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Developments in
Mental Health Law
Institute of Law, Psychiatry and Public Policy The University of Virginia

A survey of providers of treatment to sex offenders in Virginia

by Karen F. Carr

For the past year, staff in the Office of Forensic Services, Department of Mental Health, Mental Retardation, and Substance Abuse services have been assembling a directory of mental health professionals treating sex offenders in the state of Virginia. The purpose of this directory was to facilitate networking and to obtain an estimate of the number of mental health providers treating sex offenders in Virginia. The common perception was that the demand for treatment was high, but the number of providers low. Agencies providing this type of treatment were identified from numerous sources including the Sex Offender Planning Action Committee (SOPAC), a national network called Safer Society Press, and other clinicians. A total of 43 agencies treating sex offenders within Virginia were identified. Each of these agencies was sent a survey which assessed four areas: the relationship with the courts, screening methods, the type of treatment being provided, and measurement of treatment efficacy.

General Findings

Of the 43 surveys sent, 34 (80%) were returned. Of the 34 responding agencies, 23 (68%) were private agencies and 11 (32%) were public agencies. This was in contrast to our perception that primarily public agencies were treating sex offenders. Eighty clinicians were identified as directly providing treatment to the 1,019 sex offenders currently accounted for in the returned surveys. Of the 1,019 sex offenders being treated, 769 (75%) were adults and 250 (25%) were juveniles. All types of sex offenders were represented in the sample with 33 agencies treating pedophiles or child molesters, 26 agencies treating paraphilias and 18 agencies treating rapists. Fourteen agencies reported that they treat all types of sex offenders. Finally, 30 (80%) of the agencies stated that they also treat victims of sexual abuse. (See figure 1)

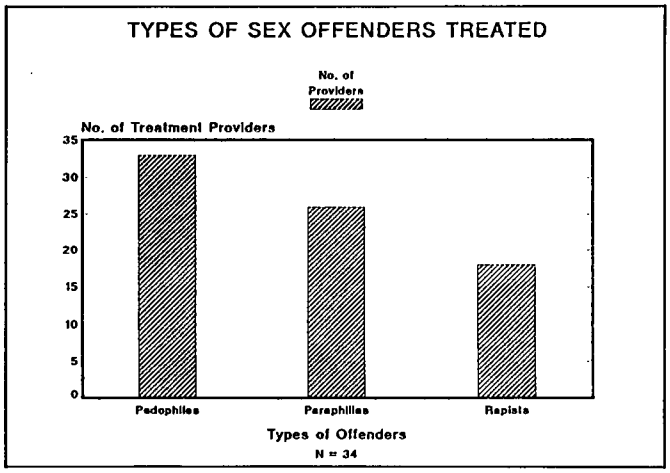

FIGURE 1

Relationship with the Courts

Sex offenders are a unique subset of clients in that they have committed a crime, but may be seen as needing treatment rather than incarceration. Courts frequently order a sex offender into treatment without having had the benefit of receiving a presentence evaluation from a mental health professional. Sex offenders may be in active denial and very poorly motivated to engage in or to make progress in treatment. They may attend treatment sessions due to the extrinsic motivation of a prison sentence which has been suspended, but intrinsic

Also in this issue:

Karen F. Carr, Ph.D., is a Forensic Psychology Fellow at the Institute of Law, Psychiatry, and Public Policy.

motivations to be honest, forthcoming, and cooperative with the treatment provider are often lacking. For this reason, a working relationship with the court system is a crucial aspect in developing an effective treatment plan for the sex offender.

Results of the survey confirmed that the large majority of sex offenders have not been evaluated for their amenability to treatment prior to being court ordered to treatment. Of the 1,019 sex offenders, only 273 (28%) were referred for presentencing evaluations prior to treatment. The majority of offenders (77%) were in treatment as the result of a court order with only 236 (23%) entering treatment voluntarily.

All 34 agencies reported that they had the ability to send offenders back to the court if they were non-compliant with treatment. Agencies used a wide variety of methods to insure cooperation with treatment including communication with the judge, communication with probation or social services, contact with family members, and treatment mechanisms such as contingency contracts. (See figure 2)

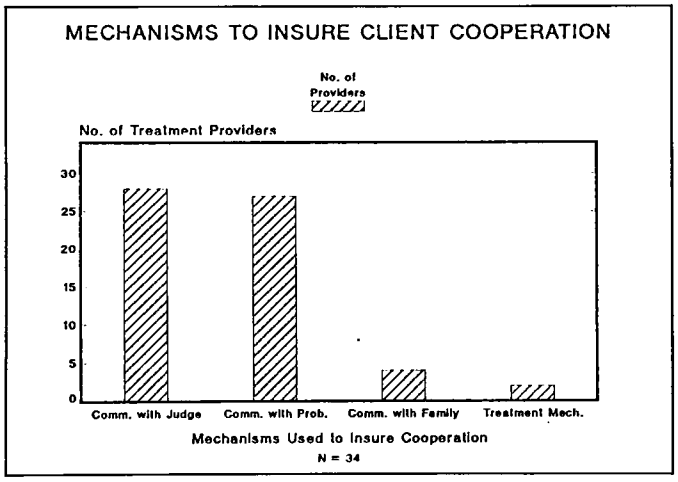

FIGURE 2

Treatment Techniques

When identifying treatment techniques, we asked agencies to report their theoretical orientations and treatment modalities. We did not ask for detailed descriptions of techniques and therefore cannot be certain of the exact methods being used by each agency. Controversy exists as to which treatment methods are most effective with sex offenders. Therefore, we surveyed what treatment approaches are most commonly used, but not necessarily what may be most effective.

Treatment providers primarily reported a cognitive-behavioral or educational model of treatment. Also common was the relapse prevention model. A smaller percentage utilized family/systems and psychodynamic methods. Most agencies reported using a combination of methods with 13 out of 34 using both cognitive-behavioral and relapse prevention. (See figure 3)

Individual therapy was the most common treatment modality (29 agencies), with group therapy being used

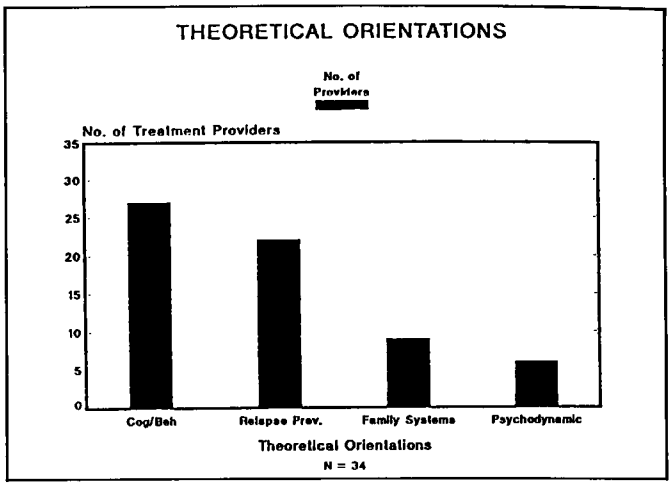

FIGURE 3

by 26 agencies and family therapy offered by 23 agencies. Fourteen agencies used a combination of individual, group, and family therapy according to treatment needs.

Treatment, consisting of stages, such as a progression from education to individual to group therapy, was used by 23 out of 34 agencies. Most used some combination of psychoeducational and psychotherapeutic techniques, with only three agencies using psychotherapy exclusively and only 2 agencies using psychoeducation only. The average length of treatment was 17

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months with a range of 6 months to 5 years. The majority of agencies reported that treatment length was open ended depending on the progress of the client.

Considerable variance was reported in terms of fees charged for services. The range for individual therapy was $4 to $90 per session. Group fees ranged from $20 to $85 per session. Evaluation fees ranged from $100 to $500. Most agencies also stated that sliding scale rates were available. The one inpatient setting reported fees of $250 per day.

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Evaluation of Treatment Success

Finally, we asked agencies what methods were used to evaluate the efficacy of their programs and also asked them to estimate success rates of their sex offender treatment. This raised the issue of how success is measured. There are problems with any method used. Relying on self-reporting means relying on the report of a client who is poorly motivated to report further offenses or even thoughts about offending. Court-ordered offenders have great incentive to tell the therapist they are improved or cured. Relying on recidivism rates is problematic because of the low

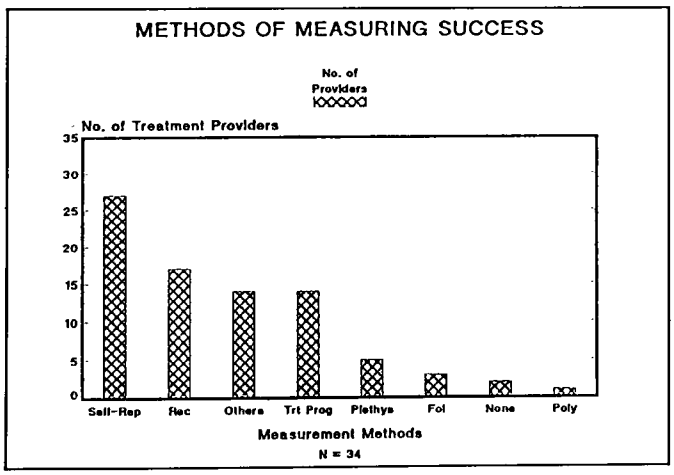

FIGURE 4

correlation between number of offenses and number of arrests or convictions. Additionally, the imperfect communication between the mental health system and the courts means that multiple offenses may occur before agencies become aware of effectiveness problems in their treatment programs. Other methods such as the plethysmograph (a physiological measure of genital stimulation in response to visual stimuli) may have greater reliability, but are expensive and also flawed. Therefore, assessing what evaluation methods are currently being used will enable work to begin towards refining these methods so that more accurate assessment of treatment effectiveness can be achieved.

According to survey results, the most common method used to evaluate treatment success was self-report with 27 out of 34 agencies using this method. Fourteen out of 34 agencies were using recidivism rates. Less common methods used are the plethysmograph, follow-up sessions, polygraph, and no methods at all. (See figure 4)

Success rates were generally estimated to be high with 20 (58.8%) agencies reporting high (above 70%) success rates. Moderate success was reported by 2 (5.9%) of the agencies. Low success was reported by 3 (8.8%) of the agencies. Nine agencies (26.5%) reported that they could not judge the success of their program. (See figure 5)

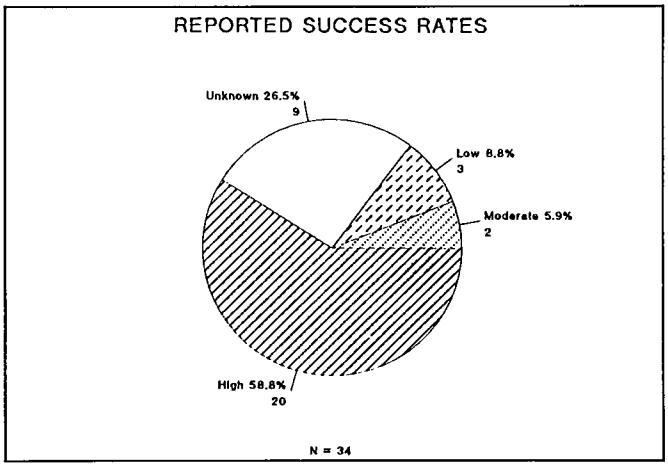

FIGURE 5

Future Directions

In conclusion, it appears that the practice of treating sex offenders on an outpatient basis is expanding and more broadly based than we had anticipated. Over 1,000 sex offenders are being treated in Virginia by private and public practitioners, primarily with cognitive-behavioral treatment techniques in individual and group therapy. The majority of these clients are court ordered and were not referred for presentencing evaluations before being ordered to participate in treatment. Many treatment providers estimate that they have high success rates, but assessment methods are currently inadequate and unreliable. If treatment for this difficult population is to continue, then progress must be made towards improving communication with the court system and refining treatment techniques and assessment methods. Finally, though it is tempting to see success in treatment methods especially when clients report it, we must be modest in our assessment of success until we have more refined ways of assessing sex offense recidivism and actual treatment progress. □

In the Virginia General Assembly — 1990

■ Group homes to be single family residence for zoning laws

Previously, the Commonwealth allowed localities to provide zoning regulations for group homes to be placed in appropriate districts. Localities could also impose additional conditions on group homes, and require such homes to be compatible with a given area.

Current changes define group homes as single family residences when they include less than eight persons who are mentally ill, mentally retarded or developmentally disabled (but not those who currently illegally use or are addicted to a controlled substance as defined in § 54.1-3401), and one or more counselors or staff members. No additional restrictions or conditions other than those imposed on single family residences shall be imposed on a group home.

SB 279; Ch. 814; adding § 15.1-486.3; repealing § 15.1-486.2.

■ Separate laws for the commitment of minors enacted

Effective July 1, 1990, the involuntary psychiatric hospitalization of minors in Virginia will be governed by a new statute, applicable only to minors. Over the last decade, minors in Virginia were either committed in accordance with the adult commitment statute, or admitted to facilities with parental consent. The prior commitment statute neither expressly prohibited admission to private facilities that did not comply with its provision nor authorized parental admission.

Parental decisions under the new statute are given considerable weight, especially with children under fourteen years of age. § 16.1-338 authorizes the 90 day admission of a minor under 14 with the consent of the parent, as defined by the statute, and the admission of a minor older than 14 with consent of the parent and the minor. Clinicians can easily extend the period of commitment.

If a minor over 14 withholds or withdraws consent, parental consent can still admit the minor in the hospital for 72 hours pending judicial approval. Under § 16.1-339, the court can order release, 90 days hospitalization, or a full commitment hearing. For the approval proceedings, the minor is appointed a "guardian ad litem" to represent him, and the hearing procedures for judicial approval are whatever the judge thinks is in the minor's "best interests."

For involuntary commitment, unlike an adult hearing, the statute requires sealed records, closed hearings, and adherence to the rules of evidence. The formation of the commitment criteria in the new law will require both more evidence and more effort at understanding than the ones in the adult statute.

The police power criterion requires a recent overt act or threat as well as a risk of "serious injury." The parens patriae criterion is more complicated. It requires that the court find an on-going "serious deterioration" in functioning that has brought the minor below a "developmentally age-appropriate" level of functioning, and that this decline is evidenced by symptomatology such as delusionary thinking, impairment in ability to eat, etc. The child's attorney could oppose commitment on the basis that no deterioration had occurred, or that the child's behavior was "age-appropriate", and that the symptoms were not severe enough.

If parents object to the commitment, abuse and neglect criteria are also considered.

For children fourteen or older, the difficulties of commitment will provide an incentive for parents and courts to commit the children perhaps *in absentia*, through § 16.1-339. This incentive is increased by the requirement under the new law that attorneys appointed for true commitment provide extensive adversarial-style services for their client, while in approval hearings, the attorneys may act as guardians ad litem with no specified responsibilities.

HB 1016; Ch. 975; amending §§ 16.1-241, 16.1-246, 16.1-275, 16.1-280, 37.1-61, 66-20; adding §§ 16.1-335 through 16.1-348.

■ Possession or transportation of firearms by persons acquitted by reason of insanity outlawed

§ 18.2-308.1:1 makes the knowing and intentional possession or transportation of any firearm by any person acquitted by reason of insanity and committed to the custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, pursuant to § 19.2-181, on a charge of treason, any felony, or any offense punishable as a misdemeanor under Title 54.1 or a Class 1 or Class 2 misdemeanor, under Title 18.2 punishable as a Class 1 misdemeanor.

Upon discharge from custody, a person so acquitted may petition the circuit court in which he resides for a permit to possess or carry a firearm. The circuit court may grant such a petition in its discretion and for good cause.

Any person who sells, barters, gives or furnishes a firearm to a person acquitted pursuant to the conditions in § 18.2-308.1:1 shall be guilty of a Class 1 misdemeanor. Sellers will be provided with information

as to the status of purchasers in the same proceedings in which the State Police inform sellers of the criminal history of purchasers.

