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Developments in Mental Health Law

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Forensic Psychiatry and Community Mental Health

by John Petrila*

The criminally insane are feared and reviled. They are kept in overcrowded, understaffed "hospitals" located in rural areas, surrounded by barbed wire, with entry doors easily opened and exit doors always locked. This population has as its members those not fit to stand trial, those acquitted by reason of insanity, transfers from correctional institutions and the "special" offenders who come with labels like "criminal sexual psychopaths." This is the province of forensic psychiatry, long a stepchild of psychiatry and misunderstood by a public that thinks of "Quincy" when the word forensic is mentioned.

Public attention, when given at all, is focused on notorious trials in which the insanity defense is pursued. The outcry which surfaces when a defendant is acquitted on the basis of psychiatric testimony is as predictable as the legislative tinkering with the defense which emerges every few years.

However, there is today a great deal of ferment in forensic psychiatry. This acitivity is occuring largely out of the public eye. It is concerned primarily not with the clinical or legal aspects of forensic psychiatry (though certainly both are implicated), but rather with the administrative side. For the first time, public departments of mental health and corrections are paying attention to forensic psychiatry as practiced in the public sector.

One visible sign of movement is in the increased numbers of states creating "director of forensic services" positions. These are usually high-level administrative positions located in the department's central office. In most states, the creation of a position like this marks the first time that the particular state has had an individual with system-wide authority who spends all of his or her time working for forensic services.

The creation of these positions has given forensic services much higher visibility within those mental health departments that have them. If there is no such position, the "ranking" forensic administrator may be the head of the state's forensic unit, a position often subordinate to hospital superintendents and department administrators and far removed from the actual locus of administrative authority. Increased visibility in a central administrative capacity means, among other things, an increased voice for forensic service in department debates over the budget. In public psychiatry, where budgets are subject to increasingly cost-conscious state governors and legislators, higher visibility for an advocate for a particular service becomes critical.

Many states are moving away from a system in which one or two maximum security units provide all forensic services. In its place is a forensic

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Institute Awarded Two Contracts

The Virginia Department of Mental Health and Mental Retardation recently awarded two major training contracts to the Institute of Law, Psychiatry and Public Policy. These contracts called for the creation within the Institute of two seperate Centers.

Over the next two years, the Center for Forensic Evaluation Training and Research will provide intensive clinical training at the Institute to selected community mental health professionals in performing competency to stand trial and insanity defense evaluations on a local, outpatient basis. The immediate goal of the program is to train interdisciplinary teams of mental health professionals in Alexandria, Charlottesville, Henrico County, Richmond, Roanoke and Portsmouth to perform these two specific evaluations. The impact of the training on the quality of evaluations received by courts in these jurisdictions and the savings in the use of state hospital facilities and state transportation will be studied to determine whether the program should be offered on a continual, statewide basis and whether changes in state law providing for these evaluations are merited.

The Mental Health Law Training and Research Center's mission is a broader one, involving such services as

—providing legal consultation and in-service training to community mental health programs throughout Virginia

—drafting revisions of statutes and regulations affecting the rights of the mentally disabled citizen in Virginia

—presenting conferences and preparing conference training materials for judges, lawyers, and mental health professionals

—publishing *Developments in Mental Health Law*

system in which it is assumed that both evaluation and treatment will occur initially in the community.

Trend Toward Decentralization

Decentralization has occured for several reasons. First, the community mental health movement has affected more and more types of mental health services and has finally reached the area of forensics. Second, lawsuits have exposed the often inhumane conditions existing in maximum security units and have ordered states to remedy the conditions. In developing remedies, states inevitably consider the alternative of decentralization. Third, a series of lawsuits has developed and validated the "least restrictive enviroment" doctrine. As a result, some states have studied their forensic populations and determined that not all need a maximum security enviroment. Fourth, economics have contributed to the trend. Doing out-patient exams in scattered communities is perceived as being both less costly and more efficient than performing forensic exams on an in-patient basis in a unit often located hours from the point of origin.

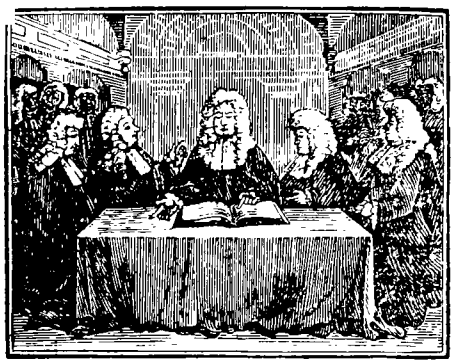
The impact of decentralization is obvious for community mental health facilities and for the communities they serve. The "criminally insane" will no longer be the sole province of a group of overburdened forensic staff operating in a maximum security unit far removed from the lives of most mental health professionals. Instead, more and more community mental health professionals will find themselves (willingly or not) becoming acquainted with forensic psychiatry.

From an administrative point of view, decentralization brings to the fore the question of "quality control." When only one or two forensic units operate in a state, the evaluations and reports will probably be of roughly similar quality. This does not mean that the quality is necessarily very good, only that the unit staff will probably develop a particular style in report writing and testifying which will serve as the forensic "currency" in all courts within the particular jurisdiction. In contrast, decentralization means that a variety of facilities and individuals will become forensic staff. These facilities and staff will have their own methods, their own style, which predictably will be different both in content and quality from that of the state's traditional forensic "experts."

The state then is confronted with three questions: how to find sufficient personnel to staff a number of forensic units; how to train this staff; and how to audit the work of the staff after training.

Ideally, the state will attempt to resolve these questions prior to determining just how decentralized the forensic system will be. The difficulties in resolving each of these questions would then govern at least in part the type of forensic system the state establishes. The system which emerges would in theory be suited to the needs and resources of the state in question. The alternative is to do this backwards, first establishing a system dependent upon "x" number of forensic units and then attempting to resolve the three questions posed above.

States have attempted to meet these issues in various ways. There has been general consensus on the way to find sufficient numbers of staff. The operating assumption is that there are not now and are not likely to be in the foreseeable future enough psychiatrists interested in public psychiatry generally and forensic psychiatry specifically to provide needed forensic services. As a result, a growing number of states authorize the use of other mental health professionals to perform forensic evaluations. Use of psychologists is most common, though at least one state (Tennessee) authorizes the use of social workers, nurses and even attorneys in certain circumstances.



Once the staff is found, it must be trained. Everyone agrees that training is necessary. However, the manner in which it is provided varies dramatically from state to state. Critical questions to be faced include who will do the training, the subjects to be covered, the duration of the training and the materials used. The extent to which decentralization has already occurred *may* affect dramatically the resolution of these questions

Content of Training

The first question that must be resolved is that of content. What subjects must be covered? This will depend in part on the type of forensic system. If a multi-facility system is the model, one can assume that the training program will have to concentrate on fairly limited "core" subjects. There are several reasons for this. First, if community based facilities are providing staff forensic exams, it is likely that those staff will have responsibilities other than forensic services. (In fact, the more decentralized the system becomes the more one can anticipate that this will be true. Most communities will not generate a caseload sufficient to justify a full-time local forensic unit. If fact, this is one of the strongest arguments for a regional rather than community based system.) It is unlikely that administrators will release this staff for long periods of time. Therefore, the training time that is available must focus on core issues of fitness to stand trial, criminal responsibility, and the assorted rigors and horrors of being an expert witness.

In contrast, in a centralized system, training can be a more leisurely affair, since staff will always be physically present. As a result, a wider variety of subjects can be covered.

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The Trainer

Once issues of content are considered, one must find people qualified to teach what the staff is to learn. Again, this process can be reversed, with the whole affair being turned over to the trainer. However, the trainer may or may not arrive at a program suited to the particular needs of the system.

The professional identity of the trainer (s) will be important. When criminal resposnsibility is the issue, lawyers and clinicians will teach the subject in different ways, will provide different emphases, and may or may not be sensitive to the issues one wants covered. For example, Michigan's training program is handled almost entirely by Department of Mental Health personnel. Those personnel happen to be clinicians. Those responsible for the training program will admit that the lack of a "legal perspective," however that is defined, is a weakness of their program. A training program dominated by attorneys is likely to suffer from the opposite malady, a scarcity of "clinical" perspective.

The type of training program ultimately presented will also vary depending on the enviroment from which the trainer comes. The tendency is to turn these matters over to universities, because public departments of mental health are generally ill-equipped to provide in-service training and because the subject at hand is "teaching,"something one assumes universities can do.

However, training programs under the auspices of a university can be problematic. University staffs may have insufficient "real-world" experience to create a training program which meets the needs of those who will be practicing in the "real world." On the other hand, lack of involvement from academicians can hurt a program. A mental health department staff, unless involved full-time with training is unlikely to keep current with either programmatic or research developments occuring outside of the narrow confines of the state in question.

Duration of Training

As noted above, practical considerations will determine how much time is available for training. If staff is spread geographically through the state, one can anticipate that at most only a few sessions, each lasting no more than one or two days, will be available. In some cases, e.g., Tennessee, the training process has been compressed to a two day session in which fitness to stand trial is the only subject. On the other hand, in a centralized system like Michigan's a person is considered to be in training for several months.

Methods Used in Training

The teaching methods used also vary, depending upon the trainers and the type of training program used. A basic decision is whether to use real cases as teaching vehicles or to rely on simulated patients. A related problem is whether to use "live" performances or tapes.

While real cases provide an undoubted edge (there is a certain fascination in evaluating a genuine axe-murder) many training programs are now using simulated interviews recorded on tape. First, these tapes can be used with any audience without question of informed consent intruding. Second, the interview can be controlled and channelled to make whatever point needs making. Third, a tape can be stopped, analyzed and replayed. For these reasons, a tape library has become an indispensable tool in a forensic training program.

The use of written materials also varies, depending upon the type of program used. Michigan, with a long training period for its own staff, has the luxury of assumming its trainees will have the time to read the mass of legal/psychiatric literature prepared for them. In contrast, a program compressed to accommodate the schedules of trainees from a number of facilities will face a potentially severe problem of "information overload." In a program of this type, written materials may assume a secondary role, both because the trainees are short of time and because the trainer will assume, correctly, that one cannot learn how to do forensic exams by reading about them.

