Volume 11, Number 1

January - June 1991

Developments in
Mental Health Law

Institute of Law, Psychiatry and Public Policy — The University of Virginia

Outpatient Commitment:
Adapting Forensic Models to the Civil Context

by Stuart B. Silver, M.D.

When I first heard the idea of outpatient civil commitment proposed in Maryland, I reacted with horror. As the director of the forensic hospital in a state with a long history of conditional release, I was probably more acutely aware of the implications of this mandate than were many of my colleagues. Our hospital had been responsible for supervising a mandatory outpatient program for insanity acquittees since 1967. The conditional release law provided a mechanism to enable the community to have some degree of comfort when discharging patients who were charged with felonies and found insane. The program has increased in intensity, complexity, and in the level of scrutiny since its inception.

Families pressed for outpatient civil commitment as a way to coerce ill relatives to receive care and not miss their prescribed medications. The mental health director looked for a mechanism to reduce the census of the state hospitals and help the system cope with insufficient resources. Legislators thought that this would be an acceptable method of encouraging community care, while minimizing the risk of disruptive behavior by mentally ill persons on the streets of constituents' neighborhoods. In contrast, legal aid attorneys and the public defender expressed skepticism about the wisdom of creating a new compulsory mechanism; I was concerned about the cost, complexity, potential for expanded liability, and absence of useful sanctions.

Consumers showed little enthusiasm for the idea. The notion that outpatient civil commitment could be a mechanism to prevent hospitalization rather than shorten it was not well articulated. The underlying premise that a judge's admonition would have more influence on a psychotic patient's behavior than would the advice of family and physicians was not opened to meaningful dialogue or scientific inquiry. When a bill to authorize outpatient commitment was presented to the legislature, the measure failed.

As director of Maryland's Mental Hygiene Administration, I have a renewed interest in considering not only the strategies for outpatient civil commitment, but also the entire involuntary commitment process including the current criteria we use. Preparing this paper has challenged me to approach the subject with a new perspective. I am told that this is dangerous territory; I am inclined to believe that.

First, I want to examine the evolution of conditional release in Maryland; then consider the broader applicability of some of our forensic experiences. I will conclude with a summary and some reflections on the relationship between outpatient civil commitment and forensic programs.

Maryland's outpatient conditional release statute, which went into effect in 1976, required that the Mental Hygiene Administration monitor discharged insanity acquittees for their compliance with specified treatment oriented stipulations. Included in early protocols were instructions on clinic appointments, medications, and employment, as well as admonitions against alcohol and substance abuse, use or possession

Stuart B. Silver, M.D. is the Director of the Maryland Mental Hygiene Administration.

Also in this issue:

of firearms or other weapons, unauthorized change of address, or leaving the state. Added to these standardized instructions were any unique conditions that the patient, treatment team, and hospital agreed upon. The conditional release document became a contract signed by the patient, the social worker and the forensic hospital superintendent. We then submitted the agreement to the court for creation of a judicial order endorsing the plan. Approved discharge plans always included a warning that any deviation from the prescribed conditions could result in the patient's return to the hospital. The evolution of this process over the past fifteen years has revealed many pitfalls not at first anticipated.

Let me attempt to reconstruct the sequence of events in the process. The first and most serious oversight was that no one offered to provide aftercare services for insanity acquittees except the Clifton T. Perkins Hospital Center, Maryland's forensic hospital. It's one thing to write a conditional release plan, but to convince others to implement it can be a problem. For example, where would patients live if family were not available or able to assist? Secondly, the hospital was difficult to reach by public transit from Baltimore, where most of our patients would reside. Even if our staff was willing, our location was weak.

One of our earliest challenges was the development of Hamilton House, a community based group housing and outpatient site in Baltimore. The Perkins staff knew that the hospital needed to develop community-oriented rehabilitative efforts to help patients make the especially difficult transition from a maximum security hospital to community living. We first established a pre-release employment program within the hospital as well as an open ward to support this 'work-out' program. When we recognized the need for residential settings for patients on trial visits to the community and about to be discharged, we sought support for a halfway house.

The realities of funding in those days dictated that Hamilton House should be administratively linked to the hospital. One major disadvantage of this arrangement was the possibility that a halfway house tied to Perkins might become a mere satellite of the hospital, extending an institutional philosophy into the community. To some extent, this occurred. Fortunately, the tie to the hospital simplified communication necessary to speed up discharges and made possible the provision of a multitude of back-up services drawing on institutional resources.