SB 311; Ch. 692; adding § 18.2-308.1:1; amending §§ 18.2-308.2:1, 18.2-308.2:2.

■ Period for detention for psychiatric treatment extended slightly

For detention for psychiatric treatment prior to a criminal trial, the forty-eight hour period specified can be extended for the same period allowed pursuant to § 37.1-67.1 if the period terminated on a Saturday, Sunday or legal holiday (see 9 **Developments in Mental Health Law** 5, January - June 1989).

HB 800; Ch. 76; amending §§ 19.2-169.6 and 19.2-176.

■ Offer, payment, solicitation, or receipt of remuneration in exchange for referral is prohibited

Hospitals licensed pursuant to § 32.1 and facilities or institutions licensed pursuant to § 37.1 may not knowingly and willfully offer or pay any remuneration, directly or indirectly, in cash or in kind, to induce any practitioner of the healing arts to refer an individual to such a facility. Excluded from the definition of remuneration are those referral arrangements not prohibited by 42 U.S.C. § 1320a-7b (b) such as Medicaid.

§ 54.1-2962.1 prohibits practitioners of the healing arts from knowingly and willfully soliciting or receiving any remuneration.

SB 107; Ch. 379; adding §§ 32.1-135.2, 37.1-186.1, and 54.1-2962.1.

■ Involuntary treatment proceedings altered

When a judge finds that a person presents a danger to himself or others as a result of mental illness, or that the person is so ill that he cannot substantially care for himself, yet institutional confinement is not necessary and orders alternative treatment, the community service board now has the power to monitor the person's compliance with its recommended treatment, and to present evidence of compliance in subsequent hearings held pursuant to § 37.1-67.2 or § 37.1-67.3.

For subsequent re-commitment orders under § 37.1-67.3, all preliminary hearing proceedings under § 37.1-67.2 now must be combined with the commitment hearing.

Neither of these statutory changes will alter current practice, except by clarifying the meaning of the previous statutory language. The new law emphasizes the necessity of prescreening for re-commitment, and the lack of necessity for a separate preliminary re-commitment hearing.

The visibility of outpatient re-commitment is raised somewhat by the new amendment and the responsibilities of the community services board are made more concrete. The community service board henceforth will have a clearer role in prescribing and monitoring an outpatient commitment placement that is tailored to the unique needs of the defendant.

In a more technical amendment, the General Assembly extended, in some cases, the period during which a patient may be detained prior to trial on a temporary detention order (TDO). This period has been extended in the past years when the normal forty-eight period of detention expired on a weekend or holiday. This year's change has the effect of extending legal holidays to 8:00 a.m. of the next day, for the purpose of determining whether to apply a 48, 72, or 96 hour time. For example, a TDO executed at 7:00 a.m. on a Sunday would require a commitment hearing by Tuesday at 7:00 a.m. under the old law, even when Monday was a legal holiday. Under the new law, when Monday is a holiday, that holiday would last until 8:00 a.m. Tuesday, and the hearing could be scheduled as late as 96 hours after detention, or Thursday, 7:00 a.m.

HB 161; Ch. 723; amending §§ 37.1-67.1 and 37.1-67.3; HB 453; Ch. 59; HB 456; Ch. 60; amending § 37.1-67.3.

■ Police may detain mentally ill without judicial order

Beginning July 1, 1990, law-enforcement officers will be permitted to detain and transport persons for the purpose of an emergency mental health evaluation. The amendment is one of the important proposals to come out of the DMHMRSAS task force on emergency hospitalization.

The amendment creates a new, alternative first step in the state commitment process, called "emergency custody." A judge or magistrate (neither of whom need consult a mental health professional), may issue an emergency custody order. Under the order, a person alleged to be mentally ill and in need of hospitalization can be detained and transported to a place designated by the community services board for an evaluation. After four hours, the person must be released or detained on a temporary detention order. The standards and procedures for a temporary detention order did not change.

Virginia has long been one of the few states requiring a law enforcement officer to first obtain a judical order, such as a temporary detention order, before detaining a mentally ill person for the purpose of

commitment. The new law for the first time gives law-enforcement officers statutory authority to detain someone for a four-hour evaluation, when the officer, "based on his observations or the reliable reports of others, has probable cause to believe that any person is mentally ill and in need of emergency evaluation for hospitalization."

This new law also gives the judge and magistrate explicit authority to order the law-enforcement officer to transport the person detained to multiple sites for services such as evaluation, ancillary medical treatment, and temporary detention. The law gives law-enforcement officers the authority to transport, on their own initiative, persons detained for mental hospitalization to medical facilities for medical treatment.

The community services board is given responsibility for designating for the judges and magistrates the places to which persons should be taken for evaluation during emergency custody.

HB 772; Ch. 429; amending § 37.1-67.1.

■ Written notification of appeal of commitment provided to petitioner

The clerk of the circuit court shall provide written notification of the appeal of commitment to the petitioner in the case pursuant to procedures in § 16.1-112. The change is a result from family members' complaints that relatives whom they had successfully petitioned the court to commit had appealed the commitment de novo to the circuit court without the family's knowledge. It is still unclear in § 37.1-67.6 whether the petitioner has the right to testify or otherwise influence the proceeding in the circuit court.

HB 1013; Ch. 274; amending § 37.1-67.6.

■ Responsibilities and costs of transportation in civil commitment decreased

The sheriff's responsibility for transportation is limited to when a person has been certified for admission to a hospital under § 37.1-67.2, court-ordered voluntary admission after a preliminary hearing, and when a person has been involuntarily committed under § 37.1-67.3.

The previous law had raised questions about the sheriff's responsibility for the informal, voluntary admission under § 37.1.65. The new law eliminates the statutory responsibility for transportation in that circumstance.

The old law also had implied that sheriffs were not responsible for transportation of a person committed to a private hospital. Now it is clear that the sheriff is responsible for transportation.

The new amendment also seems to eliminate the requirement that sheriffs transport persons who are temporarily detained under § 37.1-67.1. Other language, however, in § 37.1-67.1 makes this duty explicit, although it does not explain how the sheriffs will be reimbursed for the services in temporary detention.

HB 454; Ch. 94; amending § 37.1-71.

■ Liability of trusts

The new amendment prohibits the state or federal government from invading a spendthrift trust for payment of medical expenses or considering the trust assests in determinig eligibility for free services provided the beneficiary is medically, physically, or mentally disabled so that his ability to provide self-care is impaired.

For non-handicapped, the new law makes it almost impossible to set up trusts that cannot be required by the state to pay medical expenses.

HB 188; Ch. 927; amending §§ 37.1-110 and 55-19; repealing § 55-19.1.

■ Use of durable powers of attorney in medical decision made easier

The procedure enacted last year for surrogate medical decision making by next-of kin and others was streamlined somewhat this year. The legislature removed the previous requirement that physicians contact the patient's next-of-kin when relying upon an attorney-in-fact under a durable power of attorney to see if there was reason to question the authority of the attorney-in-fact.

SB 422; Ch. 713; amending § 37.1-134.4.

■ Advertising by facilities or institutions to be regulated

The Board shall promulgate regulations governing advertising of any facility or institution licensed pursuant to § 37.1, which shall include, but not be limited to the principles stated in the current guidelines for advertising developed by the National Association of Private Psychiatric Hospitals. Advertising shall not contain false or misleading information or representation as to fees charged for services.

SB 129; Ch. 809; adding § 37.1-188.1.

■ Requirement of child health supervision services coverage in insurance

This new section requires that all insurance policies shall make available coverage for child health supervision services. Child health supervision service means

periodic examinations of the physical and emotional status of a child by a licensed physician or someone under a physician's supervision. At a minimum, each policy shall provide benefits at the following age levels: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, and annually from the ages of two to six. Benefits are exempt from copayment, coinsurance, deductible, or other dollar limits. Premiums shall take into consideration: cost of coverage, savings because of coverage, profit, and any other data which the commission determines relevant. This requirement does not apply to insurers or health plans with less then 1000 individuals in Virginia, with less than $500,000 in premiums in Virginia, or other limited benefit policies issued to provide supplemental benefits to a policy providing primary care benefits.

SB 131; Ch. 901; adding § 38.2-3411.1

■ Limited mandated accident and sickness insurance policies now available

With these new laws, insurers and health services companies may issue limited mandated benefits plans to individuals, families, or groups of less than fifty as long as they follow the newly created criteria. Coverage is available only to those who have been without accident and sickness insurance coverage or employer-sponsored health care for all of the twelve-month period immediately preceding the effective date of the limited mandated benefit policy.

For cost control, the insurer must include provisions that exclude coverage for services not medically necessary or covered by preventive health services, and must require procedures for preauthorization by the insurer for the service. Additionally, insurers may include provisions such as the existence of a preferred panel of providers, second opinions, and procedures for utilization review by the insurer in order to control costs.

The new laws set minimum coverage for hospitalization at thirty days, and specify prenatal and obstetrical care provisions.

The limited mandated benefits policies differ from the mandated policies most significantly in the area of coverage for mental illness. Under the limited mandated benefits policies, coverage for mental illness and alcohol and drug rehabilitation, which mandated benefits plans required, will now be exempt from the statutory requirements. § 38.2-3412 which required coverage for mental, emotional, or nervous disorders, and which prohibited limits that were more restrictive than those for physical illness, will not be a part of limited mandated benefit policies. The limited benefits policies also do not include § 38.2-3413 which required that insurers make available an option for coverage for alcohol and drug rehabilitation.

In this way, the new law disregards the principle of assuring parity in the insurance of mental disorders with the insurance of physical disorders, at least in an out-patient setting. It is possible to read the new law to require minimum coverage of hospitalization whether it is for a mental or physical disorders.

HB 1108; Ch. 902; adding §§ 38.2-3425 through 38.2-3430.

■ Department for Rights of the Disabled Renamed

The new name for the Department for Rights of the Disabled is the Department for Rights of Virginians with Disabilities.

HB 417; Ch. 458; amending §§ 2.1-1.1, 2.1-1.3, 2.1-51.15, 2.1-373.4, 2.1-700, 2.1-703.1, 9.6-25:2, 51.5-1, 51.5-2, 51.5-33, 51.5-34. 51.5-35, 51.5-36, 51.5-37, 51.5-40, 51.5-46, 63.1-182.1, and 63.1-314.3; adding § 51.5-35.1.

■ Fees for judges and attorneys combined for multiple same day proceedings.

If a commitment hearing under § 53.1-40.2, involuntary admission of mentally ill prisoners, and a proceeding under § 53.1-40.1 authorizing medical or mental health treatment of prisoners who are incompetent or incapable of giving consent, are combined or held on the same day, only one fee shall be allowed for any special justices, district court substitute judges and attorneys.

The new law makes a specific provision for the civil commitment, under § 37.1-67.3, of prisoners who are within fifteen days of release from prison. For civil commitment proceedings prior to release, only one fee shall be allowed to special justices, district court substitute judges and attorneys if a commitment hearing under § 37.1-67.3 is combined with a hearing or proceeding such as the ones described above.

HB 804; Ch. 221; amending § 53.1-40.8; adding § 53.1-40.9.

■ Reports of abuse of adults to be made to law-enforcement agencies

Any person required to report abuse of an adult or any department receiving such information pursuant to § 63.1-55.3, shall report all information immediately to the local law-enforcement agency where the adult resides or the abuse is believed to have occurred, or if not known, where the abuse was discovered.

SB 218; Ch. 308; amending § 63.1-55.3.□

In the Virginia Supreme Court

Dangerousness prediction and the death penalty

***Savino v. Commonwealth,* ___ Va. ___ (1990).**

by W. Lawrence Fitch

On April 20, 1990, the Virginia Supreme Court upheld a sentence of death imposed by a Bedford County judge who relied on "psychiatric" testimony that the defendant in the case, Joseph John Savino, was a "dangerous" man who had a high probability of committing violent acts in the future.

Savino pleaded guilty to capital murder in the killing of Thomas McWaters, Jr., a man with whom he lived and shared a homosexual relationship. At his sentencing hearing, Savino presented as evidence in mitigation the testimony of a psychiatrist, Lisa D. Hovermale, M.D. Dr. Hovermale opined that, at the time of the offense, Savino was suffering from symptoms of cocaine psychosis. Moreover, she characterized the killing as essentially domestic in nature, observing that on the evening of his death, McWaters demanded sex of Savino, and, upon Savino's refusal, told Savino he was "through with him."

Under Virginia law, once the defendant in a capital case has presented psychiatric or psychological testimony in mitigation, the Commonwealth may present its own mental health expert in rebuttal. The law, however, explicitly prohibits the Commonwealth from using any statements the defendant may have made during an evaluation by the expert, or any evidence derived from such statements, to support its case in aggravation. Such evidence may be used only in rebuttal when relevant to issues in mitigation raised by the defense (Va. Code § 19.2-264.3:1). Future dangerousness is one of two factors Virginia law recognizes as "aggravating." The Commonwealth must prove at least one aggravating factor beyond a reasonable doubt in order for the sentence of death to be imposed.

The Commonwealth called as its expert Dr. Arthur Centor, a clinical psychologist who had examined Savino at the Commonwealth's request. Dr. Centor testified that Savino had never been mentally ill, was not "operating under any serious mental or emotional disturbance" at the time of the offense, and was not impaired in his appreciation of the wrongfulness of his actions or his ability to control his behavior. Over defense objection, Centor testified that Savino "show[ed] signs of future dangerousness . . . so that he would have a high probability of committing criminal acts of violence that would constitute a continuing serious threat to society in the future." Whether or not the judge should have admitted Centor's testimony concerning Savino's future dangerousness was the central question on appeal.

The Supreme Court's analysis focused on questions of constitutional law: whether Dr. Centor's testimony violated Savino's fifth amendment privilege against self-incrimination or sixth amendment right to the effective assistance of counsel. The court recognized the applicability of the fifth amendment in the context of a mental health evaluation for capital sentencing purposes (citing *Estelle v. Smith*, 451 U.S. 454 (1981) but held that Savino waived this privilege by presenting his own expert in mitigation. The court also rejected Savino's sixth amendment claim (essentially that he was not put on notice that Dr. Centor's examination could result in testimony regarding his "future dangerousness"), holding that, because Virginia law provides that presentation of expert testimony for the defense at the sentencing stage of a capital case opens the door to expert testimony for the prosecution, Savino's counsel, and thus, Savino, were on notice.

The court, however, failed to address statutory restrictions on the prosecution's use of expert mental health testimony to establish factors in aggravation. Indeed, it would appear that the court was not cognizant of the distinction between evidence in rebuttal of defense claims in mitigation and evidence in support of the Commonwealth's affirmative case in aggravation. To the extent that Centor's testimony that Savino was dangerous was based on statements Savino made to him during his evaluation, or that Savino made to Hovermale during her evaluation, or was based on evidence derived from any such statements, his testimony was in violation of statute.

Moreover, the court did not address the constitutional concerns underlying the Virginia rule: that to permit the Commonwealth to present as evidence in aggravation disclosures made by the defendant during an evaluation requested by the defense to explore factors in mitigation, or during an evaluation demanded by the Commonwealth as a condition to the presentation of psychiatric evidence for the defense, is to put the defendant to an untenable choice between his or her sixth amendment right to explore and present clinically derived evidence in mitigation and fifth amendment privilege against self-incrimination. The courts have recognized this concern in the pre-trial context, holding that no statement made during a psychiatric or psychological evaluation prior to trial (for example, to assess the defendant's competency to stand trial or mental state at the time of the offense) may be used by the Commonwealth at trial as evidence that the defendant committed the offense charged; such statements may be used only to address the defendant's mental condition as it relates to the

defendant's claim of legal insanity (*Gibson v. Zahradnick,* 581 F.2d 75 (4th Cir. 1975), *cert. denied* 439 U.S. 996 (1978). In a state like Virginia, where, at the penalty phase of a capital trial, the prosecution is obliged to prove aggravating factors beyond a reasonable doubt, these aggravating factors are functionally equivalent to the elements of the crime at the guilt phase. Accordingly, logic would dictate, statements made by the defendant during an evaluation to assess factors in mitigation, or evidence derived from such statements, would be admissible only to address such factors, not to support the Commonwealth's case in aggravation. This argument was presented to the United States Supreme Court in a Virginia case, *Smith v. Murray* 477 U.S. 527 (1986), but the Court avoided responding, on procedural grounds, finding the defendant's failure to raise the issue in his appeal to the Virginia Supreme Court a procedural bar to its subsequent presentation. In her opinion for the court, however, Justice O'Connor seemed receptive to the argument. Indeed, as Justice Stephens observed in his dissent, "[t]he record in this case unquestionably demonstrates that petitioner's claim is meritorious . . . . The court does not take issue with this conclusion."