This raises a critical point. How does one teach or transmit the art (not science) of evaluating criminal defendants? The client may be not only from an alien culture, but has possibly engaged in behavior which outrages or repulses the examiner. The evaluation is being prepared for the criminal justice system. This is a system peopled by seemingly bizarre individuals (not empathetic, caring mental health professionals) who see the defendant as either wholly guilty or wholly innocent, primitive concepts to the clinician. The judge who presides over the process may be noteworthy primarily because he views psychiatrists as charlatans. The jury may be composed of individuals who on occasion have the nerve to fall asleep during the presentation of expert testimony on the difference between "neurosis" and "psychosis." How does one *teach* this to somebody?

This is the potentially fatal flaw in the move to decentralize forensic services. Because of the practical considerations noted throughout this article, it is highly unlikely that trainees will perform a large number of "real-life" examinations during their training. They will not be forced to face their feelings when confronted with a defendant who denies even committing the offense with which he is charged. Trainees will not be forced to experience angry attorneys, skeptical judges, bemused juries. There simply will not be time in most training sessions to accomplish this.

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This is an area in which experience, objective evaluation of the experience, and more experience is the most effective way to train someone. Some decentralized systems rely on staff whose primary responsibilities are not forensic and who in many instances will not see an extensive number of forensic cases. This may assure that the quality of forensic services rendered will be low. In theory, training will fill the gap. However, it is more likely that the training will not teach the intangibles or even some of the tangibles involved in forensic psychiatry. Because of low caseloads, staff may not learn through trial by error, and in most cases there will be no subsequent audit of the quality of the trainees' work. The result may be a system that promises quality services while delivering something quite different.

The problems discussed above are not insurmountable. However, the cure may lie in procedures not particularly palatable to the community mental health professional. For example, the training program might include the requirement that trainees spend a period of time at an established forensic unit in the state. A supervisor would be assigned, and the trainee would be required to evaluate several live clients and prepare the necessary reports. The trainee could also provide testimony. The performance in each case would be evaluated by the trainers. A process like this would give the trainee at least some experience.

Also, a system of auditing reports from around the state should be developed. This implies the development of a standardized format for forensic reports. It also requires the development of a data system, whereby the auditors can keep track of caseloads, medical and legal conclusions, and other pertinent information. Of course, this requires staff to do the auditing. However, monitoring is essential to assure that a certain level of quality is maintained.

The Future of Decentralization

The decentralization of forensic systems has been based on the premise that it is better to have more than fewer individuals performing forensic exams. As a result, some states seek to expand constantly the number of communities in which forensic services are available. However, as decentralization continues, there will be increased conflict between the desire for the expeditious provision of services that a wholly decentralized system represents and the resultant problems in monitoring and quality control. One can predict that at least some states will find that the problems outweigh the benefits. A degree of "re-centralization" will then occur.

However, it is unlikely that there will be a return to a system which relies entirely on one or two maximum security units. Instead, a regional model will probably emerge as the type of system most appropriate for forensic services. In such a system, forensic units would be established in regions large enough to generate a case-load justifying a full-time forensic staff and small enough so that services are accessible to the courts.

A regional system would also obviate many of the problems in providing adequate training noted above. Since staff would have forensic work as their primary responsibility, they could more easily be expected to devote longer periods of time to training. Since the caseload would be large, a good deal of experience would be gained over time. Finally, central administrative staff would find it easier to maintain at least a minimum threshold of quality. It is simply easier to monitor the work of five or six individuals than it is to monitor the work of fifteen or twenty.

Regardless of the ultimate shape taken by forensic systems, decentralization has been and continues to be a good thing. Forensic psychiatry is finally receiving some long over-due attention. While the attention has sometimes exposed conditions that are undesirable at best, the result should be gradual improvement in the quality of forensic services provided around the country.

In the Virginia Supreme Court

Last year, the Virginia Supreme Court decided two cases which could have a substantial impact on the use of psychiatric testimony in Virginia criminal cases.

Insanity Defense Clarified?

According to the Virginia Supreme Court, it was not reversible error for a trial judge on retrial to refuse to allow the impeachment of a state psychiatrist who wrote the court before the first trial that if the defendant is found not guilty by reason of insanity he will learn nothing from the experience and will feel he has permission to be "nasty against society." The court also held that the judge did not err when he refused to instruct the jury on the sentencing consequences of finding a defendant not guilty by reason of insanity. And finally, the Virginia Supreme Court affirmed the trial judge's decision not to admit a psychiatrist's testimony that there was a "possibility" that the defendant was insane at the time of the offense. The court held that such a medical opinion was purely speculative. *Spruill v. Commonwealth*, No. 791532 (Va. S. Ct. March 10, 1980).

Psychiatric Testimony Supports Death Sentence

Earlier last year the Virginia Supreme Court affirmed the death sentence of a twenty-one year old man convicted of the rape and murder of a fifteen year old girl and the murder of her mother. In the death sentencing phase of a bench trial in Norfolk, the court heard psychiatric evidence that the defendant had acted under extreme mental or emotional disturbance (a mitigating factor in Virginia's death sentencing procedure), because of the accumulated chronic stress of his environment and the acute stress of drug abuse. The Supreme Court found no error in the trial judge's decision to disregard the chronic stress because he felt that chronic stress alone was insufficient to have "affirmatively caused" the criminal acts, and to disregard the acute stress because the defendant has voluntarily caused it by "becoming an habituate of drugs and alcohol."

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In the Virginia General Assembly—1980

Insanity Acquittees Now Get Automatic Hearing

After acquittal by reason of insanity in a Virginia court, defendants are confined indefinitely, potentially for life, under §19.2-181 of the Virginia Code. The 1980 Virginia General Assembly amended this statute to require a hearing shortly after a defendant is acquitted by reason of insanity and is committed to the state hospital, usually Central State Hospital's Forensic Unit.

Under the old law, a defendant was hospitalized without a hearing. After six months, if he requested a hearing, he could receive one, but no more frequently than once a year. In this hearing, the burden was on the defendant to prove by a preponderance of the evidence that he was both non-dangerous and "sane." Under Virginia law, a defendant who succeeded in proving that he was not mentally ill, but failed to convince the court that he was non-dangerous, continued to be hospitalized indefinitely. *Blalock v. Markley*, 207 Va. 1003, 154 S.E.2d 158 (1967).

The hospital was only required to request a hearing when it believed that the defendant was "safe and sane." In this hearing, the standards for release and the burden of proof were the same as in a hearing requested by the defendant.

The amendment to §19.2-181 leaves the procedure unchanged except to assure the defendant of at least one relatively prompt hearing after hospitalization. This is particularly important where, for various reasons, neither the defendant nor the hospital requests a hearing. The amendment does not specify the standards for release or burden of proof, but it seems fair to infer that they are identical to those in the hearings requested by the hospital or defendant.

It is doubtful that this minor change in the Virginia practice of confining individuals after acquittal by reason of insanity will permit the practice to survive constitutional scrutiny.

Recently, a patient in the Central State Forensic Unit brought an action before a federal court in Norfolk, Virginia, challenging the procedure by which he was confined. Although the case is still undecided, the court said in a preliminary matter:

> Due process is served only if, before commitment [after acquittal by reason of insanity], the defendant receives a hearing before an impartial judicial officer, at which he is present with counsel and has the opportunity to be heard, to confront and cross-examine the witness against him, and to offer evidence of his own. *See Dorsey v. Solomon, supra*, 604 F.2d at 274-75; *Powell v. Florida, supra*, 579 F.2d at 330. These procedural protections are available to persons who face involuntary commitment to a mental institution by reason of their conviction for certain offenses, *Specht v. Patterson*, 386 U.S. 605, 610 (1967), and we can see no reason why they should not apply with equal force to persons who face involuntary confinement by reason of their acquittal on the grounds of insanity. In addition, the state bears the burden in any such hearing to prove by clear and convincing evidence, *Addington v. Texas*, 441 U.S. 418 (1979), not only that the defendant is mentally ill, but also that he cannot live safely in freedom by himself or with the help of family or friends. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *Warren v. Harvey, supra*, 472 F. Supp. at 1068-69.

Harris v. Ballone, No. 80-686-N, memorandum order at 3 (E.D. Va. June 17, 1980)

Virginia General Assembly Moves on Commission Findings

Created by House Bill 1935, in the 1977 session of the Virginia General Assembly, the Commission on Mental Health and Mental Retardation studied the public care of the mentally disabled citizens in Virginia for three years and in the 1980 session sponsored House Bill 95 implementing most of the Commission findings.

Administrative Streamlining

Many of the changes in Virginia law attributable to the Commission's study consist of clearly allocating to the Commissioner of Mental Health and Mental Retardation total managerial responsibility for the Department of Mental Health and Mental Retardation, *Va. Code Ann.* §37.1-42.1 (*Cum. Supp.* 1980), and confining the State Board of Mental Health and Mental Retardation to making policy and promulgating regulations, §37.1-10. New §37.1-42 removed the requirement that the Commissioner be an M.D., emphasizing instead administrative qualifications.

Guardianship Amendments

The Commission's greatest impact on the rights of mentally disabled citizens was felt in the area of the adult guardianship laws. Both plenary guardianship for persons adjudicated "incompetent" under §37.1-128.02 and partial guardianship for persons found "incapacitated" under §37.1-128.1 underwent significant revision that stopped short of all the reform needed. Some changes in the law are:

1) the court is now required to find that the ward is totally unable to care for himself or his estate and that a finding of "incapacity... would not be appropriate," before making an adjudication of incompetency (§37.1-128.02);

2) guardianships based on incapacity must preserve as much of the ward's autonomy as possible and must specify the powers of the guardian, the length of the guardianship and the legal disabilities of the ward (§37-128.1);

3) in either kind of guardianship proceeding, the court may, but need not, order a pre-trial multi-disciplinary examination from a community services board or mental health clinic and tax the costs of the examination as part of the costs of the proceeding;

4) a complicated procedure is now available under §37.1-128.2 to appoint a stand-by guardian to act upon the death or incompetency of the legal guardian;

5) a procedure for restoring competency or capacity is now specifically provided for by statute, although it is still uncertain whether a ward is entitled here to court-appointed counsel and whether the burden of proof is on the ward;

6) a person proposed for guardianship has a right to be present at the proceeding and to be represented by court-appointed counsel if he has none;

7) the standard of proof in a guardianship proceeding is by "clear and convincing evidence," the same as constitutionally required in civil commitment proceedings.

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Mental Health Systems Act Becomes Law

President Carter signed the Mental Health Systems Act, P.L. 96-398, into law October 7, at the Woodburn Center For Community Mental Health in Fairfax, Virginia. Drafted by the Administration to implement the 1978 Report of the President's Commission on Mental Health, the Act underwent almost total revision in the Senate and further significant changes in the Conference Committee.