You may wonder about the local community's acceptance of this stigmatized population. The house, after all, sits in what has become one of downtown Baltimore's more elegant sections. Our residents are within a few blocks of notable attractions such as the Walters Art Gallery, the Peabody Conservatory of Music, the elegant shops of Charles Street, and several fashionable hotels and restaurants - in short, one of Baltimore's better locations.

But, in 1972, before the city of Baltimore was discovered, the 500 block of Cathedral Street consisted of a row of 10,000 square foot flop houses. The community didn't object to our settlement because insanity acquittees represented an improvement in the neighborhood. They, unlike other citizens, would be supervised.

Clearly, the Hamilton House admits high risk patients. They tend to be young (average age 25), unattached, often with limited family support, and with a history of serious offenses (usually murder, assault with intent to murder, or other violent crimes). The predominant diagnosis is schizophrenia, usually paranoid type. About 40% of all residents come from Perkins. One review of seventy residents admitted from Perkins revealed that five were re-hospitalized, and one was re-arrested and charged with armed robbery (his original offense, as well). The average time in the community for this group was nineteen months, with six months spent at Hamilton House. The one rearrested had been out of the house more than one year. There were no new offenses committed by residents while they were living in the house.

A second problem we faced, beyond the need to create outpatient resources, was learning how to deal with the courts when compliance with conditional release failed. In the early days, a social worker would call the original committing judge by phone, describe the infraction, and hope the judge would take action. The responses were variable and unpredictable, ranging from an immediate bench warrant to a request for a detailed written report followed by a probable cause hearing. The judge might set the matter for immediate hearing, or schedule a court hearing in six months. The law was not clear on the mechanics of revocation; arousing judges to action was unpredictable. Additionally, the remedy for non-compliance was unclear when the patient's condition did not warrant re-hospitalization.

The resolution of these problems awaited the *Hinckley* case and the resultant Governor's task force on the insanity defense which recommended constructive housekeeping on the statute. Since then,

revocation procedures are clear and the hospital prepares orders for the State's Attorney to present to the judge. We have found that the presentation of a completed order in the proper form significantly expedites the legal process.

Early in my tenure as the Superintendent, we faced a third problem. While the department of social work at the hospital was keeping manual files on Perkins patients, no one was tracking insanity acquittees at the other state hospitals. The law made no distinction between felony acquittees and misdemeanants. Nor did it excuse the department from the obligation of tracking female acquittees, who before 1984 were hospitalized at regional centers no matter what their offenses.

The Director of the Mental Hygiene Administration learned of this oversight somewhat abruptly via a mailed contempt citation. Grown weary of finding the same misdemeanant insane every few months, weary of repeated brief hospitalizations, and weary of the regional hospital's neglect of the court's commitment, a local judge took very affirmative action. In response to a hurry-up call, we developed the community forensic aftercare program based at Perkins.

The program consisted initially of one social worker and a clerk. Their mission was to monitor compliance, interpret and mediate between the courts and treatment providers in the community, provide liaison to patients and their families, facilitate revocation, train judges and providers, and maintain data. This program has doubled in size and has also assumed responsibility for monitoring those patients whom the Perkins social work department once tracked.

The extent and thoroughness of records-keeping in the aftercare office have intensified markedly. These detailed records protected the institution in some cases where problems arose in the patient's conduct in the community. We also have increased the frequency and assertiveness of monitoring as we have documented lapses.

Most community-based providers of mental health services do not relish the role of "parole agent." They are bred on the sanctity of confidentiality and prefer clients who are cooperative and motivated to those whose participation reflects ambivalence or coercion. There are no incentives in our system for these providers to afford any priority to clients on conditional release. The active consultative and supportive role of the aftercare program has helped overcome some of this resistance and eased negotiation of a reasonable distribution of responsibility for the supervised outpatiency. There is little room for lapses in the function of this program without major liability exposure for the State.

Let me illustrate with the case of Joe, a thirty-five year old patient reared in a rural part of the state. A high school dropout with limited job skills, he married in his late teens, became increasingly alcoholic, and although there were no arrests, he evidenced deteriorating social function and bizarre behavior in his early twenties. He shot and killed his wife amid increasingly paranoid delusions and eventually was adjudicated insane. On medication and away from alcohol at the hospital, his clinical course was unremarkable. Joe participated in the pre-release program,

— continued on page 20 —

Developments in Mental Health Law
is published by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The opinions expressed do not necessarily reflect the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge to Virginia residents twice a year, and to out-of-state subscribers at an annual rate of $10. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100, Blue Ridge Hospital, Charlottesville, VA 22901. Change of address requests should include both old and new addresses. Questions about letters, articles or other material to be submitted for publication should be directed to the Editor.