After learning of the Virginia Supreme Court's decision in his case, Savino abandoned his plans to appeal further. His execution was scheduled for June 29, 1990. On June 25, Savino changed his mind. Future court opinions in his case addressing any of the issues discussed above will be covered in **Developments in Mental Health Law.**

Court certifies class of mentally retarded for remedial help

***Thomas S. v. Flaherty,* 902 F.2d 250 (4th Cir. 1990)**

A Fourth Circuit panel affirmed the ruling of a district court in North Carolina that had certified a class of petitioners consisting of mentally retarded adults who are suffering because of improper past or current treatment in a state facility. The district court found that the state's decisions to confine mentally retarded persons to psychiatric wards without a diagnosis of mental illness, the administration of antipsychotic drugs, and the unwillingness to listen to the community placement recommendations substantially departed from professional norms. The district court appointed a special master to help administer a remedial treatment program in which the patients could receive proper training and treatment. The ruling enables patients who were released while the suit was pending to be eligible for help if they currently suffer from the previous hospitalization.

The Secretary for the North Carolina Department of Human Resources appealed the district court decision on several grounds. First, the Secretary argued that the district court did not give proper deference to the judgment of the treating professionals and the accreditation of the hospitals involved. The Fourth Circuit found that the district court followed the *Youngberg v. Romeo,* 457 U.S. 307 (1982) doctrine which requires judges to defer to the decisions by professionals concerning treatment in order to prevent unguided discretion in balancing individual liberty interests. The district court's findings that the treatment decisions had not been implemented, and that the practices used substantially departed from those practices as stated in the Secretary's written policy rebutted the presumption of validity on the state's part. Although the court recognized accreditation as prima facie evidence of constitutionally adequate conditions, it found that the deficiencies uncovered by the accreditation team were sufficient to negate the significance of the accreditation.

The appellate court upheld the district court's decision that the class members have a right to minimally adequate treatment. The decision will not require treatment in the least restrictive environment as the Secretary had feared, but rather requires a case by case evaluation by professionals to determine the minimally adequate training. In many cases, minimally adequate treatment or training will require community placement, the court went on to say. Such placement will be ordered only after an individualized assessment of each class member determines that it is required at a minimum. The Fourth Circuit denied that the district court had endorsed community placement as categorically preferable under due process analysis to institutional care.

More controversial is the court's holding that patients who were released after class certification are still eligible for help under the remedies. The Secretary, citing *DeShaney v. Winnabago County,* 489 U.S. 189 (1989), (see 9 **Developments in Mental Health Law,** 36, July-December 1989), contended that the state has no duty to provide services for person not under state control. Since many of the petitioners had been released while the case was pending, the Secretary argued that since they were no longer in the state's custody, the state should not have to provide treatment for them. Instead of accepting this argument, the court analogized this case to *Youngberg* in that the state does have a duty to provide services when it restrains an individual through institutionalization. The court seems to be saying that if an individual is harmed while institutionalized by a state, he or she has the right to seek the remedial treatment that was
deserved when first hospitalized. The state does not, however, have a general duty to protect persons never in its custody from third parties. The court refused to allow the state to escape its duty towards those individuals it had institutionalized simply because it had released a person while the case was pending.

The objects of the remedies of the court, to ameliorate the effects of wrong placement and to remedy inappropriate community placement, make it a

prospective remedial treatment. Because no money was awarded and the treatment was not compensatory but rather was for current harms from past treatment, the Fourth Circuit upheld the decision against the Secretary's challenge that the remedial treatment was a retroactive relief forbidden by the Eleventh amendment.

Finally, the court upheld the appointment of a special master due to the size of the class, and the necessity for individual consideration. Also, the court upheld the fact finding of the district court noting that it was in the best position to hear the evidence and to judge the credibility of witnesses.

The decision of the Fourth Circuit becomes the fourth decision in this litigation. *Thomas S. v. Morrow,* 601 F.Supp. 1055 (W.D.N.C. 1984) (*Thomas I*), *Thomas S. v. Morrow,* 781 F.2d 367 (4th Cir. 1986), *cert. denied,* 106 S.Ct. 1992 (1986) (*Thomas II*), *Thomas S. v. Flaherty,* 699 F.Supp. 1178 (W.D.N.C. 1988) (*Thomas III*). For a discussion of *Thomas II,* see 6 **Developments in Mental Health Law,** 40, January-June 1986.

Diminished capacity not a defense for murder

***Smith v. Commonwealth,* 239 Va. 243, 389 S.E.2d 871 (1990)**

In a decision announced March 2, 1990, the Virginia Supreme Court held that psychiatric evidence of "diminished capacity" was not admissible in a capital murder case. The defendant in this case, Roy Bruce Smith was convicted by a Prince William County jury of capital murder in the wilful, deliberate, and premeditated killing of a law enforcement officer. The day of the shooting, Smith had become extremely agitated with his wife. In the afternoon, she left for a company picnic without inviting Smith. He proceeded to drink eleven beers over a four-hour span. Afterward, he went to a restaurant, where he drank more. He was asked to leave when he became loud and disturbed other customers. Upon returning home, Smith discovered that his wife was gone and that some of her belongings were missing. Smith took out a rifle and a handgun and loaded them. Sitting on his front porch with the guns, Smith fired several shots into the air. When a neighbor threatened to call the police, Smith threatened that he would shoot the first police officer he saw. The neighbor called the police, who arrived just before 9:00 p.m.

Sergeant Conner, who was at the rear of the house, confronted Smith and ordered him to drop his rifle. After hearing shots, other officers proceeded into the backyard where they found Conner lying on the ground, having been shot. After a struggle, they subdued Smith and took him to the police headquarters. His blood alcohol content was 0.11 percent at that time. Conner died several hours later from wounds to the leg, arm, head, and back.

Prior to his trial, Smith filed a notice that he intended to present a diminished capacity defense. He wanted to use psychiatric evidence to show that he lacked the ability to form the necessary premeditation for capital murder. The Commonwealth moved that the psychiatric evidence not be admitted. The trial court granted the Commonwealth's motion, but nonetheless allowed Smith to proffer the evidence at trial. At trial, the court ruled the evidence inadmissible.

The psychiatrist who testified, Dr. Joseph David, diagnosed Smith as suffering from alcohol dependence and a borderline personality disorder. He stated that Smith had an I.Q. of 124, and thus had the general ability to form intentions and to premeditate, but that at the time of the offense, he did not have the capacity to follow through on his intentions. Smith contended that the evidence should have been admitted on the issue of premeditation.

In rejecting Smith's argument, the Supreme Court relied on its earlier opinion in *Stamper v. Commonwealth,* 228 Va. 707, 324 S.E.2d 682 (1985), which held that unless the insanity defense is raised, the mental state of a defendant is immaterial to the issue of guilt or innocence and therefore is not admissible at the guilt state of the trial. *Stamper* involved a charge of possession with intent to distribute marijuana. Smith argued that *Stamper* should not apply to capital murder because the defense of voluntary intoxication, which can negate specific intent or premeditation, is unique to the offense of murder.

Drawing on its opinion in *Stamper,* the Court reasoned that this court should not become dependent on the quickly changing notions of mental illness recognized in psychiatry. Moreover, the Court declared, to accept a defense of diminished capacity would be to invade the province of the factfinder by deferring to the expert for the opinion of ultimate fact.

Medical malpractice cap applied separately to mother and infant

***Bulala v. Boyd,* 239 Va. 218, 389 S.E.2d 670 (1990)**

March 2, 1990, the Virginia Supreme Court answered six certified questions that the United States Court of Appeals for the Fourth Circuit presented to it regarding the application of the medical malpractice damages cap.

Helen Boyd, Roger Boyd, her husband, and Veronica Boyd, their child brought an action against Dr. Bulala for medical malpractice stemming from the delivery of Veronica. The mother's claim alleged bodily injury due to the defendant's failure to perform necessary procedures, and mental anguish arising from

the birth of her profoundly impaired child. The father claimed damages from emotional distress. The child's claim was based on personal injuries which included permanent birth defects due to asphyxiation during delivery. On January 25, 1985, a jury returned a verdict against Dr. Bulala and awarded a total of $8,300,000.

Dr. Bulala moved the court to reduce the verdicts to $750,000, which is the maximum amount recoverable under the medical malpractice cap in Virginia (Va. Code § 8.01-581.15). The plaintiffs argued that the cap was unconstitutional. While the district court was considering this motion, Veronica Boyd died. Dr. Bulala then moved to have her personal injuries converted to a wrongful death action pursuant to §§ 8.01-25 and 8.01-56. The court overruled Dr. Bulala's motions and entered judgment in the full amounts awarded by the jury.

Dr. Bulala's appeal to the Fourth Circuit Court of Appeals raised the question of the constitutionality of the cap. While the appeal was pending, the Virginia Supreme Court upheld the constitutionality of the medical malpractice cap in *Etheridge v. Medical Center Hospitals*, 237 Va. 87, 376 S.E.2d 525 (1989). The Fourth Circuit then certified six questions to the Virginia Supreme Court which asked whether the cap applies individually to each plaintiff or overall to two or more plaintiffs, whether it applies to emotional distress and punitive damages from medical malpractice, whether Virginia law allows recovery for loss of enjoyment of life, whether the law allows Veronica Boyd to recover lost earning capacity, and what the effect is of Veronica Boyd's death after verdict but before judgment in this case.

The court held that the amount recoverable applies to each patient. Following *Etheridge*, the court reasoned that the limit of $750,000 would apply to each patient, but that it would apply "regardless of the number of legal theories upon which multiple claims are based." In this case, the court found that the mother clearly had a physician-patient relationship and would be subject to the statutory cap.

In following its holding in *Kalafut v. Gruver*, 239 Va. 278, 389 S.E.2d 681 (1990) which held that a tortfeasor who harms an unborn child is subject to liability if the child is born alive, the court held that the child did have a claim against the defendant. The court considered the child a patient of Dr. Bulala because of the relationship of the obstetrician and the delivery process, thus subjecting the child to a separate limit from the mother.

As to the emotional distress of the father and the parents' medical expenses claim, the court held that since they were derivative of the child's claim, they would be included in the $750,000 awarded to the child. The court also disallowed additional recovery for punitive damages because they would also be included within the statutory limits.

The court concluded that Virginia law does not allow recovery for loss of enjoyment of life as a separate element of damages. Based upon the evidence and that statistical averages were too remote to form an intelligent estimate of the plaintiff's earning capacity, the court would not allow Veronica to recover for lost earning capacity.

The dissent disagreed with the application of the law to the child's claim. Justice Russell, writing for the dissent, argued that because the child was never a patient until after birth and that the injury occurred before the birth, the child's claim is really derivative of the mother's claim. Given this, the dissent would include the child's damages within the mother's limited award. □

New legislation authorizing quarantine aimed at AIDS victims

by Jane E. Kurtz

Male prostitute Fabian Bridges travelled throughout Texas, spreading AIDS to an unknown number of people. His behavior instilled fear in the public and confounded health officials charged with stopping him. Desperate to halt the spread of AIDS, the Texas Board of Health decided to quarantine AIDS patients who did not cooperate with authorities. Similar incidents have been reported throughout the United States, such as the incident in Florida, where a woman with AIDS, who was charged with prostitution, was put under house arrest.[1]

States have tried a variety of ways to stop the spread of AIDS. Reporting statutes, compulsory examination, screening of blood, and quarantine are among the strategies recently employed to combat the spread of AIDS. Surprisingly, few states have seriously considered the most restrictive means, quarantine and isolation. This year, Virginia enacted a new quarantine law, primarily aimed at HIV seropositive individuals, which is certain to be controversial.

With the passage of House Bill 816, which added §§ 32.1-48.01 through 32.1-48.04, Virginia has joined with the few states authorizing the isolation of persons with communicable diseases, which can be directed at victims of AIDS. Technically, isolation refers to the separation of an individual only during the communicable

Jane E. Kurtz is a second year law student at the University of Virginia School of Law.

stages of a disease, while quarantine refers to separation of any individual simply exposed to a disease. Although most statutes, including the new Virginia statute, really concern only the isolation of an individual, the term quarantine is often used in a looser sense to resemble the technical definition of isolation.

Although no state authorizes the quarantine of an AIDS patient specifically, some states allow for quarantine of designated diseases of which AIDS is one of them.[2] Most states have general quarantine laws which do not explicitly refer to AIDS as a communicable disease.

Although the new statute in Virginia does not specifically refer to isolation of persons who are HIV seropositive, its language gives the Commissioner of Health the power to include this in the list of communicable diseases. The Department of Health has included Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus (HIV) Infection on the list of communicable diseases. Given the public's desire to control AIDS, application of the law likely will be directed to those persons infected with the disease.

Procedures for isolation

The new statute includes entirely new provisions describing the procedures to be used when isolating an individual with a communicable disease and repeals § 32.1-51 which provided for the quarantine or isolation of persons with tuberculosis or who refused to be tested, and § 32.1-52 which made the failure to comply with the tuberculosis quarantine order a misdemeanor.

The new sections enacted resemble those of the Virginia civil commitment statutes, § 37.1-67.1 et seq. The initial steps the state takes involve unrestrictive methods of counseling. The Commissioner of Health may conduct an investigation upon receipt of two verified reports or medical evidence that a person, reputed to know that he is infected with a communicable disease, is engaging in at-risk behavior. The statute defines communicable disease as an illness, designated by the Commissioner, which may be transmitted directly or indirectly, and at-risk behavior as engaging in acts in which a person knowingly transmits the disease without taking appropriate precautions or those measures that current scientific evidence shows to prevent transmittal. Effective July 1, 1989, Virginia law required that physicians report all HIV seropositive results to the Department of Health. (see 9 **Developments in Mental Health Law** 6, January-June 1989). Given that law, the Health Department already has access to the records of individuals who have been tested positive for HIV.

Counseling

The prescribed counseling would be conducted at a local or district health department and would include explanation of the etiology, effects and prevention of the specific disease. The extent of counseling and the qualifications of the counselor are not specified in the statute. Counseling could be as minimal as reading a list to an individual merely to fulfill the requirement and claim that the individual is aware of what at-risk behavior is and what appropriate precautions are. The counselor would have to submit a report noting that the individual has been informed of what constitutes at-risk behavior and appropriate precautions, and report any statements indicating the intentions or understanding of the person counseled.

Knowing that a counselor will be submitting a report of the counseling session, an individual might be hesitant to disclose information that might be helpful in counseling out of fear that any statements could lead to future quarantine. If this scenario occurs, the counseling could compound the problem rather than provide the education necessary for prevention of the spread of diseases like AIDS.

Hearing

If the Commissioner has cause to believe that the individual who previously was counseled has continued to engage in at-risk behavior without taking appropriate precautions, and has one verified report or medical evidence of such behavior, the Commissioner may petition the general district court to require the person appear to determine whether isolation is necessary. The statute does not refer to what level of evidence is necessary for the Commissioner to have cause to believe that an individual is engaging in at-risk behavior. High risk groups, such as the homosexual community, have consistently opposed quarantines for fear that status alone, such as homosexuality, will be enough for the Health Department to have cause to believe that individuals are engaging in at-risk behavior. The potential for abuse and discrimination is great when a statute such as this is so vague in defining what kind of evidence is necessary.