As passed, the Act represents important compromises on issues of state control of federal mental health funds and federal funding of state mental health advocacy programs.

State Control of Grants

The Act offers the state two levels of control over all applications for grants under the Act originating within the state. At the first level, the state can rank grant applications, including its own, in the order in which, if accepted by HHS, they will be funded. At the second level, the state has the option of rejecting an application outright and not submitting it to HHS, or of submitting it with modifications.

The state's decisions to rank and reject or modify may be appealed to HHS. HHS will disregard the state's ranking if the disgruntled local applicant shows there is "substantial evidence" that its application is better than those with a higher ranking. HHS will return rejected or modified applications for ranking or re-ranking, or disregard the modifications only if the unhappy local applicant shows that the state's action is "arbitrary or capricious."

While all states are given authority to rank applications, which they could not formally do under the Community Mental Health Center Act, only "qualified" states may reject or modify applications. In order to qualify, states must demonstrate that they are making at least a good faith effort to provide community programs for the chronically mentally ill, such as state-administered aftercare, regulation of adult homes, and prevention of over-concentration of the chronically mentally ill in any community. After HHS determines that a state is qualified, the state may enter in an agreement with HHS to become the "exclusive agent" for all grant applicants in the state.

In a qualified state which fails to live up to this agreement, or in an unqualified state which does not perform its more limited functions, applicants may approach HHS directly for funding.

Advocacy Grants

The Senate bill entered the Conference Committee with a list of rights which it encouraged, but did not require states to provide to mentally ill persons as a condition of funding. It did however require a state wishing to qualify for the higher level of control over federal funds to establish a state-wide mental health advocacy system, resembling the Developmental Disabilities Protection and Advocacy Office. This would have been funded by formula grants of at least $50,000, with a total authorization of $10,000,000.

The Act as it emerged from the Conference Committee retained the Senate's model, non-mandatory "bill of rights," but omitted the requirement that states must have an advocacy system with authority to pursue legal remedies in order to qualify for the higher degree of control over federal funds.

Instead, the Act now permits a state or a state-approved applicant to seek a discretionary grant for advocacy for FY 1982. Thereafter, for the next two years, any public or non-profit private entity may compete for an advocacy grant. This may provide an incentive for states to develop credible advocacy programs during FY 1982.

The Conference Committee also removed the requirement that grants be for a state-wide advocacy system. Although HHS regulations could restore this requirement, the statute alone would permit applications in FY 1983 from, for example, a local legal aid society or a law school legal aid society serving only one hospital or one community.

The Conference Committee not only required applicants to have "authority" to pursue legal remedies, it specified that they must also have the "ability" to pursue those remedies. Again, the significance of this change in language will depend largely on HHS regulations.

The total authorization for advocacy grants remained unchanged at $10,000,000 for FY 1982. Five to ten percent of the amount actually appropriated will be available for advocacy training or technical assistance grants. The states may in addition use formula grant monies under §107 of the Act for "establishing, expanding or operating mental health patients' rights programs." §107 repeals and in some respects replaces §314 (g) of the Public Health Service Act.

Community Mental Health Services

Finally, the Mental Health Systems Act, at least more than its early drafts, preserves the concept of the community mental health center, at the same time that it places new emphasis on services to the chronically mentally ill. While only $30,000,000 is authorized for operations grants to CMHC, most other categories of grants for services to chronically mentally ill persons ($45,000,000), severely mentally disturbed children ($10,000,000), or elderly and other priority populations ($30,000,000) can be obtained only by a CMHC in an area where one exists, unless HHS specifically finds that the CMHC is underserving the particular group targetd by the grant.

Grants under §205 for non-revenue producing activities such as consultation and evaluation ($30,000,000) are available only to CMHCs. Grants for linkages between mental health programs and primary health care facilities ($15,000,000), grants for re-training state hospital employees for community positions ($7,500,000), and prevention grants ($6,000,000) do not give priority to CMHCs. The last two grants are available directly from HHS, and thus applications are not subject to state ranking, rejection, or modification.

In the United States Supreme Court

The United States Supreme Court docket for the October 1980 Term includes a number of cases which could alter the lives of America's mentally disabled citizens.

Cert. Granted

Certiorari was granted in three landmark mental health law which will be argued this term:

• In *Halderman v. Pennhurst*, Nos. 79-1404, 79-1408, 79-145, 79-1489 (*cert. granted* June 9, 1980), the major questions before the Court are: 1) Under the 1975 amendments to the Developmentally Disabled Assistance and Bill of Rights Act, do mentally retarded persons in the custody of the state have a federal statutory right to treatment, non-discriminatory habilitation, and placement in the least restrictive environment? 2) Do the plaintiffs have an implied right of action under the Developmentally Disabled Assistance and Bill of Rights Act or may they bring the suit under the Civil Rights Act, 42 U.S.C. §1983? The Third Circuit held that mentally retarded persons have both a right to treatment and a private right of action in a decision reported at 612 F.2d 84 (3d Cir. 1979)

• On October 8, 1980 the Supreme Court heard *Estelle v. Smith*, No. 79-1127 (*cert. granted* March 17, 1980) in which the questions presented are: 1) Did the prosecution's suprise introduction of a psychiatrist's testimony in the sentencing phase of capital trial on the issue of defendant's future dangerousness require the setting aside of the death sentence on the grounds that it gave defense counsel no opportunity to prepare an effective response to the testimony or to impeach it; 2) May a criminal defendant be compelled to speak to a psychiatrist who may use statements against him at the sentencing hearing? In setting aside the death penalty, the Fifth Circuit answered yes to the first question and no the second.

• *Camenisch v. University of Texas*, No. 80-317 (*cert. granted* Nov. 3, 1980) raises the question: Under §504 of the Rehabilitation Act, 29 U.S.C. §704, must a university receiving state and federal funding procure and compensate an interpreter for a deaf student? The Fifth Circuit distinguished *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), in which the Supreme Court refused to force a college to accept a handicapped applicant, and granted injunctive relief to the plaintiff, in its opinion at 616 F.2d 127 (5th Cir. 1980).

Cert. Denied

• The Supreme Court denied petition of certiorari in *Green v. Bartholomew*, 80-1 (*cert. denied* Oct. 6, 1980). In *Green*, the Second Circuit held that the trial court properly dismissed a ninety-four year old widow's claim that a court-ordered psychriatric examination of her for the purpose of determining whether to appoint a conservator violated her first, thirteenth, and fourteenth Amendment rights.

• In *Rogers v. Frito-Lay*, No. 79-1810 (*cert. denied* Oct. 6, 1980), the Court refused to hear an appeal from the Fifth Circuit's decision that no private right of action was created by Section 503 of the Rehabilitation Act of 1973, 29 U.S.C. §793, which prohibits contractors doing $2,500 or more business with the federal government from discriminating against handicapped employees or job applicants. The opinion below is reported at 611 F.2d 1074 (5th Cir. 1980).

Appeals

• Probable jurisdiction was noted in *Harris v. Wilson*, No. 79-1380 (*prob. juris. noted* May 27, 1980), which asked whether § 1611(e)(1)(A)-(B) Of the Social Security Act, 42 U.S.C. §1382 (e)(17)(A)-(B) violates fifth amendment due process by denying S.S.I. benefits to patients in state mental hospitals between the ages of 21 and 65, who otherwise would be eligible. The lower court said that such an exclusion denied equal protection to mental patients, after determining that "mental health classifications possess many of the significant indicia of suspects classifications" in *Sterling v. Harris*, 478 F. Supp. 1046 1052 (N.D. 111. 1979). The lower court approved a similar exclusion applying to pre-trial detainees.

• Appeal was dismissed in *Bridges v. Virginia Department of Mental Health and Mental Retardation*, No. 80-51 (October 6, 1980). Plantiff-petitioner was challenging a Virginia law that requires the spouse of a person involuntarily confined in a state mental hospital, unlike other state institutions, to pay for the person's maintenance and care.

Pending

Petitions for certiorari were recently filed in three cases which raise questions concerning guardianship, incompetency hearings, and the state's obligation to provide special education.

• In *Radomski v. Knight*, No. 80-325 (*cert. filed* Aug. 28, 1980), the questions before the court are: Does a guardian have standing to bring an annulment action on behalf of his incompetent ward? Under the Maine guardianship statutes, is the marriage of an incompetent ward permitted without the approval of the guardian? The Supreme Judicial Court of Maine held at 414 A.2d 1211 (Me. 1980), that the defendant's marriage to his psychologist may be annulled because it was conducted without the consent of his guardian.

• The questions in *Diglio v. United States*, No. 80-381 (*cert. filed* Sept. 5, 1980) are: 1) in a competency hearing in Federal court, is due process violated if the burden of proof is placed on the defendant to prove a specific organic basis for incompetency rather than on the government? 2) May a defendant be convicted when there is reasonable doubt of competency?

• *Stemple v. Board of Education of Prince George's County*, No. 80-617 (*cert. filed* Oct. 16, 1980) offers the Court the opportunity to decide whether the father of an emotionally and physically handicapped girl who unilaterally removes her from a public school placement and enrolls her in a private school for handicapped children can later seek reimbursement for private tuition costs under §615 of the Education For All Handicapped Children Act of 1975, 20 U.S.C. §1415. The Fourth Circuit said no at 623 F.2d 983 (4th Cir. 1980).

Mental Health Legislation *continued*

The General Assembly did not consider the provision of public guardianship services to indigent wards, mandatory multidisciplinary examinations, or pre-trial guardianship orders, all of which are routinely provided for in a few other states, such as North Carolina.

Pre-Admission Screening

The 1980 General Assembly also adopted the Commission's recommendation that persons seeking or being proposed for admission to state mental health or mental retardation facilities be screened first by community mental health programs.

Truly voluntary admissions under §37.1-65 must be screened and approved by local mental health programs. Mentally retarded persons may not be "certified" as eligible for "voluntary" admission under §37.1-65.1 without local screening and approval. An allegedly mentally ill person who in a civil commitment procedure exercises his right under §37.1-67.2 to admit himself "voluntarily" may not do so without local screening and approval.

The General Assembly did not adopt requirements for local screening and approval for involuntary hospitalization. It did, however, make court-ordered screening an option and required the judge to notify the local mental health program of the name of any defendant within ten days of commitment, §37.1-67.3.

