MEETING THE INCREASING DEMANDS ON FAMILY ATTORNEYS REPRESENTING CLIENTS WITH MENTAL HEALTH CHALLENGES

Lynda E. Frost and Connie J. A. Beck

The changing nature of family court and increasing awareness of mental health challenges force family lawyers to navigate tricky legal, ethical, and practical issues. This article reviews increased complexity for litigants as a result of procedural changes in the current family court, the rise of pro se representation, and statutory changes encouraging shared parental care of children. It analyzes common legal and ethical challenges for attorneys representing potentially impaired clients. It details practical means of supporting clients and increasing their capacity to engage meaningfully in family court matters. This roadmap can guide lawyers in improving their knowledge and skills in order to meet legal and ethical standards for representing family law clients with mental health challenges.

Key Points for the Family Court Community:
- Trends such as procedural changes in the current family court, the rise of pro se representation, and statutory changes encouraging shared parental care of children require significant engagement and competence on the part of litigants.
- Family attorneys have a complex task in representing a possibly impaired client, as they must gauge the client’s level of functioning throughout the legal process to ensure the client has sufficient capacity to participate meaningfully.
- Legal requirements and ethical guidelines address and shape many aspects of an attorney’s interactions with a client living with mental illness.
- Experienced attorneys can support clients in maximizing their capacity to engage in family court proceedings.

Keywords: Capacity; Dementia; Divorce; Ethics; Family Law; Legal Competence; and Mental Illness.

INTRODUCTION

Most people are not at their best when they are going through a divorce. The stress, disappointment, and powerful emotions can negatively impact a person’s level of functioning. These strong negative emotions can also exacerbate symptoms of mental illness. A percentage of individuals in divorce proceedings will have significant mental health challenges that affect their capacity to participate in the proceedings. And, changes in modern divorce procedures make representing a client with impaired mental functioning or a serious mental illness an increasingly complex endeavor.

This article details how the changing nature of family court and increasing awareness of mental health challenges force family lawyers to navigate tricky legal, ethical, and practical issues. It explicates how challenges arise, in part, because of procedural changes in the current family court, the rise of pro se representation, statutory changes encouraging shared parental care of children, and increased understanding of and sensitivity to mental illness. In response to an identified need for clearly articulated standards and guidelines in order to protect litigants’ rights and address issues that occur when one or more litigants in a family law case appear to be significantly affected by an untreated mental illness (Kourlis, Taylor, Schepard, & Pruett, 2013), this article analyzes legal and ethical issues for attorneys representing potentially impaired clients. Finally, it details practical means of supporting clients in hopes of increasing their capacity to engage meaningfully in family court matters. Lawyers must improve their knowledge and skills in order to meet the legal and ethical standards for representing family law clients with mental health challenges.
THE CHANGING NATURE OF FAMILY COURT PROCEEDINGS

One of the major changes in family courts in the last 50 years is the rise of alternative dispute resolution as a means to resolve cases. Much of the negotiating surrounding divorce occurs in private meetings, settlement conferences, and mediation. Trials are much less common as more disputes are resolved through alternate mechanisms (Hensler, 2003). The vast majority of divorce-related issues are resolved in out-of-court negotiations.

As divorce laws changed in the 1970s and 1980s, the conciliation courts originally created to provide marriage counseling to help keep parents together shifted to providing family mediation to assist families in resolving disputes as they proceeded through a divorce (Brown, 1982). In most jurisdictions, if a litigant contests custody (legal decision making) or visitation (parenting time) of the children, the family is mandated to attempt to resolve the disputes through mediation before a trial will be scheduled and some jurisdictions require litigants with any disputed issues to attempt mediation (Beck & Sales, 2001). During the mediation, some jurisdictions allow attorneys in mediation sessions while others allow the mediators to decide if attorneys may be present (Beck & Sales, 2001). If the attorney is excluded from the mediation session, it presents significant challenges to an attorney representing a client with impaired mental functioning.

Paralleling the rise of mediation is the increase in pro se parties in family law cases (Applegate & Beck, 2013). The majority of divorce cases include at least one litigant who is representing him/herself; depending on the jurisdiction, estimates range from 55 to 90% (Kourlis et al., 2013). Pro se litigants seldom are trained in legal procedures and typically lack knowledge of how to present their issues to the court or respond to challenges from their spouse’s attorney. If the opposing party also has a mental illness that is interfering with his or her functioning, the attorney may find challenges in figuring out how to present the best case possible for his or her client yet not be seen as taking advantage of the pro se party.