Like civil commitment, the court may issue a temporary detention order where the individual would be detained for 48, 72 or 96 hours, depending on whether the end of detention falls on a weekend or holiday (see this **Developments in Mental Health Law** for an explanation on detention periods). Such confinement would be in the individual's home or a willing institution, but not in a jail, and would be monitored using electronic devices. Although the statute does not specify the type of electronic devices to be used, electronic devices might resemble those used for house arrest and could include a transmitter, receiver, and central computer system. The transmitter would be worn around a wrist, ankle, or neck and would send continuous signals to a receiver unit attached to the individual's phone. The receiver sends messages over the phone lines to a central computing system when the individual moves beyond a certain radius from the phone. The computer would document each time an individual was out of contact with the receiver.[3] Each person detained shall have a right to counsel.

In the hearing, the court can order isolation for no more than 120 days upon a finding by the court that (1) the person is infected with a communicable disease, (2) the person is engaging in at-risk behavior, (3) the person has demonstrated an intentional disregard for the health of the public, and (4) no other reasonable alternative exists to reduce the risk to the public. Orders for isolation may be enforced by use of electronic devices in an individual's home or by having the individual stay at a willing institution and may require the individual's participation in counseling or education.

Renewal orders require another full hearing, and every hearing is appealable de novo to the circuit court. This means that the individual is entitled to an entirely new hearing where the judge must make a finding based on behavior at the time of the hearing. If an individual can reform his behavior in the time between the original hearing and the appeal, the court will not be able to issue an isolation order. Right to counsel is also guaranteed in the appeal.

Constitutionality

Although the law's intent to protect the public from infection is laudable, the solution of limiting a person's movement because he has a particular disease is extraordinarily intrusive of the individual's private life. None of the current, older state laws governing quarantine or isolation of persons with communicable diseases have been challenged in court probably because they are so seldom used. However, when the new Virginia law is implemented, many questions concerning the state's power, the substantive rights of the quarantined individual, the procedural rights due to the individual, and the desirability of a quarantine law will surely arise.

The state's power to quarantine is an inherent power reserved to the states. The Constitution recognizes state's power to pass inspection laws in Article I § 10, clause 2. Traditionally, the courts have recognized a broad state power to quarantine. In 1902, the United States Supreme Court upheld a Louisiana law which excluded healthy persons from a locality infested with a contagious or infectious disease.[4] The Court said that the power to quarantine and regulate health exists with the states and is not repugnant to the Constitution.

The power to quarantine individuals is analogous to the more frequently discussed laws in which states civilly commit individuals. In both cases, the state is removing an individual from society because that individual poses a risk to himself and/or others. Clearly, the state does have some power to quarantine or isolate individuals who pose a health risk to the public. However, this power must be exercised in a way that does not violate the constitutional rights of the quarantined individual.

Substantive rights

An individual who is considered for quarantine possesses liberty interests to be free from restraint, and the stigma of being identified and isolated as contagious. Although the courts have recognized the liberty interests involved, they have generally upheld health and quarantine laws.[5] In deciding whether a substantive right has been violated, a court will look to the interests of the state and the means by which they are meeting the interest. A court would probably employ a rational basis test in which the statute must have a legitimate state interest, and means that meet that interest.

Virginia has joined with the few states authorizing the isolation of persons with communicable diseases which can be directed at victims of AIDS.

Courts have used the rational basis test in cases of isolation of prisoner with AIDS.[6] Under a rational basis test, the state interest of protecting the public health was found to be a legitimate one, and the means by which that is achieved, by isolating individuals who are at risk to public health, a legitimate way to meet that goal. Therefore, a court probably would not find that an individual's substantive rights were violated by a quarantine law.

However, isolating a person in society who has not committed a crime is different from isolating a prison population. A prisoner has given up some rights to begin with when he is convicted of a crime and is sentenced to a term of incarceration. Also, the living situation in prison is dramatically different from that in society.

The statute may create problems because of vagueness and overbreadth. The statute's definition of at-risk behavior fails to give notice to individuals of what behavior could result in quarantine. By requiring the Commissioner to have merely "cause to believe" that an individual is engaging in at-risk behavior, without taking appropriate precautions, the statute leaves no meaningful way to monitor the application of the quarantine. By not defining the behavior more specifically, the law could be applied to fairly innocuous behavior, such as kissing. Such an application would be overbroad and would result in the quarantine of individuals who really are not transmitting the disease. All of these scenarios would result in the deprivation of an individual's liberty because of unwarranted quarantine.

Procedural rights

Even though a state may have the power to quarantine, and the constitutional substantive rights of an individual subject to a quarantine may not be violated, the fourteenth amendment guarantees that an individual may not be deprived of life, liberty or property without procedural fairness. The procedural aspect of quarantine laws is perhaps the most important issue in this law. The United States Supreme Court has employed a balancing test since the 1976 case of *Matthews v. Eldridge* to weigh the interests of the state, the individual, and the risk of error. The interest of the state is to protect its citizens from risk of infection. The interest of the individual is the liberty interests to be free from restraint, and to not be stigmatized. The risk of error depends on the procedures given the individual.

In one of the few decisions to consider quarantine, the West Virginia Supreme Court of Appeals held in *Greene v. Edwards,* 263 S.E.2d 661 (W. Va. 1980) that all process due for civil commitment is due in cases concerning quarantine of individuals with tuberculosis. If other courts follow this case, any hearing to quarantine someone would be subject to a finding by clear and convincing evidence as the court has required for civil commitments in *Addington v. Texas,* 411 U.S. 418 (1979). The Virginia statute noticeably lacks such standards. The law simply requires a finding that the individual has a communicable disease and has engaged in and will continue to engage in at-risk behavior. Facially, the procedures governing the hearing are inadequate. Whether they would be constitutional as applied, assuming that judges use the civil commitment analogy, depends of course on the individual application of the new law.

Desirability of policy

Assuming that all of the constitutional questions are resolved, one must never lose sight of whether this type of action is desirable and feasible in our society. Because of substantive due process concerns, any kind of quarantine is going to have to be a limited kind where quarantine is linked to behavior and not to status. However, a limited quarantine is going to have a limited effect. Because a window of infection exists where an individual may have acquired the virus but will not test positive for it, many transmissions of the disease will not be affected by the new statute. If the state's goal is to protect the public health, such a quarantine may do very little to decrease the spread of AIDS. Home isolation may not affect transmission because third parties cannot be prevented from making contact with the quarantined individual. Such legislation gives the public the impression that lawmakers are making positive attempts to stop AIDS. However, because the effect of the legislation will be so limited, the statute is little more than a political gesture and money put into quarantining a few individuals could be used more efficiently for programs such as education which might decrease transmission across the board.

Because a window in infection where an individual may have acquired the virus, but will not test positive for it exists, many transmissions of the disease will not be affected by the new statute.

The statue does not address the situation of an individual who violates the isolation order. Possible solutions might be to confine the individual in an institution or to criminally prosecute violations. Ambiguities remain as to whom will be paying for the quarantine. § 32.1-45 states that the provisions of the chapter shall not be construed to mean that an individual is relieved of the expenses for any treatment. If quarantine is to be considered treatment, the individual would carry the burden of paying for the electronic monitoring devices or for possible detention in an institution. Presumably, the state would cover the costs for indigents, the numbers of which could be high given the fact that many of those affected by this statute will be recalcitrant prostitutes and IV drug users who may be unemployed or homeless.

The public's fear of the spread of AIDS and its desire to restrain those individuals who refuse to exercise caution explain the passage of this legislation. In one way, it is an attempt to help those individuals who are engaging in at-risk behavior and to protect society. Instead of criminalizing the behavior, the legislature has made it a civil isolation to perhaps lessen the stigma and to educate the individuals. Although the statute has several procedural guarantees to protect the individual, the vagueness and the discretion given to the Department of Health could lead to abuse and discriminatory application. The application of the law in the upcoming year will give the best indication as to what the problems are. □

Notes

1. *Washington Post,* Dec. 16, 1985, at A1.
2. *See* Colo. Rev. Stat. *et seq.,* and Conn. Gen. Stat. Ann. § 19a-207.
3. Ford and Schmidt, *Electronically Monitored Home Confinement,* National Institute of Justice Reports, Nov. 1985, at 2.
4. *Compagnie Francaise de Navigation a Vapeur v. State Board of Health,* 186 U.S. 380 (1902).
5. *See Jacobson v. Massachusetts,* 197 U.S. 11 (1905) (compulsory vaccination laws do not violate individual's liberty interest), and *Varholy v. Sweat,* 153 Fla. 571, 15 So.2d 267 (1943) (upheld quarantine of prostitute with venereal disease).
6. *Cordero v. Coughlin,* 607 F.Supp. 9 (S.D.N.Y. 1984).

In the United States Supreme Court

Forcible medication of inmates not unconstitutional

***Washington v. Harper*, ___U.S.___, 52 U.S.L.W. 4249 (Feb. 27, 1990)**

by Phyllis Lile-King

In a 6-3 opinion, the Supreme Court held that a state's policy which provided for forcibly medicating a prison inmate, regardless of his competency, was not unconstitutional under the Fourteenth Amendment because certain substantive and procedural safeguards were in place.

The policy in question, Washington state policy 600.30, initiated in response to *Vitek v. Jones*, 445 U.S. 480 (1980) (involuntary transfer from prison to mental hospital unconstitutional without certain due process protections), required first a determination by a psychiatrist that the inmate had a mental disorder and was either "gravely disabled" or he posed a risk of serious harm to himself, others or property. Second, the policy required a hearing before a committee composed of a psychiatrist, psychologist and the Associate Superintendent (none of whom were presently treating the inmate) which reviewed the appropriateness of the recommendation to medicate. The inmate was entitled to twenty-four hours notice of the hearing during which time he was not medicated. The inmate was also entitled to notice of the diagnosis, recommended treatment, and reasons for such treatment. The inmate had a right to be present at the hearing, present evidence, call witnesses, cross-examine witnesses, and be assisted by an independent lay advocate. The inmate could appeal the committee's decision to the prison's Superintendent, and later to a state court. The inmate was entitled to periodic administrative review of his treatment if the court upheld the committee's decision.

Harper, medicated pursuant to policy 600.30, argued that his fundamental and due process rights were violated when he was involuntarily medicated. He maintained that he should have been given a judicial hearing before being involuntarily medicated and that "clear, cogent and convincing evidence that the antipsychotic medication was both necessary and efficient for furthering a compelling state interest was required." The Washington Supreme Court unanimously agreed.

The U.S. Supreme Court, however, in an opinion by Justice Kennedy, rejected both the substantive and the procedural claims. The Court acknowledged that Harper had a significant constitutional liberty interest but weighed this against the state's interest in prison safety and security noting that Harper's right "must be defined in the context of the inmate's confinement." The Court relied on the assumption that the treatment would not have been ordered unless it was in the inmate's medical best interests. Citing *Turner v. Safley*, 482, U.S. 78 (1987), the Court asked whether the policy was reasonably related to legitimate penal interests. A compelling interest standard was not required in a prison, it held. The Court concluded there was "little doubt" that administering antipsychotic drugs was reasonably related to the prison's interest in protecting inmates and other persons. The Courts dismissed the evidentiary standard as inappropriate in this case.

Regarding Harper's procedural challenge, the Court said that the Due Process Clause did not require the "neutral and detached trier of fact be law trained or a judicial . . . officer." The Court instead reasoned that the inmate's interests may even be better protected in a hearing before medical professionals. Also, to require a judicial hearing would place a financial and professional burden on prisons and medical personnel.

The Court ruled that the independence of the members on the hearing committee, the notice requirement, right to be present, present evidence, cross-examine, and have a lay advocate assisting, all helped insure the inmate's interests were in accordance with due process requirements. Finally, the Court noted it was "less than crystal clear why *lawyers* must be available to identify . . . errors in *medical* judgment." (emphasis in original)

Justice Blackmun's concurrence urged formal commitment to ease some of the controversies this case presented.

Justice Stevens, dissented in an opinion joined by Justices Marshall and Brennan, writing that the majority "undervalued respondent's liberty interest; . . . misread the Washington . . . policy and misapplied . . . *Turner* and . . . concluded a mock trial before an institutionally biased tribunal constituted due process of law."

The dissenters pointed out that the Court, while stating that "the Due Process Clause permits" involuntary medication to protect the inmate or other if *"the treatment is also in the inmate's medical interest"* (emphasis in original), actually upheld a policy that made no mention of the inmate's medical interest. Stevens wrote that the majority misread 600.30 which does not require the treatment to be in the inmates' medical interest, but allows it if it protects the inmate, others or *even property* from serious harm. Stevens lamented that policy 600.30 "sacrifices the inmate's substantive

Phyllis Lile-King is a second year law student at the University of Virginia School of Law.

liberty interest to refuse psychotropic drugs, regardless of his medical interest, to institutional and administrative concerns." The Court's failure to distinguish between emergency and nonemergency administration of drugs resulted in the " 'exaggerated response' of forced psychotropic medication on the basis of purely institutional concerns."

Finally, the dissenters attacked the Court's faith that the committee would be disinterested and unbiased. Stevens pointed out that "current treating professionals" served on the committee, and that made it virtually impossible for them to evaluate the inmate's needs fairly. Where structural bias is clear, the dissenters would not require proof of actual bias.

Clear and convincing evidence required to terminate life-support systems

***Cruzan v. Director, Missouri Department of Health,* ___U.S.___, 58 U.S.L.W. 4916 (June 25, 1990)**

by Phyllis Lile-King

The United States Supreme Court, in a 5-4 decision, upheld as constitutionally permissible a state requirement that an incompetent patient's desire to withdraw life-prolonging treatment be proven by clear and convincing evidence.

Nancy Beth Cruzan was injured in an automobile accident in 1983 at the age of twenty-five. Estimations were that Cruzan was anoxic (without oxygen) for twelve to fourteen minutes. The lack of oxygen resulted in permanent brain damage. In efforts toward recovery and rehabilitation, gastrostomy feeding and hydration tubes were implanted in Cruzan pursuant to her then-husband's consent. Cruzan now lies in what is termed a persistent vegetative state, a condition in which she exhibits motor reflexes but has no indication of significant cognitive activity.

When it became apparent that Cruzan would not regain her mental faculties, her parents sought to withdraw the artificial nutrition and hydration. Hospital employees refused to stop treatment unless a court approved. Upon finding that Cruzan had a fundamental right under the state and United State constitutions to refuse or direct withdrawal of death-prolonging treatment, the trial court authorized that treatment be stopped. Cruzan had made some statements to a housemate a year before the accident that "suggest[ed]" that she would not have wished to continue the artificial nutrition and hydration in her present state. In addition, Cruzan's family, doctors, and guardian ad litem agreed either that Cruzan would choose to withdraw treatment or it would be in her best interests to do so. The trial court concluded that withdrawing the treatment would effectuate her fundamental right to refuse treatment.

The Missouri Supreme Court reversed, finding Cruzan's statements to her housemate not sufficiently reliable to determine her true intent. The court questioned whether the doctrine of informed consent was applicable in this case. It rejected that the state's constitution would guarantee a right refuse treatment in every situation, and also doubted that the federal constitution supported a right to refuse treatment in every situation. The U.S. Supreme Court granted a writ of certiorari to consider two issues: whether Cruzan has a right under the U.S. Constitution to direct the withdrawal of life-sustaining treatment, and if so, whether a state may require a clear and convincing standard of proof that withdrawal of treatment is what Cruzan would have wanted.

