, the fact that a bias perceiving those with mental illness as dangerous and uncontrollable has been well established may help us understand why the rule has gone in search of a reason for so long. It is hard to understand why courts continue to treat mental illness the way they do without a turn to this background norm. Yet it is definitely time for us to reconsider the rule—to move away from the fears and biases surrounding mental illness and to accept the capabilities of modern forensic psychology.