In accordance with a newly amended §37.1-70, the State Board of Mental Health and Mental Retardation must now promulgate rules regarding pre-admission screening.

Other Statutory Changes

The 1980 General Assembly also amended §13.1-543, permitting licensed practitioners of the behavioral sciences to form professional corporations with other licensed practitioners of the behavioral sciences or the healing arts.

* * *

§18.2-3-5 was repealed, removing all criminal penalties for use of hypnosis by any persons. The law was repealed primarily at the request of the state police, who asked for an exception to the law's general prohibition in order to allow its investigative use of hypnosis.

* * *

§22-10.1.1 was enacted to give hearings officers in special education hearings the authority to subpoena witnesses of records.

Supreme Court *continued*

The trial judge had also permitted psychiatric evidence of a mental disturbance at the time of the offense, offered in mitigation, to be used to prove that the defendant "would constitute a continuing serious threat to society," a requirement for the imposition of the death penalty. A psychiatrist called by the Commonwealth testified that the defendant was "a walking, ticking time bomb... there's a strong possibility that he could continue to act in a socially unacceptable manner." A psychiatrist called by the defense said only that the defendant had the "potential" for violent behavior under certain extraordinary circumstances. The Supreme Court found this evidence sufficient to support the trial judge's conclusion that the defendant would present a continuing threat if not executed. *Giarratano v. Commonwealth*, No. 791619 (Va. S. Ct. April 18, 1980).

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A Survey of Pretrial Psychiatric Evaluations In Richmond, Virginia

by Douglas A. Hastings*
and Richard J. Bonnie**

The need for more empirical information on the effect of psychiatric evaluations and testimony in criminal cases has been recognized increasingly in recent years. Nevertheless, the total body of quantitative information in this area remains very small. What little information there is generally focuses on the characteristics and post-acquittal histories of those few defendants found not guilty by reason of insanity because records on such individuals are readily accessible. This study reports the results of a detailed investigation of the disposition of a sample of criminal cases referred for pretrial psychiatric evaluations. The data yield some preliminary findings concerning assessments of competency to stand trial, the use of psychiatric information in the sentencing process, and the adjudication of insanity pleas.

Method

The initial task was to identify a manageable number of cases to be investigated. Previous research at the Institute of Law, Psychiatry, and Public Policy at the University of Virginia included a study of the hospital records of all persons admitted to the forensic units in Virginia's Central State Hospital and Southwestern State Hospital during a one-year period (July 1, 1976-June 30, 1977). There were 1,006 such cases including 813 persons referred for pretrial evaluations, 24 persons committed after being found not guilty by reason of insanity, and 169 persons transferred from correctional facilities. For purposes of the present study, the cases examined were those referred for pretrial forensic evaluations by the courts in the Richmond metropolitan area—i.e., those in the City of Richmond, Henrico County, and Chesterfield County.

Between July 1, 1976 and June 30, 1977, 108 adult defendants were committed to the Central State Hospital Forensic Unit for pretrial forensic evaluation by Richmond area courts. This number apparently represents substantially all—probably not less than 90%—of the adult defendants referred by these courts or by defense attorneys to the mental health system (private or public) for full pretrial evaluations regarding

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Institute Conferences — Spring, 1981

This spring the Institute of Law, Psychiatry and Public Policy will sponsor three public conferences of interest to both lawyers and mental health professionals. Registration information may be obtained from E.L. Marzo, Administrator, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901, telephone (804) 924-5435.

The Social Worker in Court. On April 27, 1981, the Institute, in cooperation with Old Dominion University's Mental Health Programs, will sponsor a workshop in Virginia Beach, Virginia, entitled, "The Social Worker in Court." Instructors include Irv Berkowitz, Ph.D., Michael Dyer, M.S.W., J.D., James Hanagan, J.D., Shelley Post, M.S.W., A.C.S.W., and Willis J. Spaulding, J.D. The registration fee is $35.00.

Public Law 94-142. On May 8, the Institute in cooperation with Old Dominion University's Mental Health Program will present "Public Law 94-142," a seminar on the Education for All Handicapped Children Act. This seminar will be held at the National Center for State Courts, in Williamsburg, Virginia, and is designed for psychologists, lawyers, and special education supervisors. It will be taught by Donald N. Bersoff, J.D., Ph.D., Gary B. Melton, Ph.D., and Willis J. Spaulding, J.D. The registration fee is $42.50.

Sixth International Symposium on Law and Psychiatry. On June 11 through 13, the Institute and the *International Journal of Law and Psychiatry* are co-sponsoring the Sixth International Symposium on Law and Psychiatry. The Symposium will be held at the University of Virginia School of Law in memory of the Institute's founding director, P. Browning Hoffman, M.D. Papers will be presented by Alan Stone, M.D., Gerald Klerman, M.D., John Gunn, M.D., John Monahan, Ph.D., Stephen Morse, J.D., Ph.D., David Musto, M.D., John Petrila, J.D., LL.M., Loren Roth, M.D. and others. The registration fee is $175.00.

competency to stand trial and in some cases mental state at the time of the offense as well.[1]

Information was gathered from three sources: Central State Hospital files, court records, and from direct conversations with attorneys involved in the cases. The court records were studied in the clerk's office at each individual court. Attorneys were contacted by telephone in those cases where matters were not clear from the court record or the case involved interesting issues warranting further investigation.

Findings

Dispositions

Dispositional outcomes in these 108 cases are presented in Table I. The data show that 27% of the defendants were found incompetent to stand trial (IST) at the pre-trial psychiatric examination, were committed to Central State Hospital or another mental institution, and had their criminal charges nolle prossed or dismissed. In another 13% of the cases, the defendants were declared competent to stand trial after a pre-trial psychiatric examination at Central State, but the charges were nolle prossed or dismissed (NP/DISM) upon their return to the court. In 37% of the cases, the defendants were declared competent and pleaded guilty. 15% of the defendants were declared competent and pleaded not guilty on grounds other than insanity. Finally, only 8% of the defendants (9 individuals) referred for pre-trial forensic evaluation pleaded not guilty by reason of insanity (NGRI); most of them (7) did so successfully.

TABLE 1
ALL CASES

Total	108
IST	29 (26.9%)
NP/DISM	14 (13.0%)
Pleaded G	40 (37.0%)
Pleaded NG Found G - 13 Found NG - 3	16 (14.8%)
Pleaded NGRI Found G - 2 Found NGRI - 7	9 (8.3%)

Disposition by Level of Court

When the cases are displayed according to the level of the deciding court, it becomes obvious that all of the adjudications took place in the circuit courts (courts of record) while all findings of incompetency and all but one of the dismissals were in the general district courts (courts not of record). Table 2 shows the results for circuit courts as compared to general district courts.

TABLE 2
ANALYSIS BY TYPE OF COURT

Circuit Court Cases	
Total	53
IST	0
NP/DISM	1 (1.9%)
Pleaded G	27 (50.9%)
Pleaded NG Found G - 13 Found NG - 3	16 (30.2%)
Pleaded NGRI Found G - 2 Found NGRI - 7	9 (17.0%)
General District Court Cases	
Total	55
IST	29 (52.7%)
NP/DISM	13 (23.6%)
Pleaded G	13 (23.6%)
Pleaded NG	0
Pleaded NGRI	0

Disposition by Crime Charged

The reasons for the differences in legal outcomes evident in Table 2 are revealed when these data are analyzed according to the kind of crime charged. All of the crimes involved in these 108 cases can be divided into three basic categories: minor offenses (52 cases), serious violence (20 cases), and serious theft/property crimes (36 cases).[2] Table 3 displays the offense-disposition relationship.

TABLE 3
ANALYSIS BY CRIME CHARGED

Minor Offenses	
Total	52
IST	25 (48.1%)
NP/DISM	12 (23.1%)
Pleaded G	12 (23.1%)
Pleaded NG Found G - 3 Found NG - 0	3 (5.8%)
Pleaded NGRI	0
Serious Violence	
Total	20
IST	0
NP/DISM	1 (5.0%)
Pleaded G	9 (45.0%)
Pleaded NG Found G - 6 Found NG - 1	7 (35.0%)
Pleaded NGRI Found G - 0 Found NGRI - 3	3 (15.0%)
Theft Crimes	
Total	36
IST	4 (11.1%)
NP/DISM	1 (2.8%)
Pleaded G	19 (52.8%)
Pleaded NG Found G - 4 Found NG - 2	6 (16.7%)
Pleaded NGRI Found G - 2 Found NGRI - 4	6 (16.7%)

These data demonstrate that two very different types of defendants are referred for pretrial psychiatric evaluations: (1) clearly disoriented persons charged with minor public order or property offenses, for whom pretrial evaluation is a mechanism for involuntary psychiatric hospitalization; and (2) persons charged with more serious felonies, for whom referral for pretrial psychiatric evaluation is initiated by defense attorneys as part of their exploration of possible psychiatric defenses or psychiatric abnormalities that may be relevant to sentencing. Of all defendants found incompetent to

stand trial, 86.2% were minor offenders. Similarly, 85.7% of all the cases which were nolle prossed or dismissed involved minor offenders.

Another way to view the results is that minor offenders are apparently not referred for psychiatric evaluation unless they are clearly disordered and need hospitalization. Thus, nearly three quarters of the minor offenders either remained hospitalized and were not returned to the court for disposition (48%) or had their cases nolle prossed or dismissed after a period of hospitalization and treatment (23%).

In contrast, no defendants charged with serious violence were determined to be incompetent to stand trial, and only one case was dismissed after a period of psychiatric hospitalization and treatment. Similarly, defendants charged with serious theft crimes infrequently were found incompetent (11%) or had their charges dismissed after returning from Central State (3%).

Finally, it is noteworthy that the insanity plea was never raised in minor cases; if the defendant was found to be competent he ultimately pleaded guilty. Even among the defendants charged with more serious crimes, only 16% actually pleaded not guilty by reason of insanity.

Disposition by Diagnosis

The data indicate that psychiatric diagnosis is related to outcome. The various diagnoses rendered by the Central State forensic unit regarding these defendants were grouped into five categories: functional psychosis (43 cases), major organic impairment, including severe retardation (17 cases), personality disorders (17 cases), alcoholism or drug dependence (17 cases), and transient situational disturbances or no mental disorder (14 cases). Table 4 shows the outcomes of the 108 cases grouped by diagnosis.