Justice Rehnquist, writing for the majority, acknowledged a competent person's liberty interest under the Due Process Clause of the Fourteenth Amendment to refuse medical treatment. Rehnquist, noting that this was the first time the Supreme Court had been called upon to answer whether a person has a constitutional "right to die," wrote that, "for the purposes of this case," the Court assumes that a competent person would have a constitutional right to reject nutrition and hydration. He warned, however, that the right under the Due Process Clause "does not end the inquiry." Balancing the patient's liberty interest against relevant state interests would be necessary to determine whether there was a constitutional violation.

The Court declined, however, to recognize that an incompetent person has the same right as a competent person to refuse life-saving treatment. Rehnquist dismissed the claim as question begging because an incompetent person is by definition unable to make an informed and voluntary decision about treatment.

Because Missouri authorized a surrogate in certain situations to make substitute decisions for a patient, the remaining issue was whether the state could mandate procedural requirements in order to assure that the surrogate's decision reflected as closely as possible the patient's intent. The Court noted that the constitutionality of Missouri's clear and convincing evidence standard depended upon what interests the state sought to protect.

The Court affirmed Missouri's interest in the protection and preservation of human life, especially in situations like Cruzan's where abuse by surrogates is possible. In addition, the Court said that the state could consider that proceedings concerning an incompetent person's wishes might not have the added guarantee of accuracy that adversarial proceedings provide. Finally, the state could properly decline from making judgments about "quality of life" and instead assert an unqualified interest in protecting human life. The Court concluded that the clear and

convincing standard of proof was an acceptable method protecting these interests.

Pointing out that the clear and convincing standard was used in civil proceedings, the Court wrote that the standard was appropriate here because the interests at stake were more " 'important' and "more substantial than mere loss of money,' " quoting *Santosky v. Kramer*, 455 U.S. 745, 756 (1982). In addition, the standard reflected society's judgment "about how the risk of error should be distributed between the litigants." quoting *Id.* at 755. Here, the increased burden of proof put the risk of error on the petitioners. The Court observed that the risk of error was well placed, because an erroneous decision not to withdraw treatment could be reversed, corrected or mitigated, while an erroneous decision to terminate treatment was not correctable.

Justice O'Conner concurred in the judgment that prior Court decisions infer a liberty interest in refusing unwanted medical treatment. She emphasized that the Due Process Clause "must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment." She wrote that the majority's decision "does not preclude the future determination that the Constitution requires the states to implement the decision's of a patient's duly appointed surrogate." She continued that states were free to develop other methods of protecting an incompetent patient's liberty interest in refusing treatment.

In his concurrence, Justice Scalia rejected the notion that the Constitution grants a substantive right to refuse treatment. He maintained that protection under the Fourteenth Amendment is procedural only. Defining any decision to deliberately end one's existence as suicide, Scalia endorsed the right of states to prevent one from refusing life-saving treatment. While Scalia implied that there may be "reasonable and humane limits" in requiring a person to preserve her own life, he maintained that those decisions belong to state legislatures and not federal courts.

Dissenting, Justice Brennan, joined by Justices Marshall and Blackmun, said that Missouri's policy was biased and impermissibly burdened Cruzan's right to be free from unwanted treatment. Brennan affirmed a substantive right under the Fourteenth Amendment to refuse treatment, and remarked that in Cruzan's case, no state interest could possible outweigh her right. Rejecting Missouri's asserted interest in the preservation of life, Brennan argued that the "state has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment."

If the state is concerned with accuracy, as it seemed to be here, the policy requiring clear and convincing evidence was asymmetrical by not requiring evidence of the patient's desire to continue treatment. The dissenters rejected the notion that the status quo results in a safer and better decision when a risk of error exists. For Cruzan, continuing treatment against her wishes is destructive and "robs [her] of the very qualities protected by the right to avoid unwanted medical treatment." Because the evidence that Cruzan would choose to withdraw treatment was undisputed, it was the best evidence of what her choice would be. Brennan questioned how a state's decision can be any more accurate than the undisputed agreement of her family, friends, guardian ad litem and doctors.

Justice Stevens, in a separate dissent, did not quarrel with the clear and convincing standard, but with the manner in which the state recognizes Cruzan's best interests. Cruzan, he wrote, has no interest in continuing treatment and has a liberty interest in refusing treatment. Withdrawing treatment would not adversely affect third parties, and there is no reason to doubt that Cruzan's parents were motivated by any bad faith motives in asking for termination of treatment. In the face of all of this, however, the state put aside Cruzan's interests and focused on one piece of evidence of her interests: her expressed intent. The states maintained that it has an interest in preserving life. Stevens argued that the state is defining life instead. Because the definition of life as biological function is not the traditional, historical , and everyday meaning of the term, Stevens noted that the state's interest in preserving biological function is "not commonplace; it is aberrant."

Claim exists against state for "voluntary" admittal of incompetent

***Zinermon v. Burch*, ___U.S.___, 53 U.S.L.W. 4223 (Feb. 27, 1990)**

A person with a mental disorder stated a claim, under 42 U.S.C. § 1983, when he alleged that the state of Florida deprived him of his liberty without due process of law by "voluntarily" admitting him to a hospital when he was allegedly incompetent of giving informed consent. In responding to the state's argument that the claim was barred by *Parratt v. Taylor*, Justice Blackmun, writing for the five justice majority, found the claim valid and not barred by *Parratt* because the deprivation of liberty was not unpredictable nor unauthorized, and because a postdeprivation tort remedy was not sufficient.

The issue squarely addressed by the Court was a technical one—whether Burch could challenge, in federal court, the procedural fairness of his hospital admission. The state argued that the existence of a state common law tort remedy available to Burch after his admission provided all the process that was due under the fourteenth amendment. The debate between the majority and minority opinions focussed on this question, one of critical importance to prisoners and patients of state institutions.

The ruling will affect the administrative practice of state hospitals, which is to admit patients on a voluntary basis, or to convert the status of patients from involuntary to voluntary status. Questions remain as to whether all states must now formally review the competency of voluntary patients, or if not, what kind of procedures will pass constitutional muster. These questions cannot be answered until Burch or another patient like him tries his case on the merits.

Respondent Darrel Burch brought his suit against physicians, administrators, and staff members at Florida State Hospital (FSH) after they allegedly admitted him on a voluntary basis even though he was incapable of giving informed consent. On December 7, 1981, Burch was found wandering along a Florida highway appearing hurt and disoriented.

After an initial stay of three days at Apalachee Community Mental Health Services, where he was diagnosed as a paranoid schizophrenic and was given psychotropic medication, Burch was transferred to FSH for prolonged treatment. Burch signed various forms for voluntary admission and treatment at FSH when he arrived there.

A report dated December 10, by Doctor Zinermon, noted that Burch was distressed and confused and that medication was not helpful. A nursing assessment, dated December 11, stated that Burch was still confused and believed he was in heaven. Despite the observed disorientation of Burch, the hospital allowed Burch to sign forms for voluntary admission and authorization of treatment although such forms required "informed consent." Under Florida statutes, "informed consent" requires that the person be able to make a knowing and willful decision after sufficient explanation of treatment. After five months of hospitalization without any kind of hearing, Burch was released on May 7, 1982.

Burch's complaint alleged that the defendants, under color of state law, knew or should have known that he was incapable of voluntary admission, and that by admitting him they violated his liberty without due process guaranteed by the fourteenth amendment. Florida law allows an emergency detention of to 48 hours, with the possibility of detention up to five days with a judicial order if the individual is found to be dangerous and in need of care. An individual may be admitted on a voluntary basis with express and informed consent. If an individual is determined to be incompetent, a hearing for involuntary admission is held and commitment is for a six month duration.

The district court granted the defendant's motion to dismiss under the Federal Rules of Civil Procedure 12(b)(6), relying on *Parratt v. Taylor*, 451 U.S. 527 (1981) and *Hudson v. Palmer*, 468 U.S. 517 (1984), which held that a deprivation of property without due process did not give rise to a § 1983 action if caused by random unauthorized actions and if a postdeprivation remedy was available. The district court reasoned that since Burch's allegation was against the way in which the state had applied the law, and not whether the law was adequate, the only issue was whether the state could have provided some predeprivation process in order to decrease the risk of deprivation. Because the state was unable to feasibly prevent its employees from misapplying the law, the district court found the postdeprivation tort remedies sufficient. The Eleventh Circuit Court of Appeals, en banc, reversed and remanded. The Supreme Court granted certiorari in order to the resolve the inter-circuit disagreement on when the *Parratt* exception applies.

In assessing whether Burch had failed to state a claim under Rule 12(b-(6), the court examined the applicability of § 1983 to the alleged wrongdoing. Relying on *Monroe v. Pape*, 365 U.S. 167 (1961), the court stated that a plaintiff can use § 1983 for violations of the bill of rights or for violation of substantive rights without regard to availability of state tort remedies. However, the existence of state remedies is relevant for due process violations because a violation exists only if the process provided is not sufficient.

Although the court noted that some kind of hearing prior to deprivation of liberty is required usually, sometimes a tort remedy or postdeprivation hearing is sufficient. The defendants had argued that under *Parratt* the postdeprivation tort remedy provided was sufficient procedural fairness because it is the only remedy a state can be expected to provide when predeprivation procedures cannot do anything to decrease the risk of erroneous deprivation. Additionally, they relied upon *Hudson*, which extended the *Parratt* rule to intentional deprivations of property, because the state is unable to control for the random unauthorized violations by its agents.

The court refused to limit the application of *Parratt* and *Hudson* to property cases as Burch wanted. Instead, it focused whether any predeprivation procedures could address the risk of deprivation. First, the risk is that of those people who voluntarily admit themselves to mental hospitals, many may be incompetent to sign the voluntary forms. Justice Blackmun suggested that "the very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered "explanation and disclosure of the subject matter.' "

The court further reasoned that because voluntary admission does not include the procedural safeguards that come with involuntary commitment, a danger of indefinite confinement exists because the individual cannot appreciate the voluntary admission and the rights that go with it. An individual could be unable to give informed consent yet still not fall into the involuntary commitment categories. If committed "voluntarily", the individual would be denied liberty and it would be unconstitutional under *O'Conner v. Donaldson*, 422 U.S. 563 (1975), which held that it is unconstitutional to commit a person if he does not need to be committed.

Given the obvious risks, the court emphasized the value of predeprivation safeguards. Given the broad delegation of authority to hospital staff to admit the patient, the Court criticized the lack of safeguards in the statute. Justice Blackmun described Burch's suit as "not simply attempting to blame the State for misconduct by its employees. He sought to hold state officials accountable for their abuse of their broadly delegated, uncircumscribed power to effect the deprivation at issue." The Court found the deprivation predictable, unlike in the cases of *Parratt* and *Hudson*, and that the state could specifically determine when the error would occur. Unlike the other cases where predeprivation procedures would have been impossible, the Court concluded that the state could have done something to check the competency before admittance. Because the state had delegated the authority to make admissions, the conduct was not unauthorized as in the prisoner cases. All of these factors, the court held, were reasons that the *Parratt* and *Hudson* exceptions did not apply and that a postdeprivation tort remedy was not sufficient. Given that the exceptions did not apply in this case, Burch's claim was valid and the court remanded for further proceedings.

The dissent, written by Justice O'Conner, said that *Parratt* and *Hudson* did apply in this case. Because the plaintiff did not complain against the procedures, but only that they were wrongfully employed, the case was analogous to those in which agents of the state act negligently. The dissent argued that the state was not in a position to ensure that its officials would follow procedures. For example, if a doctor was intent on subverting the competency requirement, no amount of predeprivation procedures could ensure compliance. Because a state can never adequately foresee a precise violation, the dissent reasoned that postdeprivation remedies are sufficient.

The dissent further criticized the court's reliance on the state's inappropriate delegation as creating a line-drawing problem of not knowing when a delegation would be inappropriate. They claim that the court had discovered an additional realm of required safeguards, apart of *Matthews* and *Parratt*, which puts the burden on the state to provide additional safeguards and on state actors to show that the state sufficiently constrained their power. □

Americans with Disabilities Act passed by both houses

Both the Senate and the House have passed versions of the Americans with Disabilities Act. The purpose of the ADA is to prohibit discrimination against persons with physical or mental disabilities by establishing a clear and comprehensive national statute. The ADA addresses and attempts to remedy discrimination in the areas of employment, public services, public accommodations, and telecommunications.

Title I of the Act prohibits discrimination against qualified persons with disabilities with respect to job applications, hiring or discharge, compensation, or other conditions of employment by employers with more than fifteen employees, employment agencies, labor organizations, or joint labor-management committees. Employers must make reasonable attempts to accommodate a physical or mental limitation unless it would impose an undue hardship on the business. The United States or a corporation wholly owned by the government is exempt from the definition of employer. Enforcement is through the provisions contained in the 1964 Civil Rights Act.

The public services provisions in Title II of the Act guarantees that persons with disabilities will have access to benefits from services or programs of state or local governments. Additionally, this section requires public transportation be made accessible to those with disabilities. The exact definition of public transportation is very detailed especially concerning rail travel, and air carriers are excluded from the requirements.

Title III invokes the Congress's power to regulate interstate commerce when it requires conformity to accessibility standards from privately operated businesses. Privately owned public accommodations which include hotels, restaurants, retail establishments, service establishments, museums, and schools among others, and privately owned transportation, excluding air carriers, would not be allowed to discriminate or deny access on the basis of disability.

The telecommunications section, Title IV of the Act, provides for services for the hearing-impaired and speech-impaired. The Federal Communications Commission will be able to require that services be provided for those with disabilities to the best extent possible.

Hopefully, with the ADA, relief will be available to more than 40 million persons with disabilities in this country. The national mandate for prohibition of discrimination is a positive step towards the eradication of discrimination against those with disabilities.

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Box 100
Blue Ridge Hospital
Charlottesville, VA 22901

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Interventions for prenatal misconduct

by Richard J. Bonnie

It is an old story by now that advances in clinical and scientific knowledge often raise puzzling and difficult ethical and legal problems. Advances in our understanding of congenital malformation, mental retardation, and genetic disease, and in our capacity to predict many of these conditions, have naturally called attention to the possibilities of prenatal intervention -- either to prevent the conditions from developing in pregnancies taken to term, or to prevent conception or birth.

Recent developments in tort law have, in effect, created new duties for physicians to assess and manage teratogenic risk -- by warning couples at risk of having defective children and offering them diagnostic tests and counseling. Some of these cases seem to push in the direction of a duty to abort pregnancies that would, if taken to term, produce severely defective children.

Efforts can also be made to prevent exposure to hazards not within the pregnant woman's control. Concerns about possible embryotoxicity, teratogenicity, and mutagenicity play a prominent role in the risk assessment of environmental chemicals -- in the air, water, and food supply. Regulation of environmental exposures suggests an area over which a woman may exercise at least hypothetical control -- workplace hazards. This possibility presents another conflict. If an employer adopts exclusionary policies so that women are not exposed to reproductive hazards, are women's rights to equal employment opportunities being violated?[1]

I want to focus on another aspect of this problem -- situations in which certain prenatal interventions could prevent birth defects in pregnancies taken to term.

Richard J. Bonnie, LL.B., is the John J. Battle Professor of Law at the University of Virginia and the Director of the Institute of Law, Psychiatry and Public Policy.

I want to focus only on a smaller subset of these situations -- those in which the risks to the healthy development of the fetus are within the control of the pregnant woman.

Most people would agree, I think, that the pregnant woman who has decided to bring her pregnancy to term has a moral duty to promote the fetus' well-being. The controversial issue is whether and under what circumstances this duty is, or ought to be, legally enforceable. Use of alcohol and illicit drugs poses the problem most clearly, but cigarette-smoking and failure to comply with prescribed dietary and medication restrictions can also be problematic.

What legal duties does a woman have to behave in ways that reduce teratogenic risks to her offspring? Or more broadly, what types of legal intervention would be useful and desirable for promoting reasonable prenatal behavior and for discouraging prenatal misconduct? Finally, when is coercive intervention permissible and desirable? More specifically, under what circumstance does concern about the well-being of the offspring justify coercive restriction of the pregnant woman's autonomy?