Editor
Paul A. Lombardo

Student Contributors
Jane Kurtz/Peter J. Enko

Managing Editor
Carolyn L. Engelhard

Desktop Publisher/Circulation Manager
Neva J. Dingus

Guest Contributors
Stuart B. Silver
W. Lawrence Fitch

Letters

Editor's Note: Professor Bonnie's essay highlighting legal and ethical dilemmas that arise in the case of pregnant women ("Interventions for Prenatal Misconduct," 10 Developments in Mental Health Law 2, July-December 1990) generated significant comment and several letters. Two letters of particular note received by Bonnie are excerpted below.

♦♦♦ IT SEEMS TO ME that the realities of the situation are even more complex than you suggest insofar as the state's primary interest is in protection of the fetus:

1. Although the relevant body of research is not extensive, animal studies have suggested that the principal mechanism of teratogenic effects of chronic and heavy ingestion of toxic substances (e.g., alcohol) often is genetic. When that mechanism is operative, then the purpose of coercive intervention during pregnancy is questionable.

Further, some animal research on behavioral teratogenics has shown greater *paternal* than maternal effects. In that context, the gender discrimination claim even for government speech aimed exclusively at pregnant women hardly seems frivolous to me.

I understand that at least a portion of this body of research was on the record in *Johnson Controls*. Perhaps the Supreme Court's analysis in that case will prove to be more widely applicable.

2. In the same vein, effects of fetal exposure to toxic substances are dependent on the point in pregnancy at which it occurs. For most substances (not cocaine), the primary risk to the fetus is early in pregnancy, often before the woman knows that she is pregnant. Again, the purpose of coercive intervention later in pregnancy is not clear.

3. If the assumption is that the intervention during pregnancy is part of a broader child protection effort (as your analysis seems to suggest), there is little reason to expect significant change as a result of state action against the expectant mother alone when the father is likely to be (a) an even heavier substance abuser and (b) a spouse/partner abuser.

4. In the present state of the art, there is a question whether government is capable of rehabilitating pregnant substance abusers. It is fair to say that there is no generally accepted treatment model for that population and that, in any event, no treatment is widely available for substance abusing pregnant women.

5. Of course, the question remains unanswered whether coercive intervention will serve to deter, not substance abuse, but instead treatment.

Given that so much of the legal analysis hinges ultimately on the law's potential efficacy in facilitating safe uterine and postnatal environments, one must reconcile the empirical evidence with the state's interest in the safety of children. That task is difficult under any circumstances, but it is especially hard when the data base is as limited as it is on prenatal exposure to toxic substances.

Gary Melton, Ph.D.
Professor of Psychology & Law
University of Nebraska

♦♦♦ EVERY DAY IN MY COURTROOM (and I don't feel that mine is unique) I see repeated examples of people whose existence and actions argue very strongly for enforced sterilization and mandatory prenatal care requirements. In the last year I am familiar with at least seven infants born premature with substandard birth weight to crack cocaine addicts. The average neonatal intensive care costs for each of these children just to get them through the first month or so of their addiction is roughly $200,000 per child, money that could be far better spent in other places. Nor does that say anything about the long term psychological or physiological deficits these children will suffer. The initial permanent injury to the child is tragic, but the long term social costs far exceed anything that the public is aware of. Instead of voicing platitudes about the rights of the mother or treating her as a chattel we should be addressing the real need of the public which is to economize on the finite amount of medical resources we have to treat those who are in need. Social security costs have now risen to our federal government's third greatest expenditure. A good percentage of this is being used to provide medical benefits for the poor. While I feel quite strongly that everyone is entitled to some form of health care, I don't believe that we should continue to encourage practices which allocate a disproportionate part of this to medical problems which are preventable. I believe that it was Oliver Wendell Holmes who wrote "three generations of imbeciles are enough."

Judge Ralph B. Robertson
General District Court - Richmond

In the Virginia Courts

Emotional distress claim not available for telephone call victim

Russo v. White, 241 Va. 23, 400 S.E.2d 160 (1991).

The Supreme Court let stand a trial decision dismissing a claim for intentional infliction of emotional distress based on more than 300 telephone calls. Although the defendant's numerous "hang-up" calls allegedly caused the plaintiff nervousness, sleeplessness, stress, withdrawal from activities, and an inability to concentrate at work, the resulting distress was not deemed so severe that a reasonable person could not be expected to endure it.