Additional challenges arise from changes in procedure after the divorce is finalized. A relatively new procedural mechanism in family court is the use of a parenting coordinator. To deal with the postdivorce litigation in high-conflict cases, courts have established parenting coordinator programs to assist families in resolving day-to-day conflicts out of court. These programs provide quasi-judicial authority to a third party who at times can be appointed over the objections of the parties.

Although parenting coordinator guidelines were established by two major professional associations (Association of Family and Conciliation Courts, 2006; American Psychological Association [APA], 2012), confusion remains concerning the specific issues under the purview of the parent coordinator and the processes to be used to execute the role. These programs remain controversial and several states have either banned courts from using them (Menzano, 2013) or are considering limiting the use of them unless both parties agree (Arizona Parenting Coordinator Rule Petition Review Committee, 2015). There is limited judicial oversight of parenting coordinators. If they are not well trained in understanding the dynamics of mental illness and how it might impact family functioning, the parenting coordinator could use a process to resolve conflicts that may not support the client with limited capacity in the decision-making process and thus lead to flawed decisions. For example, relying solely on e-mail communications may not provide enough information to a parenting coordinator to assess clients’ current capacity or give clients the support they need to understand and communicate their needs and wishes. The resulting decisions made may not be in the best interests of the child. A lawyer representing the client with diminished capacity would then need to petition the court for changes in the parenting coordinator decisions.

In recent years, many custody statutes have been revised to reflect a cultural preference for the continued involvement of both parents in a child’s life postdivorce. This shift presents challenges, as shared care often requires more frequent exchanges of the children and increased consultation or negotiation concerning decisions about the child’s education, health care, religion, and activities. This increased complexity and contact with the other parent can be challenging for individuals with impaired capacity. Families unable to negotiate amicably are frequently using the court system to litigate issues that in earlier years would not have come before the courts, as one parent would be
making the decisions and informing the other parent. Attorneys representing clients with impairments are challenged to fashion parenting plans with which their clients can comply.

In summary, procedural and policy changes have increased the complexity of legal representation of clients involved in family courts. Attorneys are now required to represent clients who may also be ordered to participate in programs that at times do not allow attorney presence (mediation or parent coordination), bypass traditional judicial decision making (parenting coordinator), and require increased ongoing contact with the other parent (shared care). While all of these can be beneficial to clients, the involvement of a parent with compromised mental functioning increases the complexity of an already complicated situation.

REDUCED MENTAL CAPACITY AND DIVORCE

Marital separation and the divorce process result in a number of possible changes in a person’s life including changes in living arrangements, loss of social networks (friends and family), feelings of loneliness, financial and legal problems, co-parenting conflict, and loss of time with children (Halford & Sweeper, 2013). Adjusting to these changes can stress a person’s coping skills and lead to psychological distress.

The presence of high levels of psychological distress in a divorcing population should not be confused with the presence of mental illness. But stress can precipitate or exacerbate mental disorders (Metsa-Simola & Martikainen, 2013). Further, there is a strong association between a person having a psychiatric disorder such as major depression, bipolar disorder, and some anxiety and substance use disorders, and subsequently becoming separated or divorced (Kessler, Walters, & Forthofer, 1998). Research indicates a bidirectional relationship between major depression and divorce (Sbarra, Emery, Beam, & Ocker, 2013). It is important for an attorney to understand the prevalence of depression and other mental health challenges among divorce clients.

Neurocognitive disorders (commonly known as dementia; American Psychiatric Association, 2013) are another consideration, as the United States experiences a “greying of divorce” (Brown & Lin, 2012). While the overall divorce rate for first marriages has stabilized at between 40 and 50%, there is a massive increase in the rate of divorce for people over 50 years old. This divorce rate has doubled in the two decades between 1990 and 2010 and the trend is projected to continue (Brown & Lin, 2012). Given the skyrocketing divorce rate for adults over age 50, attorneys increasingly see divorce clients experiencing neurocognitive disorders. A nationwide study estimated that in 2010, 5.2 million Americans had Alzheimer’s disease; this figure is projected to triple by 2050 (Hebert, Weuve, Scherr, & Evans, 2013). Alzheimer’s disease has key symptoms of agitation, apathy, depression, and delusions (Rosenberg, Nowrangi, & Lyketsos, 2015), all of which can impact an individual’s ability to participate effectively in a divorce proceeding.