Legal Devices for Preventive Intervention

The first line of intervention is informational. For example, most states already require a serological test for syphilis in pregnant women. In addition, one obvious effect of potential legal liability for physicians is to encourage diagnostic testing for preventable defects and to encourage physicians to identify risk factors relating to the pregnant woman's prenatal behavior and to persuade her to reduce them. Warning labels on cigarettes and on alcoholic beverages have a similar pedagogical effect.

A revealing manifestation of the

Also in this issue:

underlying controversy is that some feminist groups have opposed the alcohol "warning" proposals on the ground that they reflect a discriminatory impulse -- they are aimed only at women, of course -- and devalue the woman's autonomy. This strikes me as more than a little silly, but it signals how controversial the whole topic is.

The efficacy of informational devices depends on their persuasive effects. The issue I want to deal with here is whether persuasive strategies should be supplemented by coercive ones.

First, I'll address some of the legal devices that might be available to discourage, interrupt or punish prenatal misconduct. Then I want to consider the argument that coercion in any form is an impermissible interference with the pregnant woman's autonomy. Finally, I'll suggest a few ideas about the direction in which the law might sensibly develop.

Post-Birth Sanctions

Consider first the possibility of sanctions imposed after the fetus is born in a defective condition. One highly publicized case occurred in San Diego when Pamela Stewart, a pregnant woman with placenta previa, allegedly ignored her doctor's advice to stop using amphetamines, to avoid sex, and to go immediately to the hospital if and when she began bleeding. On the day her child was born, she had allegedly taken amphetamines, had sex with her husband, and delayed going to the hospital for "many hours" after she began bleeding. Her baby was born alive with severe brain damage and died six weeks later.

The district attorney filed misdemeanor charges against Ms. Stewart under a California statute that punishes a "parent of a minor child who willfully omits, without lawful excuse, to furnish necessary . . . medical attendance or other remedial care for his or her child." The law also included a provision that "a child conceived but not yet born . . . [is] an existing person" within the meaning of the statute. The district attorney said that he was prosecuting Ms. Stewart because she "didn't follow through on the medical advice she was given."

The trial court eventually dismissed the charges on the ground that the statute was aimed at parental failure to provide adequate financial support for their children's medical needs, or in the case of pregnancy, for prenatal care. It was not enacted, the court concluded, for the purpose of punishing pregnant women for conduct that endangers the well-being of their fetuses. At the same time, the court left open the possibility that the legislature might decide to criminalize such prenatal misconduct. In order to pose the issue, let us now suppose the legislature did this, either by amending its child abuse statute or by modifying its "reckless endangerment" statute so that it applied to the endangerment of fetuses.

Some might feel that what Ms. Stewart did reflected such gross indifference to the well-being of the fetal life she was carrying that punishment is necessary to vindicate the retributive aims of the law. Be that as it may, however, the key question for present purposes is whether the threat of a criminal prosecution for endangering the fetus or for causing it harm would deter the Pamela Stewarts of the world from behaving in this way. I would be skeptical about the deterrent effect of such a prosecution -- it seems unlikely that the inchoate threat of criminal sanctions could have much impact on a woman who is not deterred by the prospect that she will give birth to an impaired child. I suspect, however, that the threat of prosecution might have some value to the physician who is managing the pregnancy; he or she may find it useful to be able to call the recalcitrant woman's attention to the possibility of criminal liability (or of civil liability for wrongful life) in order to convince her of the seriousness of the risk.

Preventive Interventions

Whatever might be said about the deterrent efficacy of post-birth sanctions, it is clear enough that prenatal intervention would be much more useful. Consider the possibilities:

First, if the pregnant woman's conduct is itself criminal or is associated with other criminal conduct, a legitimate basis for intervention is present. In June of

– continued on page 29

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Richard J. Bonnie
W. Lawrence Fitch

In the Virginia Supreme Court

Sovereign immunity given to state physician in medical research program

Gargiulo v. Ohar, 239 Va. 209, 387 S.E.2d 787 (1990)

The Supreme Court of Virginia granted sovereign immunity from medical malpractice liability to a state employed physician engaged as a fellow in a medical research and training program.

The case concerned a research protocol to study scleroderma, a chronic disease of the connective tissues. The research was conducted at the Medical College of Virginia, in Richmond. Dr. Ohar inserted a heart catheter in Mrs. Gargiulo, a research subject, allegedly inducing a coma and causing severe and permanent injuries.

Writing for the majority, Justice Poff applied the four part test outlined in *James v. Jane*, 221 Va. 43, 282 S.E.2d 864 (1980), to determine whether sovereign immunity should apply in this case. First, the court found that the physician was employed as a student and not as an independent contractor such as an attending physician who practices in a state institution. Second, the state had an interest in training specialists by employing them in research protocols. Third, Ohar had to make judgments on prospective patients, thus giving her discretion as a doctor. Fourth, in contrast to physicians who work independently in state hospitals, the state exercised control over Dr. Ohar through her salary, her training, her inability to refuse patients, the mandatory use of state procedures, and supervision by state employees. Justice Poff concluded that sovereign immunity was appropriate in this case.

The dissenters, Justices Stephenson and Compton, disagreed, arguing that Dr. Ohar was like a private physician in a state hospital. They emphasized that Dr. Ohar was a licensed and board certified physician specializing in internal medicine and not an intern or trainee. They said a physician-patient relationship should be subject to liability, and that granting sovereign immunity to licensed physicians discourages good medical practice. The dissent asserted that the state's interest in decreasing the cost of medical malpractice insurance was not compelling enough to grant sovereign immunity.

In the Federal Courts

Federal suit for failure to maintain safe environment dismissed

Lindsay v. Northern Virginia Mental Health Institute, 736 F.Supp. 1392 (E.D.Va. 1990)

The superintendent and an attending psychiatrist of the Northern Virginia Mental Health Institute (NVMHI) were dismissed from a lawsuit via a motion for summary judgment in a case concerning a patient who escaped from the institute and died of hypothermia.

The family of Carolyn S. Lindsay filed suit for a violation of her civil rights. The allegations included failure to maintain a safe and secure environment and medical malpractice. Lindsay was admitted to NVMHI in December of 1987 in response to her refusal to be treated by a private psychiatrist. She had attempted suicide on two occasions and believed that she suffered from a contagious disease and could not be near other people. Lindsay escaped through a window within twenty-four hours of her admittance to NVMHI. In February of 1988, Lindsay's body was found in a wooded area. The cause of death was hypothermia.

The court entered summary judgment for the institute's superintendent, on the basis that he was not a "person" under 42 U.S.C. § 1983. Because the plaintiffs sued the superintendent in his official capacity, they were, in essence, suing the state. Such suits are not allowed under § 1983. The court granted summary judgment for the attending psychiatrist, on the ground that he enjoyed qualified immunity. Because the plaintiffs did not put forth evidence that negligence had occurred, the court found that no issue of fact existed to justify continuing the suit. The institute itself had been dismissed from the lawsuit following an earlier motion.

Although the case was dismissed from federal court, plaintiffs may bring their medical malpractice claim in state court.

CLARIFICATION

A new provision of the Virginia Code (SB 218; ch.308; amending sec. 63.1-55.3.) requiring reports of abuse to adults was described in the previous edition of *Developments*. The law already required a report to be made to the local department of social services by caretakers and others when abuse of adults was suspected; suspected sexual abuse of adults now requires a second report to a local law enforcement agency.

Mental illness not a bar to reduction in sentencing for acceptance of responsibility

U.S. v. Braxton, 903 F.2d 292 (4th Cir. 1990)

Mental illness does not necessarily bar a reduction in sentencing for acceptance of responsibility, according to a Fourth Circuit Court of Appeals opinion of May 8, 1990. Because rehabilitation is no longer a purpose of incarceration under federal law, lack of remorse due to mental illness is not determinative in sentencing.

Thomas Braxton was confined to St. Elizabeth's Hospital in Washington D.C. after having been found not guilty by reason of insanity on a charge of bank robbery in 1974. In 1988, four deputy marshals attempted to apprehend Braxton after he escaped from St. Elizabeth's. Braxton twice fired a .38 caliber revolver through a door opening at the deputies when they tried to arrest him. He informed them that he was not returning to the hospital and that he would kill them if they came into his apartment. Braxton subsequently plead guilty to charges of assault of a federal officer and use of a firearm during a violent crime.

Arguing in favor of a motion for a reduced sentence, the defense asserted that mental illness prevented Braxton from showing remorse, and that without remorse, he could not be rehabilitated and accept responsibility for his action. Thus, he could not qualify for a reduced sentence under federal sentencing guidelines. The motion was denied.

The Court of Appeals reversed because rehabilitation is not a goal of incarceration under federal law. Although a guilty plea is not determinative, the court stated that it is one of the factors that a court should consider when it reviews reductions in sentence available to those who accept responsibility following a crime.

The Court of Appeals remanded the case for sentencing. The District Court may still deny the reduction, but it may not base its decision on the defendant's mental illness and inability to show remorse.

Requirements for supplemental security income reviewed

Flowers v. U.S. Dept. of Health and Human Services, 904 F.2d 211 (4th Cir. 1990)

On May 29, 1990 the U.S. Court of Appeals for the Fourth Circuit reversed a decision of a lower court denying a claim for supplemental security income benefits. According to the appellate court, the trial decision was not supported by substantial evidence. The court reiterated the rule that if a claimant cannot return to his past relevant work, he can establish a significant work related limitation of function and can qualify for supplemental security income benefits under § 12.05(c) of the Social Security Act.

Claimant Stroun Flowers applied for benefits, alleging that he was disabled due to seizures and a hip problem. Flowers was born in 1944 and completed the seventh grade in school. He worked from 1971 to 1978 driving a large tractor at a sawmill, but has been unable to work since July of 1978. With a Verbal IQ score of 72, a Performance IQ score of 66, and a Full Scale score of 68, Flowers met the IQ requirements of § 12.05(c). The remaining question was whether he met the condition for a physical "impairment imposing additional and significant work-related limitation of function."

An administrative law judge ruled for the Social Security Administration that Flowers was not disabled because his complaints were neither "credible nor corroborated by medical evidence" and that the impairments did not prevent him from performing his past relevant work. The Secretary of Health and Human Services (HHS) adopted these findings and both a magistrate and a federal district judge ruled that substantial evidence supported the decision.

The Court of Appeals disagreed, declaring that no substantial evidence existed to support the HHS position because medical evidence, which had not been contradicted, showed that Flowers' disability prevented him from doing his past work.

The court relied on the report of a physician who had treated Flowers following an accident. His report concluded that Flowers had a seizure disorder. Additionally, a report from Petersburg Hospital indicated that Flowers was taking the prescription drugs Dilantin and Phenobarbital to control seizures. Finally, the court relied on the disability report requested by the Secretary. That report stated that Flowers was unable to do any of his past jobs, and that due to a possible seizure disorder, he was "limited in work involving exposure to unprotected heights, moving machinery and driving motor vehicles." Because Flowers could not return to his work as a timberjack driver, the Secretary's decision was in error and Flowers was entitled to benefits.

Insanity acquittees secure social security benefits

Kriegbaum v. Katz, 909 F.2d 70 (2nd Cir. 1990)

In an opinion announced July 16, 1990, the United States Court of Appeals for the Second Circuit decided that New York cannot use legal processes to secure insanity acquitees' social security benefits to defray the cost of institutionalization. New York had sought payment to defray the cost of institutionalization from the estates of Raymond Kriegbaum and Walter

Sendziak who had saved $48,776.33 and $18,114.86, respectively, in social security benefits. Both Kriegbaum and Sendziak were involuntarily committed to a state facility following trial court findings that they were not guilty "because of mental disease or defect," of crimes charged. A 1985 New York law requires insanity acquitees to pay for the costs of their institutional care (§ 43.03(c) Mental Hygiene Law). The state sent invoices to the conservators of each estate asking for payment for services rendered. When the conservators refused to pay, the state Attorney General's Office initiated proceedings in the New York State Supreme Court to secure payment for Sendziak's care, but did nothing other than send bills for Kriegbaum's care.

The conservators filed a complaint in Federal District Court alleging that the New York law violated their right to due process under the Fourteenth Amendment and that it was inconsistent with § 207 of the Social Security Act. The District Court agreed and enjoined the state from pursuing the matter in any legal proceeding.

The Court of Appeals affirmed the judgment, basing its decision on the Supremacy Clause of the United States Constitution which makes federal law superior to state law. Section 207 of the Social Security Act provides that no monies paid under the Act shall be subject to legal process. The court endorsed the policy encompassed by this section of federal law, enacted in order to protect social security beneficiaries and their dependents from the claims of creditors.

The state argued that the "special proceedings" to compel Sendziak's payment were not legal processes, but were efforts to get the conservators to abide by their obligations to pay for maintainance including institutional care. The court rejected this argument, noting that federal regulations prohibit the use of any legal process to coerce payment, and commenting that "haling someone into court" was obviously "legal process" as defined by New York law. Because Kriegbaum was not subject to any legal process, he did not have a cause of action against the state and the bills sent to him were not improper.

Forensic Symposium

The Institute's Forensic Evaluation Training and Research Center will present its 20th Semi-Annual Forensic Symposium Friday, May 3, 1991, at the Omni Hotel in downtown Charlottesville, Virginia.

For information, contact Neva Dingus, Program Coordinator, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901. Phone: (804) 924-5435.

Hospital allowed to fire nurse for failure to reveal HIV test results

Leckelt v. Board of Commissioners of Hospital District No. 1, 909 F.2d 820 (5th Cir. 1990)

On August 28, 1990 the United States Court of Appeals for the Fifth Circuit held that the termination of a nurse by the government-funded Terrebone General Medical Center (TGMC) for failure to disclose the results of a test for HIV infection did not violate the Federal Rehabilitation Act of 1973, Louisiana civil rights law, or Constitutional rights to equal protection and privacy.

TGMC's board of commissioners decided on April 7, 1986 that it would ask nurse Kevin Leckelt to be tested for HIV antibodies following reports that Leckelt was homosexual and was a roommate of a TGMC patient with AIDS. After Leckelt refused to reveal the results of a recent HIV test, the board decided that he would not be allowed to work until he complied with the request. The board also stated that should the results be positive, Leckelt would be placed on leave with pay pending further review. By April 27, 1990, Leckelt had not reported his test results. TGMC terminated him for failure to comply with hospital policies.

Leckelt filed a claim in Federal District Court alleging that the hospital's requirement to submit to testing for HIV and his subsequent termination violated his civil rights under state and federal law. The District Court found in favor of the hospital on all causes of action. The Court of Appeals affirmed the judgment.

Leckelt's primary challenge was focused upon the Federal Rehabilitation Act of 1973, which prohibits federally funded programs from discriminating against otherwise qualified handicapped individuals solely because of the individual's handicap. Assuming that HIV is an impairment under § 504 which prohibits discrimination, the appellate court found that the discrimination was not based solely on Leckelt's perceived handicap. TGMC's policy on disease control required employees to report exposure to infectious diseases and to be tested for them. Leckelt's sexual orientation put him into a high risk group for contracting HIV and AIDS, and the hospital suspected that he had been exposed to HIV in contact with his roommate. The court concluded that the hospital could require him to submit to testing and reasoned that the hospital fired Leckelt for failure to comply with policies on disease control and not because he might be HIV positive.

The court found no violation of Fourteenth Amendment equal protection rights because the requirement to submit to testing was rationally related to the state's legitimate interest in protecting both health care workers and patients. Leckelt's right to privacy under the Fourth Amendment was not violated because Leckelt had no reasonable expectation that the results would be private, given the infection control practices at TGMC.