TABLE 4
ANALYSIS BY DIAGNOSIS

Functional Psychosis		
Total	43	
IST	23	(53.5%)
NP/DISM	5	(11.6%)
Pleaded G	11	(25.6%)
Pleaded NG Found G - 1 Found NG - 0	1	(2.3%)
Pleaded NGRI Found G - 0 Found NGRI - 3	3	(7.0%)
Major Organic Impairment		
Total	17	
IST	6	(35.3%)
NP/DISM	2	(11.8%)
Pleaded G	4	(23.5%)
Pleaded NG Found G - 2 Found NG - 0	2	(11.8%)
Pleaded NGRI Found G - 0 Found NGRI - 3	3	(17.6%)
Personality Disorders		
Total	17	
IST	0	(0.0%)
NP/DISM	1	(5.9%)
Pleaded G	9	(52.9%)
Pleaded NG Found G - 5 Found NG - 1	6	(35.3%)
Pleaded NGRI Found G - 1 Found NGRI - 0	1	(5.9%)
Alcoholism or Drug Dependence		
Total	17	
IST	0	(0.0%)
NP/DISM	3	(17.6%)
Pleaded G	10	(58.9%)
Pleaded NG Found G - 2 Found NG - 0	2	(11.8%)
Pleaded NGRI Found G - 1 Found NGRI - 1	2	(11.8%)
Situational Disturbance or No Mental Disorder		
Total	14	
IST	0	(0.0%)
NP/DISM	3	(21.4%)
Pleaded G	6	(42.9%)
Pleaded NG Found G - 3 Found NG - 2	5	(35.7%)
Pleaded NGRI	0	(0.0%)

As Table 4 suggests, determinations of incompetence to stand trial and findings of not guilty by reason of insanity are rooted in extreme psychiatric disorders or abnormalities. Of all those defendants found incompetent to stand trial, 79.3% were diagnosed as functionally psychotic, while the remaining 20.7% were organically impaired or profoundly retarded. Of the seven persons in the entire study who successfully pleaded not guilty by reason of insanity, six were out of these two diagnostic categories.

On the other hand, a diagnosis of major mental disorder or serious abnormality did not necessarily preclude a conviction. Of those defendants diagnosed as functionally psychotic, 27.9% were convicted, while 35.3% of those diagnosed as organically impaired were convicted.

Discussion

One objective of this study was to obtain some reliable data regarding the frequency of psychiatric referrals and insanity pleas in criminal cases in Virginia. Recent reports have shown that judges, attorneys, and legislators—not to mention the public as a whole—overestimate the frequency of insanity acquittals.

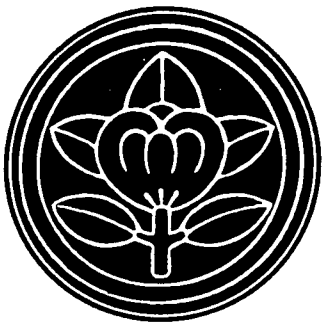
Because of the approach taken in this study, every case (given the limits discussed earlier) involving a referral for pretrial psychiatric evaluation in the study jurisdictions was included, and therefore it is possible to estimate the frequency of these cases as a percentage of all criminal cases in the relevant jurisdictions. During the year under consideration, approximately one percent (0.97%) of all criminal cases in the Richmond area jurisdictions involved referrals to Central State Hospital for psychiatric evaluation.[3] In about one quarter of one percent (0.26%) of all criminal cases,

Continued on page 12

the defendants were found to be incompetent to stand trial and were committed to a mental institution. As was indicated earlier, cases resulting in this disposition virtually always involve persons charged with minor offenses. Clearly, incompetency commitments function as an alternative to either civil commitment or criminal insanity disposition in such cases. Actual insanity pleas occur only in more serious cases. However, this happens rarely. Of the total number of felony cases at the circuit court level, an insanity plea was entered in only 0.67% of the cases with 0.52% of the total resulting in successful NGRI pleas.[4]

Incompetency Determinations

The fact that all determinations of incompetency among those persons referred to Central State were in the district courts and 86% of these defendants were charged with minor crimes suggests that the courts rather routinely process people through to the mental health system where the mental disorder appears to be significant and the crime does not. Moreover, the attorneys interviewed believe strongly that where more serious crimes are involved, state mental health officials are disinclined to find defendants incompetent because there is a great deal more pressure to bring these defendants to justice—i.e., to resolve the matter via the criminal justice system. In cases where the Commonwealth is determined to prosecute, initial findings of incompetence often result in temporary stays by defendants in Central State until they are "restored to competency" and returned to the court. In less serious cases, the defendants are more likely to be committed to Central State indefinitely or have their charges dismissed by the court when they return after a period of psychiatric hospitalization.



Insanity Pleas

Defense attorneys were unanimous in their view that a successful not guilty by reason of insanity plea is possible in only a small number of cases and under unique circumstances. In the first place, other dispositional alternatives are generally considered more attractive for minor offenders—e.g., dismissals, suspended sentences, or jail terms likely to be shorter than any stay in a psychiatric hospital. Thus, only in cases where the defendant faces severe sanctions is the NGRI plea generally considered.

The defense attorneys emphasized that for the most part they do not enter a plea of NGRI unless they have an extremely strong case. Thus, NGRI cases in the jurisdictions studied were rare but usually successful. The data show that only nine such pleas were entered in the period of one year, but that in seven of these cases the defendant was found NGRI. Most of the attorneys interviewed stated that they only make the plea when one of the psychiatrists from the state forensic unit is willing to testify for the defense.

The jury was waived in all but one of the NGRI adjudications investigated. The consensus of the attorneys was that since such defenses are generally only raised when the defense attorney is confident of the psychiatric testimony to be rendered (usually by a state psychiatrist), there is less chance that a judge would reject such testimony than a jury, which is always more unpredictable. (In one of the two cases of unsuccessful NGRI pleas, a private psychiatrist testified for the defense and the defense attorney requested a jury trial.)

Plea Bargaining and Sentencing

According to the attorneys interviewed, psychiatric information definitely plays an important role in plea bargaining, sometimes to reduce the grade of the crime and sometimes to win a favorable sentence recommendation from the prosecution. Several of the cases examined in this study involved defendants who were diagnosed by Central State as having a mental problem of some kind and in need of treatment, but were judged competent to stand trial. Where the defense attorney could work out an arrangement for appropriate and acceptable outpatient care for the defendant, the sentence was often suspended, in whole or in part. In a few cases where the crime was serious and the sentence was not suspended entirely, the defendant was nevertheless sent to a special facility with, for example, an alcohol rehabilitation program rather than to the state penitentiary. Of the 27 circuit court felony cases examined where a guilty plea was entered, the court records showed clearly that in 19 (70%) the psychiatric information had an impact on the sentence that was favorable to the defendant.

The attorneys interviewed stressed that defense counsel must do the legwork to arrange alternative treatment in order for the defendant to receive a favorable sentence. Moreover, clear-cut information, preferably from a state psychiatrist, about the defendant's disorder is necessary. Thus, where an attorney is diligent in obtaining detailed information from Central State through direct contact, he/she may be of significant assistance to the client even if a guilty plea is entered. In some cases, according to some of the attorneys, the defendant is so obviously disordered that despite a finding of no mental illness by the Central State staff, the prosecutor will cooperate in bringing a lesser charge or recommending a suspended sentence, so long as the attorney can arrange proper treatment.

NOTES

1. Cases involving pretrial evaluations where the evaluation was done at a community mental health clinic or by a private psychiatrist are missing from this study. However, informed individuals such as court clerks, attorneys, and Central State staff members estimate that the number of pretrial evaluations taking place in such settings is very small, perhaps only an additional one percent. On the other hand, many defendants about whom there is some question of competence or mental disorder are screened in jail by psychiatrists employed by the court. A significant percentage of these defendants are found to be not seriously disturbed at this stage and pretrial evaluation goes no further. The cases examined herein are those in which the court psychiatrist recommended further evaluation at Central State Hospital.

2. Crimes categorized as minor offenses were: assault, possession/drugs, drunk in public, trespassing, breach of peace, property damage, drugs without prescription, concealed weapon, forgery, worthless checks, shoplifting. Crimes categorized as serious violence were: murder, rape, attempted murder, attempted rape, maiming, and armed robbery. Crimes categorized in the serious theft/property category were: auto theft, grand larceny, burglary, robbery, extortion, breaking and entering with intent to commit larceny, and embezzlement. There were a few cases of arson, and it was decided that these would best be grouped with the serious theft/property crimes.

3. Statistics on the total number of criminal cases were obtained from computer records at the Supreme Court of Virginia in Richmond. The total is based on the number of cases which came before the various general district courts, since essentially all circuit court cases either were appealed from district court or began with a preliminary hearing there.

4. Since all NGRI pleas were adjudicated in circuit courts and since all involved felonies, only total felony statistics in the relevant circuit courts were used to produce these percentages.

In the Virginia General Assembly — 1981

In its short 1981 session the Virginia General Assembly enacted new procedures for authorizing involuntary sterilization, a new procedure for authorizing treatment of physical injury or illness without recourse to guardianship, as well as significant modifications of statutes involving civil commitment, pretrial detention of mentally retarded residents of state facilities, Medicaid fraud, the production of medical records in court proceedings, rape, Alcohol Safety Action Program fees, and other subjects of interest to mental health professionals. Unless otherwise noted these new laws will go into effect July 1, 1981.

New Sterilization Laws

1981 Virginia Laws ch. 454 (S 537), repeals Virginia Code sections 37.1-171.1 and 54.325.3 through 54.325.6, and enacts sections 54.326.01 through 54.326.07. The new law increases procedural protection for mentally incapacitated persons proposed for involuntary sterilization, at the same time as it gives the court particularized criteria on which to base an authorization of such a sterilization.

Virginia's former sterilization law, which last underwent amendment in 1979, called for a circuit court hearing, the purpose of which was to immunize the physician performing the sterilization from civil or criminal liability.

The court, without necessarily hearing from experts or the defendant, could authorize sterilization if it found that certain vague standards were met. Those standards varied depending on whether the defendant had attained the age of twenty-one, an archaism reflecting the former age of majority.

The old criteria for authorizing an involuntary sterilization of a defendant under twenty-one were:

1) the defendant is mentally retarded; and
2) the operation is in the best interest of the defendant.

The criteria for persons over twenty-one were:

1) the defendant is mentally retarded;
2) the operation is in the best interest of the defendant;
3) the operation is also in the best interest of society;
4) the defendant has been adjudicated incompetent.

The new sterilization law creates extensive procedural safeguards to insure a fair and accurate determination of the need of sterilization. The General Assembly also took major strides toward defining what that "need" is.