Taken together, the high incidence of psychological distress and mental illness or dementia intersect with the increasingly decentralized and complex evolving mechanisms in family court to heighten the need for family attorneys to improve their toolkit. Book learning is insufficient to address their contemporary challenges and relevant skill building is too often omitted from the law school curriculum (Hedeen & Salem, 2006). Bloom’s three domains of learning (Bloom, 1956) are the inspiration for a more comprehensive focus on improving knowledge (cognitive domain), skills (psychomotor), and attitudes (affective). To meet the demands placed on them by the growing number of clients with mental health challenges, attorneys must enhance their capabilities in all three domains.

IMPROVING KNOWLEDGE: LEGAL ISSUES AND CLIENTS WITH IMPAIRED CAPACITY

A diagnosis of a mental illness does not automatically deem a person incompetent to participate in family law proceedings. Mental illnesses and distress fall along a continuum from acute symptoms
which can be significantly debilitating to symptoms that are well managed with appropriate treatment. A client could have limited capacity (Coy & Hedeen, 1998) to participate in negotiations, decision making, or parenting or could be completely competent in these arenas. From a legal perspective, functioning, not diagnosis, is the relevant factor, and the precise standard varies by context. The complex task of the attorney representing a possibly impaired client is to gauge the client’s level of functioning throughout the legal process to ensure the client meets the legal standard of capacity that applies to a specific task or process and to support the client in maintaining that level of capacity.

CAPACITY TO CONTRACT

When a client hires an attorney, the two sign a legal agreement in order for the attorney to represent the client. Consequently, unless the court has appointed the attorney to represent the client (e.g., attorney ad litem), the client must have sufficient capacity to sign a contract. State law, which governs capacity to contract, historically focused on a cognitive standard of whether the individual understood the nature and consequences of the contract. Cases challenging a contract for legal services are rare and difficult to win, as even impaired individuals generally understand they are paying a lawyer a specified fee in order for that lawyer to represent them in a legal proceeding (Perlin, Champine, Dlugacz, & Connell, 2008).

CAPACITY TO MAINTAIN A DIVORCE ACTION

With or without the representation of an attorney, a client who is delusional or psychotic may prompt questions about whether that client has legal capacity to maintain a divorce action. Generally, state mental health codes permit individuals who meet the criteria for civil commitment to a psychiatric hospital to make their own personal decisions, including decisions regarding marriage (Mossman & Shoemaker, 2010). But for individuals under a legal guardianship, in most jurisdictions the guardian or intermediary is not allowed to file for divorce on behalf of the person under guardianship (Mossman & Shoemaker, 2010). Perlin and colleagues (2008) identify a trend in many jurisdictions of permitting a guardian to sue for divorce under specific circumstances (that vary by jurisdiction). But for the vast majority of cases in which the impaired individual is not under a civil commitment or guardianship order, there is little legal guidance and the guidance that exists varies on the criteria and procedures used to gauge capacity. Mossman and Shoemaker (2010) proposed a detailed model statute on competence to maintain a divorce action that draws heavily on existing legal standards for competence to stand trial in a criminal case and competence to make medical decisions. It is a functional standard detailing the abilities a party must have relating to expressing preferences, understanding relevant facts and their implications, thinking rationally, and articulating reality-based reasoning (Mossman & Shoemaker, 2010). The authors propose detailed procedures designed to assess and ensure these abilities, but they fail to identify a funding source for the court-ordered evaluations and treatment detailed in the model statute.

When the person with questionable capacity is the respondent of the divorce action, a different set of legal issues arise. Incapacity was often an independent ground for divorce in fault-based systems, although in some jurisdictions the same impairment barred a divorce action (Mossman & Shuemaker, 2010). The mental disability could also be used as a defense to a fault-based divorce action (Perlin et al., 2008). With the dramatic increase in unilateral and no-fault divorces, this cause-based analysis is less significant. No-fault divorce may not be an option, though, in jurisdictions with special requirements, for example, that both parties agree to a no-fault divorce (Perlin et al., 2008).