In the United States Supreme Court

Health care providers allowed to sue state over Medicaid plan

Wilder v. Virginia Hospital Association, 110 S. Ct. 2510, 58 U.S.L.W. 4795 (June 18, 1990)

The United States Supreme Court decided on June 14, 1990 that the Virginia Hospital Association could sue the state of Virginia under 42 U.S.C. § 1983 to enforce the Boren Amendment of the Medicaid Act. Justice Brennan, writing for the majority, found that the Medicaid statute created an enforceable right for health care providers to receive "reasonable and adequate" reimbursement from the states. This decision will allow health care providers to challenge a state's Medicaid reimbursement plan through litigation.

The Boren Amendment requires that the reimbursement rates that states set for hospitals be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . to assure . . . reasonable access." The Amendment affects nursing homes, intermediate care facilities, hospitals, and intermediate care facilities for the mentally retarded.

The Virginia Hospital Association, a nonprofit corporation of public and private hospitals in Virginia, alleged that Virginia's prospective reimbursement formula was not adequate and reasonable, nor did it assure access to inpatient care. The Supreme Court's decision did not address whether the plan was reasonable; it merely allowed the Association to bring the claim.

Review denied in *Thomas S.* case

Flaherty v. Thomas S., 902 F.2d 250 (4th Cir. 1990), *cert. denied*, 59 U.S.L.W. 3326 (Oct. 29, 1990)

The United States Supreme Court refused to review the Fourth Circuit's decision in *Thomas S. v. Flaherty*, (see 10 ***Developments in Mental Health Law*** 9, January-June 1990). The denial of review allows the decision of the Fourth Circuit to stand.

Thomas S. involved mentally retarded patients who were confined without diagnosis of mental illness and treated with antipsychotic drugs.

The Fourth Circuit's ruling allowed patients who were released while the suit was pending to be eligible for help if they suffered from their hospitalization. The court concluded that evidence presented in the case rebutted the presumption that the hospitals were giving adequate care. The court determined that the patients had a right to minimally adequate treatment, to be assessed via case-by-case evaluations.

The most significant effect of the Fourth Circuit's decision is that it allowed certification of a class of mentally retarded adults who allege suffering because of improper past or current treatment in a state facility. Although the state does not have a general duty of care to persons never in its care, the court held that a duty does exist to those patients who may be harmed by state policies. The class certification will allow all of those affected patients to sue the state.

Connecticut ruling on court ordered psychiatric exam allowed to stand

State of Connecticut v. Manfredi, 569 A.2d 506 (Conn. 1990), cert. denied, 59 U.S.L.W. 3326 (Oct. 29, 1990)

The U.S. Supreme Court denied review of a Connecticut case in which a trial court ordered a psychiatric evaluation of a defendant before he filed notice of his intent to rely on the defense of insanity.

Defendant Russell Manfredi was arrested for murdering his wife. In support of a motion to modify his bond, Manfredi presented the testimony of a psychiatrist who recommended that Manfredi be placed in a psychiatric hospital. At the request of the state, the court ordered a second psychiatric evaluation, approving the exam on the grounds that the defendant had already introduced psychiatric evidence, and the state needed to know how the case would proceed. Manfredi was found competent to stand trial, and subsequently invoked an insanity defense. A jury found him guilty of murder.

Manfredi appealed his conviction, arguing that the court should not have required a psychiatric exam before he had placed his mental status at issue by giving notice that he would rely on the insanity defense.

The Connecticut Supreme Court ruled that the trial court acted within its authority under Connecticut law. While the court conceded that the Fifth amendment protects a criminal defendant from compulsory psychiatric examinations, (*Estelle v. Smith*, 541 U.S. 454 (1981)), it noted that a defendant waives this right when he places his mental status at issue by filing notice of intent to rely on the insanity defense. The court reasoned that because Manfredi had introduced substantial evidence regarding his psychological problems, the trial court had reasonable grounds to believe that the defendant's mental status would be at issue.

The Connecticut court limited its holding to cases where substantial evidence regarding mental status exists, and required the trial court to indicate the basis for its finding on the record and to issue an appropriate protective order regarding communication between the state and the examining physician.

Forcible medication to restore competency for execution reviewed

Perry v. Louisiana, 59 U.S.L.W. 4007 (Nov. 13, 1990)

In an opinion announced November 13, the Supreme Court vacated the judgment of a Louisiana trial court that would have allowed state prison officials to forcibly medicate an inmate to restore his competency for execution. The questions before the Court were: (1) does the Eighth Amendment's prohibition against cruel and unusual punishment bar a state from forcibly medicating an inmate to restore competency? and (2) does the Fourteenth Amendment's due process guarantee allow the prisoner the right to refuse such medication?

In 1983, Michael Owen Perry was convicted of murdering his parents, two cousins and a two year old nephew. He was sentenced to death for each of the five murders. Since his conviction, Perry has been treated for schizoaffective disorder in the Louisiana State Prison psychiatric unit. A major feature of his treatment consists of intramuscular and oral doses of Haldol.

At oral argument on October 2, Perry argued that forcible medication is cruel and unusual because it is not treatment and it violates "evolving standards of decency" as demonstrated by trends in state legislatures. Additionally, he argued that even with medication, he did not meet the standard for competency and could not be executed. Perry also claimed that Louisiana and federal law give him the right to refuse medication.

Louisiana contended that because the medication is necessary to improve Perry's health it is treatment, and disagreed with Perry's claim that a national consensus exists on this issue. The state focused its argument on the contention that Perry does meet the competency standards when medicated, and that the state's interest in rendering an inmate competent for execution outweighed his right to refuse treatment.

The Supreme Court's *per curiam* decision remanded the case to the Louisiana trial court for further consideration in light of the recent opinion in *Harper v. Washington*, 494 U.S. ___(1990)(see ***Developments in Mental Health Law*** 15, January-June 1990) a case that dealt with due process issues arising in the context of forced medication of an inmate.

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News From Other States

Maryland court follows *Harper* rule in hospital case

Williams v. Wilzack, 573 A.2d 809 (Md. 1990)

One year ago, in *Washington v. Harper*, the United States Supreme Court gave constitutional clearance to the forced medication of a prison inmate on an administrative finding that the inmate was mentally ill and dangerous. The court recognized that the inmate had a "constitutional right to refuse treatment" but decided that if the inmate were dangerous, and if treatment would be in the inmate's best interests, then treatment could be administered despite his objections and regardless of whether he was competent to make an informed treatment decision. The court declared that "the extent of the prisoner's right under the constitution to avoid the unwanted administration of anti-psychotic drugs must be defined in the context of the inmate's confinement." Because the context of Harper's confinement was a prison housing highly dangerous individuals, the court reasoned, the state's interest in safety and security outweighed Harper's interest in avoiding medication. Moreover, the court ruled, no judicial hearing would be necessary to over-ride an inmate's refusal of treatment. An administrative hearing conducted by a panel of prison personnel not involved in the inmate's treatment would suffice, so long as the inmate received notice of the hearing, was represented by an advocate (not necessarily an attorney), and was given an opportunity to present evidence and cross-examine witnesses at the hearing.

Harper was significant because it was the first United States Supreme Court opinion squarely addressing the right of an institutionalized person to refuse treatment with neuroleptic medication. Because the court's opinion in *Harper* relied heavily on previous prisoner's rights decisions, however, some observers have reasoned that it would have little or no impact on the developing law concerning the "right" of civilly committed patients to refuse medication.

Recently, however, the Maryland Court of Appeals -- Maryland's highest court -- ruled in *Williams v. Wilzack* that the *Harper* approach to resolving questions of treatment refusal was constitutionally acceptable in the context of a state hospital housing involuntarily committed forensic patients. The patient in this case, Laquinn Williams, was involuntarily admitted to Maryland's Clifton T. Perkins Hospital, a maximum security facility, after being found not criminally responsible (not guilty by reason of insanity) for attempted rape and battery. He was diagnosed as schizophrenic,

paranoid type. When he expressed a wish not to take the Mellaril prescribed by a hospital physician, his treating psychiatrist invoked a statutory procedure to force the medication. The procedure -- one that is applicable to all involuntarily committed patients in Maryland, not just patients in forensic mental health facilities -- called for a clinical review by a panel consisting of the clinical director of the hospital, a psychiatrist, and a non-physician mental health provider. The panel was to consider a number of factors, including the patient's reasons for refusing treatment, the patient's capacity to make treatment decisions, and the potential consequences of forcing or foregoing the treatment.

The panel in Williams' case found that administration of Mellaril was the least intrusive treatment that would be effective and that without this treatment Williams would likely regress and become more hostile. When Williams threatened to obtain an *ex parte* injunction against the forcing of medication, the hospital convened a second review panel. It reached the same conclusion as the first. It also reasoned that to withhold the Mellaril would "lengthen the time of hospitalization, maintain the barrier to relating with others, and perhaps allow Mr. Williams to further disintegrate." The day after this second panel announced its decision, Williams sued in state court, alleging violations of his state and federal rights to privacy, due process, and freedom of speech, thought, and religion. Both Williams and the state moved for summary judgment. The court granted the state's motion and denied Williams', finding that the state acted in compliance with the statute and that the statute itself was constitutional. Williams appealed, arguing that, under both the state and the federal constitutions: (1) a competent person has a protected right to make his or her own treatment decisions, absent an emergency; (2) due process requires that a judicial hearing be conducted to determine whether a person might be medicated involuntarily; and (3) persons facing forced medication enjoy procedural rights not accorded by the Maryland statute, including the right to notice of the place and time of the hearing, the right to counsel at the hearing, the right to attend the hearing and question witnesses, the right to a written decision, and the right to appeal an adverse determination.

In assessing Williams' claim, the court reviewed in some detail the leading federal cases relating to the question of a psychiatric patient's "right to refuse" medication, ultimately deciding, on the basis of the U.S. Supreme Court's opinion in *Harper*, that Williams' constitutional rights had been violated. Because the procedure pursuant to which Williams' treatment refusal was overridden did not on its face require the kinds of due process protections mandated by *Harper* (e.g., notification of a hearing, right to be present at the hearing, right to the assistance of an advisor), it was constitutionally inadequate, the court reasoned. Moreover, the court declared, in the absence of a valid statutory mechanism for determining Williams' rights, common law principles would govern, and, in Maryland, the common law would prohibit the nonconsensual administration of medication to a mentally competent adult under non-emergency circumstances. Although the court did not resolve Williams' other claims (that forced treatment absent a court adjudication of incompetency was unconstitutional), its heavy reliance on *Harper* would suggest that it would have been less sympathetic to those claims. Thus, in Maryland at least, it would appear that *Harper*, a case involving a prison inmate, has established the constitutional parameters for determination of a psychiatric patient's "right to refuse treatment."

– W. Lawrence Fitch

ATTORNEY GENERAL ISSUES OPINION ON TREATMENT WITHDRAWAL

In response to a request from Roanoke delegate G. Steven Agee, the Attorney General clarified the application of Virginia's Natural Death Act [Va. Code Sec. 54.1-2981] to situations in which a substitute decisionmaker may consent to withdrawal of treatment from a patient. The opinion explored the conditions that must be present before an advanced written directive may be honored. While the Natural Death Act allows competent adults to prepare a written declaration authorizing withdrawal or withholding of treatment, such a directive has no effect unless the patient is suffering from a terminal condition. Thus, many patients who are incurably comatose or surviving in a persistent vegetative state cannot benefit from earlier written directives they made to avoid life prolonging procedures, because they do not fit the statutory definition of having a "terminal condition."

Virginia law, according to the Attorney General, does contain an alternative to the Natural Death Act that would allow a patient's wishes to be carried out, despite the absence of terminal illness. The General Assembly passed a substituted consent statute in 1989 [Va. Code Sec. 37.1-134.4] that permits surrogate medical treatment decision-making for patients determined "incapable of making an informed decision" about their care. The new statute would allow the designated surrogate to consent to care and also authorize withdrawal or withholding of care, including nutrition and hydration. The surrogate's authority could apply when the patient was incurably comatose or in a persistent vegetative state, even though no terminal illness had been diagnosed.

The standard of proof that must be met for surrogates to withstand a court challenge of their decisions is "preponderance of the evidence" [Va. Code Sec. 37.1-134.4(F)]. According to the Attorney General, a written directive designating a substitute decisionmaker for health care and authorizing that person to terminate treatment should meet that standard or even the standard of "clear and convincing evidence" required in other jurisdictions.

. . . prenatal misconduct

-- *continued from page 22*

1988, a trial judge in Washington, D.C. sentenced Brenda Vaughn to a jail term for second-degree theft, despite the fact that she was a first offender. In open court, and in a sentencing memorandum later published in the *Washington Post*, the judge explained that he had given Ms. Vaughn a jail term in order to protect the fetus that she was carrying from exposure to further drug use: "She had continued to abuse cocaine, did it while she was pregnant, and stood a substantial chance of harming society's most precious resource -- a helpless child-to-be . . . ." A former student who works as a public defender in Washington wrote me, saying: "I have seen at least two judges in D.C. hold a pregnant drug addict in jail, acknowledging that they would otherwise have been released or placed on probation. The only thing that surprises me is that they are honest about what they are doing."

The judge's authority to incarcerate Brenda Vaughn was predicated on the fact that she had committed a crime. (Her offense was forgery of $700 in checks.) But what if a pregnant woman who has committed no crime endangers her fetus -- as by drinking excessively? May she be involuntarily hospitalized under a state's civil commitment laws or enjoined by court order from drinking?

Involuntary commitment is possible if the state statute includes alcoholism or drug addiction in the definition of "mental disorder" and if the court is willing to find that the woman's conduct poses a danger to "others." Here, as usual, the interpretive question is whether the fetus "counts" as a "person." Although I have seen no judicial opinions on this issue, one case involving a psychotic mother has been reported in the psychiatric literature.

Judicial powers to intervene in these situations would be considerably broader in scope if courts were able to act under the statutes governing child abuse and neglect. Of course, if these statutes were amended or construed to cover fetal abuse or neglect, this would also trigger reporting obligations for physicians and other care-givers, and would substantially expand the coercive powers of the state. This approach would also raise difficult questions about the range of prenatal risk-taking that constitutes "abuse" or "neglect."

Child abuse and neglect statutes embody a general principle that parental autonomy in child-rearing is appropriately overridden when the parental conduct is demonstrably harmful to the child. However, these statutes present a serious danger of excessive intervention and unfairness because they are inherently vague and indeterminate in scope. Where, after all, is the line between merely questionable parenting and destructive parenting? Nonetheless, in this context, the difficulty of defining the sphere of parental misconduct has not been regarded as a persuasive reason for leaving parents alone, and picking up the pieces later on.

The potential utility of this type of intervention if it were extended to the prenatal context, as well as the problems it would raise, are both illustrated by a case that arose in Baltimore a few years ago (1983). A physician requested a court order from the juvenile court to enjoin a woman in her seventh month of pregnancy from using drugs. The fetus already showed signs of retarded growth and the physician averred that continued drug use would "further retard, inhibit and prevent its further growth and development and was life-threatening." He stated that the woman used substantial amounts of Quaalude, Valium, morphine and cocaine, and that a previous child had been born prematurely, was addicted at birth and was at high risk for Sudden Infant Death Syndrome. The court ordered the woman to enroll in a drug rehabilitation program and to submit to weekly urinalysis until the second baby was born.

> ***Coercive intervention should be permissible in extreme circumstances, although it should be avoided in most.***

In light of the extreme danger posed by the woman's conduct, this case may seem to be an appropriate one for preventive intervention. However, even in this case, the woman's attorney raised the spectre of the "slippery slope." "What bothers me," he said, "is that this could result in putting all [pregnant] women in a pen and forcing them to adhere to state standards of good prenatal care."

In Brenda Vaughn's case, the judge who put her in jail was criticized for treating her as a "vessel for the fetus" and for relying on a principle that could lead to "jailing [pregnant women] who smoke or drink alcohol." In response, the judge observed that "this court is not empowered to search for and lock up any pregnant woman found abusing her fetus. It has only exercised its responsibility to sentence a defendant who committed her crimes because of her addiction to cocaine, an illegal substance . . . . Alcohol and smoking, which can also harm a fetus, are not yet illegal substances." Even having said this, though, the judge was still speculating about broader theories of intervention: he observed, in passing, that "it is illegal to sell or provide alcohol or cigarettes to minors . . . . Perhaps someday those substances will be similarly regulated for pregnant women . . . ."