Examples of the new procedural safeguards are:

1) the petitioner has the burden of showing by clear and convincing evidence that sterilization is needed;
2) a complete and comprehensible medical explanation of sterilization must be given to the defendant, and to the defendant's guardian, spouse or parent;
3) the views of the defendant must be elicited and taken into account to the maximum extent possible;
4) the authorized sterilization may not occur earlier than thirty days after the court's order;
5) the court must obtain independent medical evidence of the medical, sonial and psychological characteristics of the defendant;
6) on the issue of the defendant's ability to properly care for offspring, specific "empirical" evidence must be produced.

The General Assembly also gave the courts elaborate substantive guidelines to follow in deciding when to authorize an involuntary sterilization. Now to authorize such a sterilization of anyone eighteen years of age or older the judge must find:

1) the defendant has been adjudicated incompetent or incapacitated for the purposes of consenting to sterilization and is unlikely to develop the ability to give consent in the near future;
2) the defendant is engaged or will soon be engaged in sexual activity that a competent person would not intend to result in pregnancy;
3) there is no alternative method of contraception to sterilization;
4) the proposed sterilization procedure conforms to standard medical practice and does not present an unreasonable risk to the defendant;
5) the defendant's mental disability is of such severity as to render him or her permanently incapable of caring for and raising a child.

Nearly the same standards are used when the defendant is a minor age fourteen or older. Instead of a formal adjudication of incompetency or incapacity, the judge need only find that the minor defendant is too impaired to make an informed decision regarding sterilization and is unlikely to develop an ability to make such a decision in the near future.

The court may not authorize sterilization of a minor under age fourteen. Notwithstanding this limitation, and, for that matter, the other safeguards in this law, the General Assembly retained a provision which allows physicians to sterilize without court approval patients of any age for "sound therapeutic reasons."

While the General Assembly in 1979 removed the last explicit references to heredity from what was once primarily a eugenic sterilization statute, aimed at protecting society from the "inferior" offspring of mentally impaired persons, the "best interest" standard was vague enough to permit eugenic considerations to continue to influence judges asked to authorize a sterilization.

The new standards may be seen as defining a sterilization decision in the best interest of the defendant as that decision which the defendant would make if he or she were not mentally impaired. In this sense the statute may be defended as providing roughly the same access to a medical service, available to, if only rarely sought by, adults who are not mentally impaired. Since Virginia law does not give non-impaired minors access to voluntary sterilization, it is hard to see why on this rationale impaired minors age fourteen or older ought to have it on an involuntary basis.

The courts will also continue to consider the best interest of society, but that interest has been narrowed to one of preventing the birth of a child whom the defendant cannot properly care for rather than a child who is genetically "inferior." Nonetheless, this rationale for sterilization is likely to generate more controversy because of the penalty it imposes on persons who are predicted to be poor parents, only if they are also mentally impaired, and because of the inherent difficulty in defining what constitutes poor parenting. This criterion could also divert the court's attention from more legitimate concerns such as the defendant's capacity, availability of alternative forms of contraception, and the like.

Virginia's involuntary sterilization laws gained global notoriety when they withstood constitutional challenge

Continued on page 20

Informal Authorization of Medical Treatment

1981 Virginia Laws ch. 141 (S 717), enacts section 37.1-134.2, allowing circuit court judges, general district court judges, and special justices to authorize necessary medical treatment of adults incapable of giving informed consent, without recourse to statutory guardianship or involuntary protective services procedures. The informality of this new law is in striking contrast with last year's amendments to the guardianship law. See 1 *Developments in Mental Health Law* 5 (1981).

Because both the guardianship and involuntary protective services procedures were perceived by some hospitals as too time-consuming, they had in recent years instead initiated civil commitment proceedings against patients whose capacity to give informed consent was doubted, and then provided treatment under the authority of section 37.1-67.4, prior to any hearing. Because the civil commitment process should be directed only against mentally ill individuals in need of mental hospitalization and because community mental health programs in Virginia have in the last year become more active in preventing the inappropriate invocation of that process, this method of obtaining authority for the medical treatment of persons incapable of giving consent has become less attractive to hospitals.

The new law, section 37.1-134.2, may be used to authorize treatment where the patient is shown "because of advanced age, impaired health, physical disability, mental illness, mental retardation, or any other mental or physical condition, to be incapable, either mentally or physically, of giving informed consent to treatment."

There are no limitations on the kind or duration of treatment which may be authorized in this manner, except that the treatment must be "medically necessary," and may not consist of nontherapeutic sterilization, abortion, or mental health care. Indeed, the court may authorize in a general way not only a specific treatment, but all unspecified "related treatment" that the physician may find medically necessary.

While the court must appoint an attorney to represent the patient, all evidence may be submitted by affidavit, unless an objection is made, and the patient is given no explicit right to be present at the hearing. Both the petition for authorization and the order may be oral, as long as a written order is "subsequently" entered.

No emergency need be alleged or demonstrated to use this process and thereby avoid the many procedural safeguards present in the guardianship law, sections 37.1-128.01 *et seq.*, or the involuntary protective services law, sections 63.1-55.2 *et seq.* If, as will now become unlikely, a guardian has been appointed under either of those laws, the new process may not be used. But where there is no guardian and the court finds the patient incapable of consenting to treatment, it will not appoint, as these other laws would, a guardian who on behalf of the patient can give or withhold consent, according to the guardian's determination of what is in the patient's best interests. Instead, the medical treatment will proceed in effect without consent. The incapacitated patient's best interests will be protected only by the finding that the treatment is "medically necessary."

If treatment is authorized in this way, the health care providers cannot be later held liable for failure to obtain informed consent. If the authorization is refused, based on a finding that the patient was capable of giving informed consent, and the treatment is rendered with the patient's purported consent, the health care providers cannot be held liable on a theory that the patient was incapable of giving consent. The second consequence of this procedure is questionable since the refusal of an authorization usually will mean only that the petitioner has failed to meet his burden of showing by clear and convincing evidence a lack of capacity, not that someone has proven the patient to be capable of giving informed consent.

The petition may be brought in the general district court or the circuit court. If a general district court authorizes treatment, the patient has ten days to seek an appeal *de novo* in the circuit court. The patient has ten days from an adverse circuit court decision to appeal to the Supreme Court, apparently as a matter of right. The statute fails to either authorize or enjoin treatment during the pendency of an appeal.

Under section 37.1-134.2 a special justice may authorize treatment, although no provision is made here or under section 37.1-89 for the payment of the special justice. Attorneys appointed to represent patients may receive any fee the court "may determine." These fees are to be paid out of appropriations for civil commitment procedures, now administered by the Supreme Court. This suggests that the General Assembly believed that civil commitment rather than guardianship or involuntary protective services was being used to obtain authorization for medical treatment in most instances where the new statute would be used.

Despite the intensive study and careful revision Virginia's guardianship laws have received in recent years, section 37.1-134.2, which obviates the need for a guardian of the person in most cases, was passed with only limited discussion on language in the original bill which authorized hearings conducted over the telephone, which was deleted, and the need for an express exclusion of nontherapeutic sterilization from the treatments authorized, which was added.

Civil Commitment

1981 Virginia Laws ch. 463 (S 785), made two changes in the procedure by which mentally ill persons may be involuntarily hospitalized in Virginia. This procedure presently consists of three basic stages. Initially a petition for the temporary detention of a person alleged to be mentally ill and in need of hospitalization is presented to a judge, who may then order the arrest and detention of that person for a period no longer than forty-eight hours, or if that period expires on a weekend or holiday, seventy-two hours. The second stage consists of a preliminary hearing in which the defendant is allowed to enter the hospital on a voluntary basis for a minimum period of time, if the judge determines that the defendant is both willing and able to consent to do so. If the defendant is either unwilling or unable to consent to voluntary admission, the third stage of commitment, the involuntary commitment hearing, occurs. At the commitment hearing the judge decides whether the criteria for commitment are met, and may order involuntary hospitalization for a period of 180 days or less.

Ch. 463 amends section 37.1-67.1 to allow the initial petition for temporary detention to be submitted to not only a judge, but to a magistrate as well. Unlike the judge, however, the magistrate may order temporary detention only "upon the advice of a person skilled in the diagnosis or treatment of mental illness." This person, who need not be a physician, will probably be on the staff of a community mental health program assigned to screening petitions for commitment.

Ch. 463 also requires the chief judge of every general district court to assure that either a judge or a magistrate is available at all times to consider petitions for temporary detention. Presumably this would not have been practical without expanding the authority of magistrates.

Although magistrates in Virginia often have no legal training, they may be in a better position to make independent and informed decisions on the need for temporary detention, particularly insofar as they act only upon the advice of a community mental health professional. The past practice has been to use special

justices to issue temporary detention orders. These special justices are lawyers appointed to act in civil commitments and related proceedings, and paid only for the hearings at which they preside. Thus they receive no remuneration for considering a petition for temporary detention, except when the petition is granted and a hearing held.

A related act, 1981 Virginia Laws ch. 233 (H 1384), amends section 37.1-67.4 to allow the preliminary hearing and involuntary commitment hearing to be held in the jurisdiction where the patient is being detained temporarily, before a judge other than the one who issued the temporary detention order. This has been the practice in some areas without psychiatric facilities, where the defendant would be picked up on a temporary detention order and transported to a distant state hospital pending a hearing. The hearing would then be held on the hospital campus before a judge from that area. The alternative of transporting the patient back to his or her home jurisdiction for a hearing and then back to the hospital was viewed as expensive to the state and stressful to the patient, although witnesses and evidence of community alternatives to hospitalization would be more available.

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Pretrial Detention of MR Residents

1981 Virginia Laws ch. 528 (H 1322), amends section 19.2-123 of the Virginia Code to allow residents of a state mental retardation facility charged with a criminal offense to be placed in the custody of the director of that facility pending trial. This act addressed a problem which arose from the practice of charging residents who committed what might be criminal acts against the staff or other residents and letting the courts determine whether the residents were competent to stand trial or criminally responsible. These mentally retarded defendants, usually found incompetent to stand trial, were being held initially in local jails and subjected to abuse at the hands of other prisoners.

Group Home Zoning

1981 Virginia Laws ch. 611 (H 252) amends section 15.1-486.2 of the Code of Virginia which requires local zoning ordinances to permit the use of group homes.