CAPACITY TO PARTICIPATE IN MEDIATION

Beck and Frost (2006, 2007) have identified separate legal concerns that arise in the context of divorce mediation. Mediation is designed to lead to a legally binding mediation agreement. Yet
parties to a divorce action have fewer protections and controls than in a formal judicial process and existing standards give mediators and attorneys little guidance on how to gauge an individual’s capacity to participate in mediation. They propose a model statute that clarifies:

A person is incompetent to participate in mediation if he or she cannot meet the demands of a specific mediation situation because of functional impairments that severely limit 1. A rational and factual understanding of the situation; 2. An ability to consider options, appreciate the impact of decisions, and make decisions consistent with his or her own priorities; or 3. An ability to conform his or her behavior to the ground rules of mediation (Beck & Frost, 2006, p. 25).

If an individual fails to meet this low minimum standard for participating in mediation, then educational or therapeutic interventions or including a support person in the mediation process might increase the person’s level of functioning. If not, alternative legal processes with more judicial oversight and involvement are better options.

**OTHER LEGAL ISSUES**

The Americans with Disabilities Act (ADA, 1990) requires reasonable accommodations for individuals with “mental impairments” who seek to access public services such as judicial proceedings. To fall under the ADA, an individual must have an impairment that limits a major life activity, have a record of such an impairment, or be regarded as having such an impairment. Some individuals with serious mental illness would reach this level of limitation.

There are important legal issues around disclosing mental health treatment in a divorce proceeding. Because mental health conditions and treatment still carry a great deal of stigma, they can be used during a contentious proceeding, for example, to challenge a person’s credibility or parenting skills. Under most circumstances, treatment records are protected by the Health Insurance Portability and Accountability Act (1996) and state laws on evidence, privilege, and duties. But savvy lawyers may attempt to access records through subpoenas and court orders. Seighman, Sussman, and Trujillo (2011) provide a detailed analysis of the protection and disclosure of mental health records in the context of domestic violence survivors.

Clearly a client with impaired functioning can present an attorney with complex legal issues. The attorney must also be attuned to ethical dilemmas that can arise.

**IMPROVING KNOWLEDGE: ETHICAL ISSUES AND CLIENTS WITH IMPAIRED CAPACITY**

Legal ethics can vary by jurisdiction, but almost all states have adopted a version of the American Bar Association’s (ABA, 2013) Model Rules of Professional Conduct (MRPC). The vast majority have also adopted the comments to the MRPC (ABA, 2011). The following analysis, therefore, relies on the most recent version of the MRPC and comments, although attorneys should always check the relevant state law for guidance.

Ethical questions can arise from the first time a potential client contacts an attorney. Confidentiality adheres to the conversation, even if the individual seeking consultation does not become a client (MRPC 1.18(b)) and the lawyer is prohibited from representing the opposing party unless both parties give informed consent in writing (MRPC 1.18(d)). The individual seeking representation must have the legal capacity to contract for services (see above) or to provide informed consent to permit the attorney to represent the other party. In some cases a third party may seek legal representation for an impaired party. For example, an adult child or a sibling might seek to hire a lawyer to represent a severely depressed mother who is being sued for divorce. The existence of a third party who pays for the legal services does not change the attorney–client relationship; the depressed mother is still
considered the client, the information obtained is confidential, and the client must provide informed consent to the payment arrangement (MRPC 1.8(f)).

To gauge a client’s ability to provide informed consent, the attorney is not expected to conduct a clinical assessment, but lay people often can determine whether an individual’s functioning is impaired. In another context, the American College of Trust and Estate Counsel Commentaries on MRPC 1.14 suggest assessing capacity by reviewing “the client’s ability to express the reasons leading to a decision, the ability to understand the consequences of a decision, the substantive appropriateness of a decision, and the extent to which a decision is consistent with the client’s values, long-term goals, and commitments.” (American College of Trust and Estate Counsel, 2006; Bennett, 2005). The Commentaries also suggest consulting with a mental health professional as needed.