Permissible Boundaries of Preventive Intervention

Although the cases I have mentioned now lie on the fringes of the law, it should be evident that we are not lacking for theories of intervention. Speculation about these possibilities has become a cottage industry among legal commentators. Personally, I am inclined toward the view that coercive intervention should be permissible in extreme circumstances, although it should be avoided in most. However, even in saying this, I am rejecting a position taken by many legal commentators who have addressed this subject. For example, Nelson and Milliken conclude that the pregnant woman's undoubted moral obligation to "behave in a manner intended to benefit and not harm her fetus" should not be legally enforced -- apparently under any circumstances. As they explain, "the social policies and values at stake in resolving maternal-fetal conflict lead us to believe that it is best to avoid maternal coercion."[2]

Much of the commentary on this subject has focused on the issue of compelled surgical interventions, especially court-ordered cesarean sections. The case of

Under what circumstance does concern about the well-being of the offspring justify coercive restriction of the pregnant woman's autonomy?

27-year old Angela Carder recently drew national attention to the issue of forced cesarean deliveries in a highly unusual context. Ms. Carder was 26 weeks pregnant and near death from cancer. She was heavily medicated and her own wishes regarding the cesarean delivery were unclear. However, her parents declined to consent in light of the danger it posed to Angela and in light of their own understanding of Angela's preferences. Upon application of the George Washington University Medical Center, a court ordered the surgical delivery which was fruitless -- the premature child died after two hours and Ms. Carder died two days later.[3]

Angela Carder's case is admittedly atypical, but it highlights a more general cluster of clinical situations in which surgical intervention is necessary to promote fetal well-being. It is useful to reflect on this problem not only because it has received so much attention but also because it helps to clarify the fundamental philosophical issue.

Fetal Surgery and Cesarean Delivery

Fetal surgery is now available experimentally for prenatal care of some deformed fetuses. This development led bioethicist John Fletcher to express the ethical intuition that "the fetus with a treatable birth defect is on the threshold of becoming a patient." In light of the pregnant woman's legally protected prerogative to abort, characterizing the fetus as "a patient" is admittedly awkward. Yet, if the woman intends to carry the pregnancy to term, it can sensibly be said that the fetus has contingent, prospective moral rights. Although the fetus may have not legal right to be born, it has a right, contingent on birth, to be protected from harm -- and an entitlement to be born without preventable handicaps. At least it can be said, as I noted earlier, that the pregnant woman has a moral duty to provide whatever medical attention is deemed essential to the fetus' healthy development.

If all this is accepted, should this obligation be legally enforceable? Under ordinary legal principles, fetal surgery requires the mother's consent and there may, of course, be some risk to her. Nelson and Milliken seem to take the position that compulsory treatment is impermissible if there is any risk to the mother, regardless of the nature of the offsetting benefits to the fetus. They also seem to think that this view is constitutionally compelled. They concede that a "plausible" case for compulsory treatment can be made "when either the failure to provide it would put the fetus at great risk of serious physical harm or the treatment promises to be of significant benefit to the fetus, and the risk of the treatment itself to the mother and fetus are low or minimal." But they then go on to reject even this view on the ground that these risk-benefit judgments are inherently subjective and speculative and should therefore be left entirely to the pregnant woman.

Here is a test case. Assume that women with genital herpes can infect their fetuses during passage through the birth canal, that 50% of the exposed infants who are delivered vaginally become infected, that half of them die and the other half sustain permanent brain damage, and that the infant can be protected by cesarean delivery if active herpes infection is diagnosed in the mother before she is too advanced in labor to prepare for surgery. If these assumptions are true, we have a very compelling case for overriding a woman's refusal to consent to a cesarean delivery in lieu of the vaginal delivery which poses a high risk to the fetus.

The constitutionality of compelled surgery under these circumstances is unresolved and, as Nelson and Milliken note, a subject of intense debate among legal commentators. One naturally begins with the Supreme Court's abortion jurisprudence -- *Roe v. Wade* and cases subsequently decided. At first glance, it would appear that *Roe v. Wade* has clear implications for the problem of prenatal surgery and, more generally, for non-surgical coercive interventions. Two propositions would seem to emerge:

First, coercive intervention to protect fetal well-being is permissible after viability. The state's interest in potential life has become "compelling" at this point, overriding the woman's right to abort. It follows under *Roe* that her refusal to permit surgical intervention to prevent death or severe defects could also be overridden.

Second, the pregnant woman has an unqualified right to abort before viability. Her right of privacy is absolute until this stage of the pregnancy. Thus, it would seem to follow that the state has no constitutionally legitimate interest in protecting the well-being of pre-viable fetuses. According to this reasoning, the greater would include the lesser -- if the mother can abort the fetus, she can refuse surgery that would merely enhance the prospects for healthy development; it would be anomalous to force the woman to undergo fetal surgery and then have no recourse should she exercise her right to abort the recently treated fetus.

Upon reflection, I think that neither of these propositions is correct, and that viability is not the constitutionally significant factor in this context. Instead, I think the critical issue is whether the intervention involves significant risks to the pregnant woman's own health.

First, with respect to post-viability situations,

Compelled surgical intervention that involves any significant risk to the pregnant woman is either unconstitutional or objectionable as a matter of ethical principle.

the state's authority to protect fetal life is not unqualified. As Nelson and Milliken point out, all *Roe v. Wade* held is that the state may prohibit abortion at this stage, and even this holding was qualified by the proviso that abortion cannot be prohibited if it is necessary to protect the life or health of the mother. The implicit principle here is that the woman has a constitutionally protected interest in deciding what risks to her own well-being are worth taking to bring the fetus to term. Nelson and Milliken argue that this implies that all risk-benefit judgments relating to the possible conflicts between the fetus' interest and the interests of the pregnant woman are committed exclusively to the woman and may not be second-guessed by the courts.

This does not follow, however. If the woman intends to bring her pregnancy to term, the conflict is no longer between the fetus' contingent interest in being born and the woman's own life or health. Instead, it is now between the fetus' interest in being born without major impairment and the pregnant woman's interest in making decisions about medical intervention that may affect her own well-being. The Court has made it clear that the woman has an exclusive prerogative, in consultation with her physician, to decide whether the fetus should be born, given the risks of birth to her own health; but does it follow that she has an exclusive prerogative to weigh the benefits to a fetus who will be born against the risks to herself? A few courts have concluded, without extensive discussion, that she does not and have compelled women to undergo cesarean delivery notwithstanding their religious objections to the procedure.

I will not try to resolve this issue. Instead, I want to assume that the view expressed by Nelson and Milliken is correct and that a compelled surgical intervention that involves any significant risk to the pregnant woman is either unconstitutional or objectionable as a matter of ethical principle. Nelson and Milliken, and other commentators of like mind, have endorsed a more sweeping proposition -- that any compelled intervention, even one that does not pose risks to the pregnant woman's own health, is unacceptable. This, it seems to me, goes too far.

Non-Surgical Interventions

The cases mentioned earlier involve coercive efforts to dissuade pregnant women from drinking or using drugs, to monitor their compliance, and, as a last resort, to assert custodial control. These interventions do not implicate the woman's right to decide whether to carry the pregnancy to term or to make decisions regarding whether risks to her own health should be subordinated to the well-being of her fetus. The woman's interest, quite bluntly, is simply in being left alone, to be free of any interference in deciding how to accommodate her preferences about how she lives her life with the interests of the fetus she intends to bring to term.

It seems to me that nothing in *Roe v. Wade* speaks to this question. Nor do any of the so-called "right to refuse treatment" cases which hold, in effect, that competent persons are entitled to make decisions about their own health, however irrational their choices may seem to others. Here the fetus's contingent interest in being born in a healthy condition is at stake. The appropriate starting point here, it seems to me, is not *Roe v. Wade* but rather the duties owed by parents to their children, duties which are legally enforceable and which obligate parents to protect their children from harm. This leads me to conclude that prenatal intervention should not be regarded as categorically objectionable, either as a matter of social policy or constitutional law.

To say that prenatal intervention is not categorically impermissible is not to say that it is always, or even usually, a good idea. The pregnant woman's autonomy should be respected except under the most exceptional circumstances. The slope is admittedly a slippery one, and there is some virtue in a categorical rule against coercion in a medical environment where the preferences of pregnant women may too easily be cast aside.[4] However, I think it is possible to draw a line with reasonable specificity between conduct that warrants coercive intervention and conduct that does not. For example, permissible interventions would include mandatory diagnostic testing and screening procedures, even if they would be invasive. For extreme cases, mandatory hospitalization or outpatient supervisors should

be permissible if pregnant women are unable or unwilling to refrain from using alcohol or other drugs in a way that poses an imminent and substantial danger to fetal well-being.

Conclusion

This is admittedly a controversial position, and I do not want to be misunderstood. I do not mean to transform the fundamental balance of values reflected in our law or to ignore the practical limits of legal intervention. Take the case of dietary restrictions for pregnant women whose fetuses are at increased risk of having PKU deficiencies. In this context, the law might be useful as leverage, but the potential for oppressive state intervention would be too great. (Imagine the impact of a mandatory reporting statute for fetal neglect in this context and the spectre of "pregnancy police" responsible for monitoring the woman's diet.) To permit legal intervention in such situations would reflect a fundamental transformation in the governing conception of the pregnant woman -- from "autonomous agent" to "fetal container." I do not want to abandon the presupposition in favor of autonomy. I want only to argue that it should not be unqualified and that, in some contexts, the case for overriding the woman's prerogatives is a compelling one.

[This article was developed from a presentation given at the "Symposium on the Neurologically Impaired Individual: Teratogenesis", November 11, 1988, at Richmond Virginia.]

NOTES

[1] The already extensive legal literature on this topic can be expected to multiply further in the wake of a decision in *Auto Workers v. Johnson Controls Inc.*, 886 F.2d 871, 59 U.S.L.W. 3304, argued October 10, 1990 and currently under consideration in the United States Supreme Court. The case involves a woman who challenged a work rule prohibiting women of child-bearing age from working on an assembly line where potentially toxic automotive batteries were manufactured, unless she could present medical evidence of sterility.

[2] See Nelson and Milliken, "Compelled Medical Treatment of Pregnant Women: Life, Liberty and Law in Conflict," 259 *Journal of the American Medical Association* 1060 (Feb. 19, 1988).

[3] See *In Re A.C.*, No. 87-609, District of Columbia Court of Appeals, April 26, 1990. See also Curran, "Court-Ordered Cesarean Sections Receive Judicial Defeat" 323 *New England Journal of Medicine* 489 (August 16, 1990). Settlement of the subsequent lawsuit against the medical center by Ms. Carder's parents included the adoption of a broad new policy requiring extensive attention to the wishes of patients or their surrogates in future cases. The policy also committed the medical center to avoid judicial intervention in almost all cases. See Greenhouse, "Hospital Sets Policy on Pregnant Patients' Rights," *The New York Times*, November 29, 1990.

[4] A survey of more than 50 physicians in training showed that 46% endorsed the opinion that a woman who disregards medical advice should be held against her will so that fetal health can be protected, and 26% were in favor of a state system to monitor pregnant women who do not seek care within the hospital system. See Kolder, et al. "Court-Ordered Obstetrical Interventions" 316 *New England Journal of Medicine* 1192 (May, 1987). Such attitudes rightfully lead to heightened concern for maternal autonomy, and questioning of proposals that would lessen it. See, for example, Purdy, "Are Pregnant Women Fetal Containers?" 4 *Bioethics* 273 (1990).

Civil commitment training

The Institute of Law, Psychiatry and Public Policy will offer four two-day seminars in civil commitment on March 25-26, April 15-16, April 29-30, and May 6-7, 1991, in Charlottesville. This training has been made possible by a grant from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

The seminars cover the constitutional and statutory aspects of civil commitment, guardianship and confidentiality. The instruction will be provided by Paul Lombardo and other members of the professional staff of the Institute. The instructional materials have been developed with the assistance of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Office of the Attorney General.

Each seminar is limited in enrollment to twenty students. Priority will be given to employees of Virginia community services boards, actively engaged in pre-admission screening who have had no prior training at the Institute. If space is available, registrations will be accepted from judges, lawyers, law enforcement personnel and others interested in civil commitment. Persons or agencies may register for a seminar by writing or calling the Institute no later than thirty days prior to the date of the seminar. A confirmation of registration, agenda and materials will be sent to persons upon admission to a seminar.

There will be a $10 charge for the training materials.

THE FOURTEENTH ANNUAL SYMPOSIUM ON MENTAL HEALTH AND THE LAW

presented by

The University of Virginia
Institute of Law, Psychiatry and Public Policy
Division of Continuing Education
Office of Continuing Legal Education
Office of Continuing Medical Education

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

and

The Office of the Virginia Attorney General

Richmond Marriott Hotel
Richmond, Virginia

March 7-8, 1991

THURSDAY, MARCH 7

8:00 a.m.	**Registration and Coffee**
9:00 a.m.	**Welcoming remarks** King E. Davis, Ph.D. R. Claire Guthrie, J.D. Richard J. Bonnie, LL.B.
9:45 a.m.	**Memorial Tribute to Warren Stambaugh**
	MALPRACTICE, LIABILITY AND THE THERAPEUTIC STANDARD OF CARE
10:15 a.m.	**How the Legal System Influences Treatment Choices** Seymour Halleck, M.D.
11:00 a.m.	**Break**
11:15 a.m.	**Developing a Standard of Care: Implications of Recent Cases** James L. Kelley, Esq.
Noon	**Discussion**
12:45 p.m.	**Luncheon in the Capital Ballroom**
	OUTPATIENT CIVIL COMMITMENT
2:00 p.m.	**Mental Illness, Danger and Outpatient Commitment** Virginia Hiday, Ph.D.
3:00 p.m.	**Adapting Forensic Models to the Civil Context** Stuart Silver, M.D.
4:00 p.m.	**Break**
4:15 p.m.	**Panel Discussion** Moderator: Paul A. Lombardo, Ph.D., J.D. Discussants: W. Lawrence Fitch, J.D. John A. Kasper, Jr., M.D. Russell C. Petrella, Ph.D.
5:00 p.m.	**Recess**
5:30 p.m.	**Reception (Cash Bar) - Capital Ballroom**

FRIDAY, MARCH 8

8:30 a.m.	**Coffee**
9:00 a.m.	**In the Wake of *Zinermon*: Medication, Treatment and the Problems of Incompetent Assent** Moderator: Richard J. Bonnie, LL.B. Discussants: John C. Fletcher, Ph.D. Steven K. Hoge, M.D. Matthew J. Lambert, III, M.D. C. Robert Showalter, M.D.
10:45 a.m.	**Break**
11:00 a.m.	**Violence and Mental Disorder** John Monahan, Ph.D.
Noon	**Adjourn**

UPDATES FOR VIRGINIA PRACTICTIONERS

WORKSHOPS

1:30 - 3:00 p.m.	**Civil Commitment** Paul A. Lombardo, Ph.D., J.D. Jane D. Hickey, J.D. Evelyn R. Fleming, Ph.D., J.D.
1:30 - 3:00 p.m.	**Forensic Evaluation** W. Lawrence Fitch, J.D. Gary Hawk, Ph.D.
1:30 - 3:00 p.m.	**Social Security and Mental Disability** C. Cooper Geraty, LL.M.
3:30 - 5:00 p.m.	**Confidentiality and Duty to Warn** Steven K. Hoge, M.D. Paul A. Lombardo, Ph.D., J.D. Julie A. Stanley, J.D.

For further information, call (804) 924-5435

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
Charlottesville, Virginia 22901

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