In the spring of 1987, Patricia B. Russo met Burton White. Within the next three months, Russo received numerous "hang-up" calls. Her complaints to police culminated in White's misdemeanor conviction for causing the telephone to ring with the intent to annoy. In spite of the conviction, the calls continued. Russo claimed she had received more than 340 calls by January of 1988. Russo alleged that a number of the calls were placed while White had her house under surveillance. Russo also alleged that the "hang-up" calls and the fact that she was a single parent unable to "judge White's proclivity for violence", caused severe emotional distress and nervousness, sleeplessness, stress and its physical symptoms, withdrawal from activities requiring her to leave her daughter, and a lack of concentration at work. White argued that even if these claims were true, Russo had failed to state a legally valid claim for intentional infliction of emotional distress.

Justice Compton, writing for the majority, noted that the tort of intentional infliction of emotional distress is disfavored because it involves subjective evaluations of behavior that are often not amenable to proof. Compensation may still be awarded, however, if the plaintiff demonstrates that: 1) the wrongdoer's conduct is intentional or reckless; 2) the conduct is outrageous and intolerable; 3) the alleged wrongful conduct and emotional distress are causally connected; and, 4) the distress is severe. *Womack v. Eldridge,* 215 Va. 338, 210 S.E.2d 145 (1974).

White admitted that his conduct was reckless and he had caused Russo's distress. Given the average of 5.6 calls a day over a two month period, the court agreed with Russo and assumed without deciding that the conduct was indeed outrageous. The court, however, did not agree with the plaintiff regarding the severity of the distress. Noting that liability only arises when the distress inflicted is so extreme or severe that no reasonable person could be expected to endure it, the court stated that Russo's failure to claim that she had any objective physical injury, sought medical attention, was confined at home or in a hospital, or that she lost income, indicated a lack of adequate severity to support the claim.

Writing in dissent, Justice Hassell asserted that Russo had properly pled the tort of intentional infliction of emotional distress. Stating that he believed White's actions to be outrageous, Hassell went on to say that no reasonable person could be expected to endure the injuries that Russo had suffered. Pleading stress and its physical symptoms should had been enough for the complaint to survive a motion to dismiss based on failure to state a claim, since physical injuries are not a required element in such an action.

Hepatitis is compensable under Virginia's workers' compensation act

Fairfax County v. Espinola, 11 Va. App. 126, 396 S.E.2d 856 (1990).

The Court of Appeals upheld a decision by the Industrial Commission awarding workers' compensation benefits to a claimant who contracted hepatitis as a result of exposure to blood and blood products while employed by the Fairfax County Police Department.

Mario Espinola worked with the police department for ten years as a medical technician. During that period, he administered over 5,000 blood tests and breathalyzer tests to persons arrested for driving while intoxicated and was exposed to blood approximately 200 times. In February 1988, Espinola's physician diagnosed chronic non-A non-B (NANB) viral hepatitis, likely to have been contracted by exposure to blood during his employment with the police department. Espinola's last day of employment was May 17, 1986. He filed an application for benefits with the Commission on July 17, 1988.

The Industrial Commission found that sufficient evidence existed to demonstrate that Espinola had contracted the disease from his employment. It also found that Espinola's application was timely as he filed it within two years of communication of the diagnosis of the disease and within five years of the last injurious exposure.

The court affirmed the Commission's factual findings and ruled that a claimant must show by clear and convincing evidence that the disease: (1) arose out of and in the course of employment; (2) did not result from outside exposure; and (3) is an infectious disease contracted in the course of employment in a hospital... or is characteristic of and caused by conditions peculiar to the employment. Although Espinola was not aware of specific exposure to NANB hepatitis, the Court determined that testimony of several medical experts was credible.

The court also found that Espinola filed his claim within the proper statutory period. The county argued that the last "injurious exposure" was on May 12, 1982, the date of the last known exposure. The court, however, agreed with the Commission that the last injurious exposure was Espinola's last day of employment. Virginia Code § 65.1-62 defines injurious exposure as "an exposure to the causative hazard of such disease which is reasonably calculated to bring on the disease in question." A claimant can prove causation by showing actual causation or by showing that the exposure was such that it would generally cause the disease. Due to Espinola's routine exposure to blood during his employment, his final day with the police department was deemed the last injurious exposure.