Assuming an individual has sufficient capacity to form the initial attorney–client relationship, the MRPC delineate who decides what during the course of representation. The client determines the ends of the representation, although the attorney is prohibited from asserting frivolous claims (MRPC 1.2(a), 3.1). The client provides input on the means to reach those ends (MRPC 1.4(a)(2)). Typically clients will defer to the attorney’s specialized knowledge regarding technical, legal, and tactical issues (MRPC 1.2 comment 2). It is the attorney’s duty to zealously represent the client’s position (MRPC preamble, para.2). The attorney also fills a role of an advisor or counselor (MRPC 2.1). But the attorney should stay within his/her professional competence and should also recognize that in family law cases, some challenges might fall within the expertise of mental health professionals (MRPC 1.1.2.1 comment 4).

If the client becomes increasingly impaired over the course of representation, the attorney must maintain as normal a lawyer–client relationship as possible (MRPC 1.14). Standard duties such as maintaining confidentiality and responding promptly to reasonable requests for information still apply (MRPC 1.6, 1.4). And always the lawyer must treat the client with attention and respect (MRPC 1.14 comment 2). The attorney, however, may not be able to fully inform a client with diminished capacity because of that client’s jeopardized comprehension or impulsive responses (MRPC 1.4 comments 6, 7).

If the lawyer comes to believe the client is at substantial risk of physical, financial, or other harm from which the client cannot protect him or herself, the lawyer may consult with others who can protect the client (MRPC 1.14(b)). It is important to recognize the parameters of confidentiality protections in these circumstances. Protections under the MRPC are more expansive than attorney-client privilege under evidentiary rules, and they cover both privileged and unprivileged information learned during the course of representation (MRPC 1.6 comment 3). While confidentiality protections apply, they are not absolute and the lawyer may reveal information as necessary to protect the client (MRPC 1.14(c)). The attorney may disclose information in order to prevent death or serious injury, either to the individual or to another person (MRPC 1.6(b)(1), comment 6). People with mental health challenges are more often victimized than the general population (Teplin, McClelland, Abram, & Weiner, 2005) and there may be a duty to report abuse under state law, particularly with older clients. Rule 1.14 (Client with Diminished Capacity) raises particularly complex challenges (Gallagher & Kearney, 2003). In difficult situations, a lawyer should seek legal advice on his/her obligations under the ethical rules and whether this type of consultation is allowed (MRPC 1.6 comment 9).

Even if a client becomes increasingly irrational and demanding, the attorney can withdraw only if there is no material adverse effect on the client unless there is another good cause for withdrawal (MRPC 1.16(b)(1)). In contrast, the client can discharge the attorney at any time, with or without good cause (MRPC 1.16 comment 4). But if the client lacks the legal capacity to discharge the attorney, the attorney should take protective action under Model Rule 1.14 (MRPC 1.16 comment 6). Regardless of who terminated the professional relationship, the attorney has a continuing ethical duty to mitigate the consequences of the termination to the client (MRPC 1.16(d)) and must fulfill the duties lawyers have to all former clients under Model Rule 1.9.

In some cases it might be the pro se opposing party who is impaired. The MRPC delineate the role of an attorney under those circumstances. The attorney is required to make reasonable efforts to effectively explain to the opposing party the role of the opposing counsel and clear up any
misunderstandings (MRPC 4.3). The attorney should be careful not to give the opposing party any legal advice, except for a recommendation to hire an attorney (MRPC 4.3). The attorney may feel his or her client’s best interests are served by asking the court to appoint a guardian ad litem for the pro se opposing party, thus reducing the risk of an appeal of the final decree.

Mediators in family disputes can find ethical guidance through the Model Standards of Practice for Family and Divorce Mediation (MSPFDM; adopted in 2001 by the ABA House of Delegates) (ABA, 2001) and the Model Standards of Conduct for Mediators (MSCM; adopted in 2005 by the ABA House of Delegates, the American Arbitration Association, and the Association for Conflict Resolution). According to the MSPFDM, before and during the mediation process, a mediator must be attuned to the capacity of the participants (MSPFDM standard III(9)). While the mediator is required to maintain confidentiality, if a participant threatens suicide or violence and appears likely to act upon the threat, the mediator must report the threat to the intended victim and the authorities if such reporting is permitted under applicable law (MSPFDM standard VII(22)).