Previously the statute served primarily to announce a general state policy encouraging the use of group homes in "normal residential surroundings" for mentally retarded individuals, as long as the group homes were properly dispersed through the state. This policy was implemented only by requiring that local zoning ordinances permit group homes in "appropriate residential zoning districts." These local ordinances could impose on group homes in these districts conditions not required of other dwellings in that district, both to protect the residents of the group home and assure the "compatibility" of the group homes with the other dwellings.

An attempt to amend this statute to require that local zoning ordinances permit group homes in a single-family district, surely the most "normal" residential district, was defeated. The statute was however amended to extend what little protection it provides to mentally ill and physically handicapped individuals who wish to reside in group homes, as well as mentally retarded and developmentally disabled individuals.

Medicaid Fraud

With the enactment of 1981 Virginia Laws ch. 255 (H 756), the General Assembly greatly expanded the definition of Medicaid fraud and gave the Attorney General sweeping authority to audit and inspect the medical records of Medicaid patients and to compel anyone to answer any "legal and pertinent question, or to produce a book or paper or other evidence" connected with an audit or inspection. See new sections 32.1-310 *et seq.*

In addition to criminal sanctions, the new law exposes a person violating any of its many provisions to civil penalties of "not to exceed three times the amount of such excess benefits or payments."

Both common law and statutory confidentiality of patient records are impaired by this new law. The patient and the provider seeking Medicaid reimbursement are deemed by section 32.1-310 to have authorized the Attorney General and certain employees of the Department of Health "to inspect and audit all records in connection with the providing of such services." Section 32.1-320 further exempts records generated from Medicaid-funded services from the Virginia Privacy Protection Act of 1976, section 2.1-377 *et seq.*, or "any other statute which makes or purports to make such records privileged or confidential."

The new law does prohibit the Attorney General from disclosing medical information thus obtained except where the "disclosure is directly to the official purpose" for which it was obtained. It also prevents the use of records in any legal proceeding without the patient's "waiver of the applicable evidentiary privilege." This, however, offers little assurance of privacy to the patient in light of the breadth of the Attorney General's official purpose and the narrowness of Virginia's physician-patient privilege contained in section 8.01-399.

Production of Medical Records

1981 Virginia Laws ch. 457 (S 654) makes seven major changes in section 8.10-413 of the Code of Virginia. This section formerly functioned only to make copies of medical records admissible as evidence on the same basis as the original and to give patients and their attorneys a right to inspect, by subpoena if necessary, their medical records. Now, in addition, this statute provides that:

1) a health care provider whose records are subpoenaed for a trial may respond by mailing to the clerk of the court an authenticated copy of the records;

2) the court may then order, after notice to the health care provider, production of the original, if the copy is not sufficiently legible;

3) the party requesting the subpoena is liable for the reasonable cost of copying and mailing the records;

4) when an attorney asks to inspect or copy his or her client's records the health care provider may insist on seeing written authorization from the client;

5) where the patient is deceased or believed by his or her treating physician to be mentally or physically incapable of giving consent to release of his or her records, certain persons, and in a certain order (e.g., personal representative, guardian, or spouse), have a right of access to the records without consent;

6) the statute now seems to apply to all health care providers and not just to physicians and hospitals;

7) the statute purports to apply to health care providers outside the state, "if the records pertain to any patient who is a party to a cause of action in any court in the Commonwealth of Virginia."

Criminal Sexual Assault

The long fought for reform of Virginia's rape laws finally occurred this year when the General Assembly enacted 1981 Virginia Laws ch. 397 (S 258), defining and proscribing not only rape, but such other forms of criminal sexual assault as forcible sodomy, inanimate object sexual penetration, and sexual battery.

Previously the state was required to prove that the rape was against the will of the victim, by force. The new criminal sexual assault laws now require only that state show that the rape, or other sexual offense, be against the will of the victim, "by force, threat or intimidation, or through the use of the complaining witnesses mental incapacity or physical helplessness." See, e.g., section 18.2-67.1.

"Mental incapacity" is defined by the Code now as "that condition of the complaining witness existing at the time of an offense under this article which prevents the complaining witness from understanding the nature or consequences of the sexual act involved in such offense and about which the accused knew or should have known." Unconsciousness is included in the definition of "physical helplessness." See section 18.2-67.10.

While this definition of mental incapacity clearly could encompass mental retardation and some mental illnesses, it may also include intoxication. The proof of a lack of understanding will in any event be difficult in all but the most extreme forms of mental impairment.

Ch. 397 also repeals section 18.2-64, which made sexual intercourse with any female patient or resident in, on leave from, or escaped from a state mental health or mental retardation facility statutory rape, regardless of the mental condition of the victim, or even the fact that she was married to the defendant. This law interfered with the rights of patients and residents to social interaction and was probably unnecessary in light of the redefinition of criminal sexual assault.

Waivers of ASAP Fees

1981 Virginia Law ch. 195 (S 546) amends section 18.2-271.1 to allow a person charged with driving under the influence of alcohol to enter an Alcohol Safety Action Program (ASAP) without payment of all or any of the hitherto mandatory $200.00 fee, "upon a positive finding that the defendant is indigent." Successful completion of ASAP counselling, or any other alcohol rehabilitation or education program the court allows the defendant to enter prior to sentencing, usually results in conviction on a lesser charge, such as that of careless driving.

Minimum Drinking Age

1981 Virginia Laws ch. 24 (H 188), raised the minimum age for off-premises consumption of beer from 18 to 19. Eighteen year olds may still drink beer on the premises of a licensed restaurant or other establishment. The purpose of the amendment was to prevent a "spillover" of drinking among minors who might go to school or have other social contacts with eighteen year olds willing to purchase beer for them. One effect of the new law will be to place eighteen year old Virginians in the unique position of being permitted to drink beer in a bar but not to purchase it in a grocery store. See sections 4-37 *et seq.*

Other Legislation of Interest

Also enacted in the 1981 General Assembly session were the following provisions: repeal of state sovereign immunity from claims up to $25,000 for injury caused by state employees (ch. 449); creation of a Corrections Supervision Fund, with required payments from prisoners and ex-offenders who are on probation, work-release or parole, but exempting those people physically or mentally incapable of working (ch. 634); reduction of the contribution to be made by parents with incomes over $25,000 whose children receive state-supported treatment for phenylketonuria (ch. 164); and creation of a complete hearing assessment program for handicapped children (ch. 7).

Licensure of a number of professional regulatory boards, including social workers, psychologists and professional counselors saw some minor changes (ch. 447), and the definitions of social work methods and principles were updated (ch. 555). Also amended were licensure standards for homes for adults and child welfare agencies, authorizing conditional licenses for only up to six months, in most cases, when full licensure is denied (ch. 222). In addition, adult home administrators must now consider the ability of non-ambulatory residents to exit a home in an emergency before approving admission (ch.275).

In the United States Supreme Court

Decided

• On March 3, 1981, the Supreme Court divided 5-4 over the question of whether the Social Security Act violated the equal protection obligation of the fifth amendment's due process clause by denying Supplemental Security Income (S.S.I.) benefits to otherwise eligible patients in state mental hospitals between the ages of 21 and 65. *Schweiker v. Wilson*, 49 U.S.L.W. 4207 (March 3, 1981). *See* 1 *Developments in Mental Health Law* 7 (1981).

§1611(e) (1) (A)-(B) of the Social Security Act, 42 U.S.C. §1382 (e) (1) (A)-(B) generally excludes patients in state mental hospitals from S.S.I. benefits, but does allow some patients to receive a reduced benefit of about $25.00 a month, provided their treatment is being paid for by Medicaid under Title XIX of the Social Security Act. §1905(a)1 of the Social Security Act, 42 U.S.C. §1396d(a)(1), in turn prohibits Medicaid payments to patients in public mental hospitals age 21 or older and under age 65. Thus patients in public mental hospitals are ineligible for reduced S.S.I. benefits if they are age 21 or older and under age 65.

The lower court viewed this as discrimination against persons on the basis of mental illness. *Sterling v. Harris*, 478 F. Supp.. 1046 (N.D. Ill. 1979). Since the lower court thought that mental health classifications had some of the characteristics of a suspect classification such as race, it required the government to show more than just a rational basis for the denial of S.S.I. benefits to some mental patients. Instead the district court required the legislative scheme to display a "substantial relation" to the primary purpose of S.S.I. Under this intermediate level of judicial scrutiny, the denial of benefits was found unconstitutional.

Justice Blackmun, writing for the majority, found it unnecessary to say whether mental health classifications were suspect, and subject to heightened judicial scrutiny. The denial of benefits turned upon, in his opinion, residence in a public institution, not mental illness. Many persons not mentally ill were also denied benefits, such as prisoners and tuberculosis patients. And many mentally ill persons received benefits after discharge, or if they were under age 21 or age 65 or older, while they were in the hospital.

Applying the usual "rational basis" test, Justice Blackmun first looked at the denial of Medicaid to some mental patients. He concluded that Congress legitimately and intentionally refused to allocate scarce federal resources to treatment in public mental hospitals which it viewed as a "traditional" responsibility of the states. 49 U.S.L.W. 4211.

Justice Blackmun, while admitting that the legislative history did not disclose readily why Congress used the Medicaid classification to decide who would receive S.S.I. benefits, reasoned that Congress legitimately could decide to deny benefits to persons receiving treatment at state expense, and give benefits only to persons receiving federally supported treatment.

Justice Powell, joined by Justices Brennan, Marshall, and Stevens, found the classification irrational. There was no reason to believe that just because the state was receiving no federal support for a patient, it would be more likely to give that patient a comfort money allowance. Whatever the merits the Medicaid classification might have, they could not be transferred to the S.S.I. classification.

Because Justice Powell found that the statute could not pass the "rational basis" test, it was unnecessary for him to determine whether it was based on a suspect classification and therefore subject to a stricter test. He did intimate, however, that the denial of benefits was based, perhaps inadvertently, on a mental health classification.

• As *Developments in Mental Health Law* was going to press, the Supreme Court substantially reversed the Third Circuit Court of Appeals' holding in *Penhurst State School and Hospital v. Halderman*, Nos. 79-1404, 79-1414, 79-1415, 79-1489.

Continued on page 18

Petition for Certiorari Denied

• On February 23, 1981, the Supreme Court denied petition for certiorari in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, No. 80-930, an action which arose because of Blue Shield's policy of only paying for clinical psychologists' services when they are billed through a physician. The Fourth Circuit Court of Appeals had held that this policy was a restraint of trade in violation of §1 of the Sherman Act since it forced two independent economic entities, psychologists and psychiatrists, to act as one with the necessary result of diminished competition in the health care field. 624 F. 2d 476 (4th Cir. 1980).