Juror predisposed against insanity defense allowed to stay on jury

Boblett v. Commonwealth of Virginia, 10 Va. App. 640, 396 S.E.2d 131 (1990).

The Virginia Court of Appeals held that a trial court did not abuse its discretion by failing to strike a juror who was allegedly predisposed against the insanity defense. The juror thereafter affirmed his ability to follow instructions from the court regarding the insanity defense.

Appellant Ricky Boblett was charged with attempted murder, conspiracy to commit capital murder, maliciously causing property damage, and the possession of an explosive device. The charges stemmed from Boblett's involvement with Lisa Layman. Two months after she broke off their engagement, Boblett wired explosives to Layman's car. He also tried to hire one of his high school students to kill her. While in jail, Boblett solicited an undercover state police agent to kill Layman. At trial, Boblett raised an insanity defense based on his use of anabolic steroids. During jury selection, Boblett moved to have three jurors stricken for cause because they expressed bias against the insanity defense. The court struck only two of the jurors. Following a guilty verdict, Boblett appealed the trial court's refusal to strike the third juror and argued that the court abused its discretion by not

striking a juror predisposed against the insanity defense.

The court of appeals found no error in the trial court's decision. The juror expressed personal doubts about the insanity defense with statements such as "I don't think I believe in insanity" and "I can't understand that somebody can mentally not be responsible...." However, when questioned about his ability to follow instructions, the juror responded, "Oh, I could follow orders, I mean, whether I agree or disagree with the law."

The court of appeals noted that the trial court is entitled to great deference in the decision of whether to seat a juror. In examining the entire jury selection process, the court found that because the juror stated that he could follow instructions notwithstanding his personal beliefs, and that the trial court could evaluate the juror's demeanor, the decision was not reversible error.

Evidence of diminished capacity to negate premeditation for murder not allowed absent insanity defense

Bowling v. Commonwealth of Virginia, ___ Va. App. ___, 403 S.E.2d 375 (1991).

The Virginia Court of Appeals ruled that a trial judge did not commit reversible error by disallowing the evidence of a defendant's diminished mental capacity to negate the element of premeditation for capital murder. Absent an insanity defense, the court held that evidence of diminished mental capacity was irrelevant.

Thomas Bowling was convicted of capital murder and use of a firearm during commission of a murder. While robbing a service station, Bowling shot the manager who gave Bowling fifty dollars from his own pocket, but was unable to open a locked safe. At Bowling's trial, another member of the group planning the robbery testified that before going to the service station, Bowling took a loaded gun and inquired about having to kill the attendant.

The defense attempted to introduce evidence at trial that Bowling was at the lower limits of the borderline range of the Weschler Adult Intelligent Scale and lacked problem solving skills as well as elaborate abstract thinking capability. Bowling claimed that the evidence was relevant because it negated the element of premeditation necessary to prove guilt in capital cases. He compared his case to other capital cases where courts have allowed evidence of voluntary intoxication as a defense to premeditation.

The court of appeals relied upon *Stamper v. Commonwealth*, 228 Va. 707, 324 S.E.2d 682 (1985), in rejecting Bowling's argument. In *Stamper*, the Virginia Supreme Court held that "unless an accused contends that he was beyond that borderline [of insanity] when he acted, his mental state is immaterial to the issue of specific intent." In a similar case, the Virginia Supreme Court rejected the use of diminished capacity to prove inability to follow through on intentions without an assertion of the insanity defense. *Smith v. Commonwealth of Virginia*, 239 Va. 243, 389 S.E.2d 871, *cert. denied*, 111 S.Ct. 221 (1990). (See 10 ***Developments in Mental Health Law*** 10, January-June 1990). The court of appeals found that the evidence in the record supported the trial court's finding that premeditation did exist.

Confession of defendant with low IQ held to be voluntary

Terrell v. Commonwealth, ___ Va. App. ___, 403 S.E.2d 387 (1991).

The Virginia Court of Appeals upheld the conviction of a defendant possessing an IQ between 71 and 75, stating that his confession was voluntarily made after a knowing and intelligent waiver of his *Miranda* rights.

Charges against appellant Edward W. Terrell stemmed from three separate assaults between 1984 and 1987 involving abduction, rape, sodomy and attempted sodomy. After being arrested by police on January 6, 1988, Terrell received *Miranda* warnings, stated that he understood them, and signed a written waiver of his rights. During lengthy questioning regarding the assaults, police made factual misrepresentations to Terrell, including a warning that the most recent victim might have had AIDS that could have been passed on to her attacker. Police also led Terrell to believe that hairs consistent with a victim had been found on his clothing, and that these hairs could serve the same function as fingerprints. Psychiatric evaluation revealed Terrell to have an IQ between 71 and 75, and characterized him as a person who desired to please authority.