If the mediator believes a participant is unable to participate effectively because of a mental condition, she or he must stop the process (MSPFDM standard XI(3)). In contrast, the broader MSCM simply suggest that a mediator who thinks a party lacks capacity should simply “explore the circumstances and potential accommodations, modifications or adjustments that would make possible the party’s capacity to comprehend, participate and exercise self-determination” (MSCM standard VI(A)(10)). But the MSCM allows for ending the mediation if participant conduct does not permit conducting a mediation in a manner consistent with the standards (MSCM standard VI(C)).

Clearly family attorneys and mediators must build their knowledge of legal and ethical issues involved in representing clients with mental impairments. Knowledge alone, however, is insufficient in the current environment. Attorneys must develop new skills to work effectively with these clients.

IMPROVING SKILLS: IDENTIFYING A CLIENT’S IMPAIRED MENTAL FUNCTIONING

Most attorneys are not trained as mental health professionals and diagnosis is beyond their expertise. To further complicate the process, attorneys typically interact with individuals from a broad range of cultures and will not always be familiar with normative notions of appropriate behavior and expression of emotions (Paniagua, 2014). Diagnosis is not the point; in this context, mental illness could be a proxy for impaired capacity. Lawyers constantly make informal assessments of their clients’ capacity (Sabatino, 2000). The key issue is whether the client’s level of functioning is adequate to meet the demands of the context in which negotiations are conducted or decisions made (Beck & Frost, 2006).

An attorney who suspects a client might have compromised functioning can do several things to address that concern. Asking directly about a mental health diagnosis during the first interview can be off-putting. People can feel stigmatized by a diagnosis and research shows that over a third of people will fail to report a diagnosis of depression (Bharadwaj, Pai, & Suziedelyte, 2015). Instead, the attorney should interact with the client and observe details of that interaction.

The attorney should be cautious about talking too much. Open-ended questions avoid hinting at a particular response and give a better indication of a client’s processing of information (Frost & Volenik, 2004). Inquiring about a client’s beliefs about the process and analyzing the reasoning behind the response can provide helpful insight into the rationality of the client’s thought process. Toward the end of the interview, it can be useful for the attorney to ask the client to repeat something mentioned earlier in the interview and to explain something previously discussed. This gives the attorney an opportunity to gauge the client’s memory, recall, and comprehension of information (Frost & Volenik, 2004). Follow-up at a future meeting can be important, as a client’s capacity often fluctuates and can grow along with trust in the attorney.

From the responses of the client in these interviews, an attorney can observe if the client has any oddities in use of language or speech patterns or unusual or bizarre thoughts. While a range of emotions is expected, attorneys need to be cautious in making attributions of normality to emotional responses of
their clients, particularly if these responses remain strong and do not recede over time. Clients may also provide information that leads the attorney to believe that they lack insight into their current situation. Depending on myriad factors associated with the family (length of separation, who decided to leave or file for divorce, emotional state of any children; Emery, 2011), clients may be experiencing high levels of stress that interferes with cognitive functioning. An attorney may observe that a client has difficulty making or sticking with decisions or struggles to change plans when the situation warrants.

A vulnerable group is clients with intellectual disabilities (formerly called mental retardation; Federal Register, 2013), with or without a diagnosis of co-occurring mental illness. One factor that impedes detection of the disability and increases vulnerability is that not all people with intellectual disabilities exhibit physical characteristics commonly associated with Down syndrome (Devoy, 2014). Thus, attorneys cannot assume that they will easily be able to recognize a client with an intellectual disability, especially people with a mild disability who can successfully work and engage socially. A second factor that makes this group vulnerable is that people with intellectual disabilities often have a predisposition to please authority figures, which includes nodding and agreeing to closed-ended questions without comprehending their meaning (Devoy, 2014). Unbeknownst to the attorneys, clients may actually be confused and unable to appreciate the long-term effects of particular decisions but will not stop the attorney to ask for clarification, sometimes actively trying to prevent any discovery of the disability. Consequently these clients would not receive potential accommodations that would assist them in understanding the legal process (Bonnie, 1990).

If any client responses raise red flags, an attorney may want to consider consulting with a mental health professional. In addition, Logan (1992) and the ABA/APA (2005) have developed detailed descriptions of possible mental health–related issues (Logan) and worksheets (ABA/APA) to assist lawyers in understanding the range of potential mental health issues clients may present and to decide if additional investigation or actions are needed to ensure client capacity.