• On January 12, 1981, the Supreme Court denied petition for certiorari in *Concerned Parents and Citizens for the Continuing Education of Malcolm X v. New York City Board of Education*, No. 85-535, in which the Second Circuit Court of Appeals had held that the transfer of a handicapped child to a similar program in a different school did not trigger due process protection under the Education of All Handicapped Children Act, 20 U.S.C. §§1401 et seq. (1975).

• The Supreme Court also denied petition for certiorari in *Kimpel v. Illinois*, No. 80-302, on January 12, 1981. The Illinois Court of Appeals, Third District, had held below that twenty-year old psychological evaluations of a murder defendant could be properly considered by the sentencing judge. The court said that error, if any, caused by receipt of the reports was harmless. 78 Ill. App. 3d 929, 35 Ill. Dec. 254, 297 N.E. 2d 626 (1979). *See* also *Ochs v. U.S.*, No. 80-1534 (*cert. filed* March 9, 1981), in which a similar question is raised concerning the use of outdated psychological material in sentencing.

• Petition for certiorari was denied in *Greich v. Pittsburgh National Bank* No 80-1206 on March 23, 1981. The case involved a court-appointed guardian who made payments from a ward's veteran's benefits to the state for his institutional care and maintenance pursuant to a court order and with the consent of the Veteran's Administration. The Pennsylvania Supreme Court had held that absent fraud the guardian could not be held individually liable for the ward's institutionalization costs.

Argued Before the Supreme Court

• In a rare two hour oral argument on December 8, 1980, counsel for Pennsylvania and counsel for the retarded patients residing in Pennhurst State School and Hospital debated whether the Developmentally Disabled Assistance and Bill of Rights Act established a right to individually determined habilitation in an appropriate, least restrictive environment. Counsel for Pennsylvania contended that the Act is simply a statement of federal policy to be encouraged through federal funding under the statute. *Pennhurst State School and Hospital v. Halderman*, Nos. 79-1404, 79-1414, 79-1415, 79-1489. *See* 1 *Developments in Mental Health Law* 7 (Jan. 1, 1981).

• On March 31, 1981, the Supreme Court heard argument in *Camenisch v. University of Texas*, No. 80-317. *See* 1 *Developments in Mental Health Law* 7.

Petition for Certiorari Filed

• In *Board of Education of Hendrick Hudson Central School District v. Rowley*, No. 80-1002 (*cert. filed* Dec. 15, 1980), the question before the Court is whether the "appropriate public education" requirement of the Education for All Handicapped Children Act entitles a deaf public school student to the services of a sign language interpreter in the classroom. Emphasizing the narrow scope of its holding, the Second Circuit Court of Appeals found that a deaf child, who was provided with an individualized educational program by her school district, was further entitled to a sign language interpreter so that one hundred percent of what transpires in the classroom is accessible to her.

• The question before the Court in *Matthews v. Oregon*, No. 80-874 (*cert. filed* Dec. 1, 1980) is whether an alleged mentally ill person has a right under the Fifth and Fourteenth Amendments to remain silent in an involuntary civil commitment proceeding. The Oregon Court of Appeals held that the Constitution grants no such rights. 46 Or. App. 757 (1980).

• In *Scanlon v. Battle*, No. 80-827 (*cert. filed* Nov. 20, 1980), the Court can consider whether Pennsylvania's refusal to provide handicapped children more days of education than are provided to non-handicapped children violates the Education for All Handicapped Children Act. The Third Circuit Court of Appeals held that Pennsylvania's 180-day annual limit on public education provided to any child precluded formulation of reasonable individualized educational programs for the mentally retarded and emotionally disturbed children as required under the Act.

• On February 23, 1981, petition for certiorari was filed in *Youngberg v. Romeo*, No. 80-1429. In a suit brought under 42 U.S.C. §1983, the Third Circuit Court of Appeals held en banc that an involuntarily committed retarded patient had rights to freedom from bodily restraints, to personal security, and to adequate treatment, rights which were violated when he was shackled and when he was injured by himself, other patients, and possibly hospital staff on over seventy occasions.

• In *Dahl v. Akin*, No. 80-1325 (*cert. filed* February 5, 1981), the question before the Court is whether a daughter's abuse of State Court process by falsely representing her father's men-

Continued on page 19

tal capacity in order to be appointed his guardian and to commit him to a mental hospital constitutes conduct "under the color of state law" and thus gives rise to a cause of action under 42 U.S.C. §1983. The First Circuit held that it did not.

In the Fourth Circuit Court of Appeals

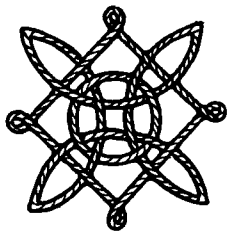
• The Fourth Circuit Court of Appeals affirmed dismissal of an action brought under 42 U.S.C. §1983 against the judge who ordered plaintiff's involuntary commitment to a state hospital, the doctor who under court order examined plaintiff, and the state-appointed attorney who represented him. While the district court had dismissed the action on the ground of immunity, the Fourth Circuit affirmed on grounds of no state action. *Hall v. Quillen*, 631 F. 2d 1154 (4th Cir. 1980).

• The Fourth Circuit also held that the U.S. District Court for the Eastern District of Virginia properly declined to exercise jurisdiction over an action brought by the parents of a handicapped child involving a controversy regarding her education under the Education of All Handicapped Children Act. The court found no justif ication for a federal action since state proceedings were taking place under an identical Virginia statute. *Scruggs v. Campbell*, 630 F. 2d 237 (4th Cir. 1980).

In the Virginia Supreme Court

• The Virginia Supreme Court held that a trial court can require a defendant who intends to present an insanity defense to be examined by a psychiatric committee over the defendant's objections. The court held that such an examination is necessary in order that the Commonwealth may have the examiners available as rebuttal witnesses. Although the court found no express statutory authorization for a compelled psychiatric evaluation, it concluded that psychiatric examinations authorized by Virginia Code §19.2-169 to determine whether a person charged with a crime is mentally competent to stand trial may also consider the question of mental state at the time of the alleged offense. *Shifflett v. Commonwealth*, 221 Va. ____ (1981).

• Virginia Blue Cross and Blue Shield must pay for the service of clinical psychologists. In a case related to *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia* (*see* "In the United State Supreme Court" elsewhere in this issue), the Virginia Supreme Court upheld the State Corporation Commission and found that §38.1-824 of the Virginia Code, which requires payments to optometrists, opticians and psychologists under prepaid medical plans, is constitutional. The court did agree with Blue Cross that the statute was discriminatory in requiring Blue Cross to make such payments between 1973 and 1979 when commercial group insurance companies were not under a similar obligation. *Blue Cross v. Commonwealth*, 221 Va. 249 (1980).



• In a decision of significance to anyone with a relative receiving treatment or habilitation in a state mental health or mental retardation facility, the Virginia Supreme Court held that the state Department of Mental Health and Mental Retardation was entitled to full reimbursement of the actual per diem cost of treatment of a former patient, despite an earlier agreement it had made with the daughter of the patient to accept the railroad retirement benefits of the patient in satisfaction of his monthly charges. The court said that neither the daughter, who was the representative payee of the retirement benefits but who was not the patient's guardian, nor the Department's reimbursement field representative had the authority to enter into a binding compromise of the state's claim for full reimbursement. The court interpreted section 37.1-109 of the Virginia Code, under which the agreement to accept partial payment had been made, as allowing the Department to retroactively modify those agreements. Other statutes had the effect of compelling the Department to ignore the agreement and seek full reimbursement for up to five years of care from the estate of the patient when he died, because collection would no longer create a hardship for the patient or his dependents. Although the state may have led the daughter to believe that she had entered into a valid compromise, sovereign immunity prevented the application of the doctrine of equitable estoppel. *Commonwealth v. Sheriff of Nottoway*, 211 Va. 306 (1980).

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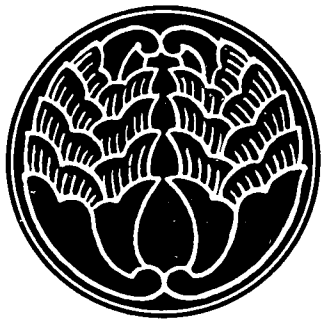
Virginia General Assembly-Civil Commitment

Continued

Finally, 1981 Virginia Laws ch. 475 (H 1121), amends section 16.1-241 to allow juvenile and domestic relations court judges to preside over the commitment and certification of mentally ill and mentally retarded adults. Such proceedings may still be heard by general district court judges and special justices, and may be appealed *de novo* to circuit court judges. The juvenile and domestic relations district court judges retain exclusive original jurisdiction over the commitment and certification of children, which in Virginia otherwise proceeds in the same manner as the commitment and certification of adults.

The use of juvenile and domestic relations district court judges in the commitment of adults seems generally consistent with their responsibility for intra-familial criminal offenses, which may often resemble the crises that provoke commitment petitions. This amendment also increases the pool of judges available at night and on the weekends and holidays when these crises often occur.



In the Virginia Supreme Court

Continued

• In *Thomason v. Carlton*, 221 Va. ____ (1981), the Virginia Supreme Court overturned a jury's determination that a decedent had lacked testamentary capacity because of old age and the effects of a stroke. A majority of the court relied upon testimony to the contrary by witnesses who were present at the signing of the will. Two members of the court dissented on the grounds that there had been credible evidence to support the jury's verdict.

Virginia General Assembly-Sterilization

Continued

Buck v. Bell, 274 U.S. 200 (1927), and later were cited in support of some Nuremberg defendants. The original statute, directed primarily at the person institutionalized in state mental retardation facilities, resulted in the involuntary sterilization of over 8,300 persons before 1972, when it was substantially changed. Under this statute the sterilization of someone in an institution was authorized through an administrative hearing within the facility which could be appealed *de novo* to a court, but rarely was.

Claiming a denial of due process on behalf of Virginians involuntarily sterilized prior to 1972 under this procedure, the American Civil Liberties Union of Virginia recently filed a complaint in federal court, styled *Poe v. Lynchburg Training School and Hospital*, No. 80-0172-L (W.D. Va., filed Dec. 29, 1980.) While this complaint raises some interesting issues, such as the effect of the statute of limitations, it is unlikely to have any effect on the new involuntary sterilization law in Virginia.

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