**IMPROVING SKILLS: SUPPORTING CLIENTS WITH MARGINAL CAPACITY**

There are a number of things an attorney can do to support and improve the capacity of a client to engage in a divorce proceeding. First, it is essential to build a trusting relationship with the client from the start. Individuals with mental disabilities may be more likely to have their first impressions of the attorney colored by paranoia, naiveté, or errors in thinking and judgment (Louisiana Appleseed, 2011). A careful explanation of the confidential nature of the relationship is important (ABA/APA, 2005). The relationship with opposing counsel could be confusing to a client. Explaining the nature of collegiality and any preexisting friendship can diminish the risk of a courteous relationship with the opposing attorney being misinterpreted as a lack of zeal in representing the client (Louisiana Appleseed, 2011). Multiple meetings and one-on-one time spent building the attorney-client relationship can lay the foundation for difficult questions and result in more fruitful responses (ABA/APA, 2005; Sabatino, 2000).

Next, if the client’s cognitive functioning is marginal, the attorney should take extra measures to provide support. The ABA/APA (2005) guidelines for attorneys working with older clients with cognitive decline are helpful in the context of family law. A fast-paced conversation full of legal jargon can be challenging and unproductive. For clients with low cognitive skills, the attorney should break information into manageable pieces. Questions should be short and allow plenty of time for response. Repeating and summarizing information and providing a written version can boost comprehension. So can asking a client to explain information in his/her own words and correcting any misunderstandings. Meetings should be modest in length and allow for breaks. The modality of communication (e.g., telephone, in-person, e-mail, letters) should be one the client is most likely to understand and retain, with multiple modalities used as needed to keep good records. These many measures can serve to boost the client’s cognitive functioning (ABA/APA, 2005; Sabatino, 2000).

The attorney can also strive to maximize the client’s engagement in the decision-making process. The ABA/APA handbook recommends an older technique of gradual counseling that deconstructs the decision-making process by identifying goals, stating the problem, ascertaining values, comparing options
to goals, and giving feedback (ABA/APA, 2005; Smith, 1988). The rapidly developing field of supported decision making may soon provide additional guidance in this regard (Kohn & Blumenthal, 2014).

The stress of divorce can diminish a person’s level of functioning (Halford & Sweeper, 2013), so it is likely that effective self care could promote improved cognition and engagement. A supportive person can play a role in various portions of the legal process (California Family Code Section 6303(a) – (e) (2015); Folberg, Milne, & Salem, 2004). Depending on the client’s concerns about confidentiality, the support person may attend meetings with the attorney and be present during legal proceedings. Local resources and peer groups can provide important support (Margulies, 1994). Evidence-based recovery-oriented programs such as Wellness Recovery Action Planning can guide individuals in developing plans to maintain and support wellness and to take action if their mental health is deteriorating (Fukui et al., 2011).

In addition, there are specific accommodations attorneys can make depending on whether the client is participating in a mediation session, a settlement conference, or a trial proceeding. Screening clients prior to mediation can identify potential problems, but mediation researchers analyzing recent neuroscience research note that the capacity of an individual to engage productively in a process will vary over time and with different mediation processes (Hedeen, 2012). Mediators can adapt the process by limiting overly stimulating components, inviting the presence of a support person, or utilizing techniques like shuttle mediation. Long mediations that become endurance events place particular stress on individuals with mental disabilities (Hedeen, 2009). Training mediators to better understand emotions is critical to successful conflict resolution (Lund, 2000).

Settlement conferences can be a key component of the legal process. Thorough briefing of the client prior to attempting to reach a settlement is increasingly valued by the professionals seeking to resolve the dispute (Hedeen, 2012). Research has shown family lawyers to be particularly adversarial in their approach to negotiations (Schneider & Mills, 2006). Yet the increase in collaborative divorce proceedings allows for and encourages the inclusion of mental health professionals and others who can facilitate reaching a settlement (Mosten, 2009). Helping professionals can be included in negotiations or mediations even if they do not follow a collaborative divorce model. The development of planned early negotiation with its emphasis on relationship building is another example of more supportive practice that can better engage clients in the divorce process (Lande, 2011).

For the small proportion of cases that make it to an adversarial trial, it is essential to adequately prepare a client with impaired capacity. The National Center on Domestic Violence, Trauma & Mental Health suggests a number of strategies to support the client (Seighman et al., 2011). The attorney and client can practice direct and cross examination so that the client is familiar with the process. A support person can attend the proceedings. The attorney can request a recess if the client is overwhelmed. The attorney can also consider requesting accommodations under the ADA (1990), but should weigh the potentially prejudicial effect of highlighting the client’s mental health challenges (Seighman et al., 2011).

**IMPROVING ATTITUDES: CULTIVATING RESPECT AND HOPE**

For family attorneys working with clients with impaired capacity, improving their own knowledge and skills is important, but not sufficient. People with mental health challenges are the focus of significant stigma. Many attorneys, like people in general, have negative images and concerns about people with mental illness. The impact of stigma can be as harmful as the psychiatric disorder itself (Hinshaw, 2007). Increased knowledge about mental illness can reduce stigma, as can more contact with individuals with mental illness (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012).

The use of language can have an important impact in promoting or reducing stigma. For many years, individuals have promoted “person first” language in order to prioritize the person over the disorder (e.g., “a person with schizophrenia” instead of “a schizophrenic”; Barnish, 2014; Brown & Bradley, 2002). A basic ethical principle requires attorneys to treat a client with a disability with respect (MRPC 1.14) and choice of language can be an important component of respect.
Recently, the “medical model” of psychiatric care has been widely criticized as focusing on symptoms and labelling (Frost, Heinz, & Bach, 2011; Leamy, Bird, Boutillier, Williams, & Slade, 2011). A “recovery model” places the individual at the center of the treatment process and emphasizes hope and goals for the future rather than symptom abatement. In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a consensus statement developed by over 110 expert participants identifying ten fundamental components of recovery: self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope (SAMHSA, 2006). In the decade since these components were identified, many states have overhauled their mental health service systems to ground those services in these recovery components. Popular culture and the legal system lag behind, but this evolution in attitudes is essential for attorneys to provide quality representation for clients with impaired capacity.

CONCLUSION

The changing nature of family court and the increasing number of litigants with mental health challenges compel family lawyers to improve their knowledge, skills, and attitudes to best represent their clients. Attorneys should consider complex legal, ethical, and practical issues in doing their work so as to protect their clients’ interests and fulfill their own obligations. They need to gauge their clients’ capacity to participate in the legal proceedings and adapt their services to optimize their clients’ abilities. Sensitivity to the client’s level of functioning requires lawyers to slow down, listen carefully, and weigh options to boost capacity and address legal and ethical challenges related to impaired capacity.

REFERENCES


Lynda E. Frost, J.D., Ph.D., serves as the director of planning and programs at the Hogg Foundation for Mental Health, where she oversees major initiatives and grant programs, leads strategic and operational planning, and manages program staff. She joined the foundation as associate director in 2003. She is an experienced administrator and attorney with legal expertise in human rights, juvenile justice, criminal law, and mediation. At the University of Texas at Austin, she is an assistant vice president in the Division of Diversity and Community Engagement and she holds an appointment as a clinical associate professor in the LBJ School of Public Affairs and the College of Education. She previously held academic positions at the University of Virginia Schools of Law and Medicine, the American University in Cairo, and the University of Richmond School of Law, teaching mental health, criminal, and international law. She has published numerous articles and is the co-editor of a book entitled *The Evolution of Mental Health Law*.

Connie J. A. Beck, Ph.D., is an associate professor in the clinical psychology program at the University of Arizona, Department of Psychology. Her research interests focus broadly on investigating aspects of the legal system to determine how the legal system can be adjusted to minimize psychological distress for those who use it. For the past 20 years, she has conducted federal grant-funded research investigating short- and long-term outcomes for divorcing couples experiencing intimate partner violence and mediating their disputes. This work includes a large-population, longitudinal, archival study through multiple official databases (mediation, superior court, law enforcement). With colleagues from Indiana, she developed a risk assessment instrument for the mediation context and is currently conducting a randomized controlled trial of two models of divorce mediation for highly violent couples (i.e., shuttle and videoconferencing) as compared to those couples returning to court. Her new research, with a colleague from Arizona, includes a pilot study testing a batterer treatment program adapted for adolescent boys charged with domestic violence against a parent/primary caregiver. She is also involved in research investigating children and adolescents who repeatedly return to child protective services. She teaches graduate and undergraduate courses in ethics and a psychology of divorce course she developed for undergraduates.