Addressing the issue of Terrell's waiver of his *Miranda* rights, the court stated that a waiver must be voluntary and constitute a knowing and intelligent relinquishment and abandonment of a known right or privilege. Whether or not such a waiver has occurred depends upon the particular facts and circumstances surrounding each case, including the background experience and conduct of the accused. Here, the record indicated that Terrell was advised of his *Miranda* rights, was willing to talk with police, and possessed sufficient intelligence and experience with the criminal justice system in order to support the finding that he executed a valid waiver.

Turning next to the issue of Terrell's confession, the court stated that a ruling on voluntariness must consider the totality of the circumstances surrounding the inculpatory statements. These circumstances include the details and techniques of the interrogation as well as the personal characteristics of the accused. Relevant personal characteristics encompass intelligence, education, prior experience with police, use of drugs or alcohol, emotional and mental disability, and deprivation of physical comforts. Regarding the intelligence of the accused, the court stated that there was no strict standard for the acumen below which a confession will be deemed involuntary. Taken together, these factors may yield a determination concerning how much free and unconstrained choice was involved in the inculpatory statements, and whether the maker's will and capacity was overburdened or critically impaired.

In holding that Terrell's confession was voluntary, the court cited prior cases where defendants possessing IQ's between 69 and 78 were held to have given voluntary confessions based on prior knowledge of *Miranda* warnings and previous encounters with the criminal justice system. The record indicated that Terrell had four prior felony convictions and had been incarcerated for three years.

Hypnotically refreshed testimony ruled inadmissable

Hall v. Commonwealth of Virginia, ____ Va. App. ____, 403 S.E.2d 362 (1991).

In an opinion announced in April 1991, the Virginia Court of Appeals all but closed the door on the use of hypnotically refreshed testimony in court.

Declaring that "manipulation of the mind through hypnosis may lead to uncertain and unreliable results," the court ruled inadmissible the testimony of a witness for the prosecution in a criminal case as to facts recalled under hypnosis. The court took care to distinguish *Rock v. Arkansas*, 483 U.S. 44 (1987), however, in which the United States Supreme Court rejected as unconstitutional a rule prohibiting the admission of a criminal defendant's hypnotically refreshed testimony, because such a rule would create an arbitrary restriction on a defendant's right to testify.

The defendant in this case, Dock Hall, was charged with murder, robbery, and use of a firearm in the commission of both murder and robbery. An eyewitness was able to describe for police a vehicle parked near the scene, although she could not recall a license plate number. She recalled the number under hypnosis. At trial, and over the defendant's objection, she was permitted to testify as to this recollection. Hall was convicted. On appeal, he argued that, because the eyewitness testimony was altered by hypnosis, she was incompetent to testify, at least with respect to matters recalled during and subsequent to hypnosis. In response, the Commonwealth argued that the issue was one of credibility rather than admissibility and that the weight to be afforded hypnotically refreshed testimony was for the jury to decide.

Writing for the Court of Appeals, Justice Keenan discussed the "dangers inherent in the forensic use of hypnosis:" (1) vulnerability to both conscious and unconscious suggestion; (2) confabulation (imagination of details to fill in gaps in memory); (3) confusion of fact and fiction, both during and after hypnosis; and, (4) strengthened subjective confidence in the recollection of facts initially recalled under hypnosis. Justice Keenan observed that courts in other states "have adopted varying methods to govern the use of hypnotically refreshed testimony at trial." Some have established a rule of *per se* admissibility, essentially finding the issue to be one of credibility, not admissibility. Others have ruled that hypnotically refreshed testimony is admissible so long as the hypnotic session was conducted in accordance with specific guidelines designed to enhance reliability. A few courts have decided that the matter is one for the trial judge to determine on a case by case basis, looking at the totality of the circumstances. The majority of courts, however, bar hypnotically refreshed testimony on the ground that such testimony fails to satisfy the standard of admissibility of scientific evidence established in *Frye v. U.S.*, 293 F. 1013 (D.C. Cir. 1923). (*Frye*

requires that the scientific principle or discovery upon which evidence is based must have gained general acceptance in the relevant professional community.)

Although the Virginia Supreme Court has not adopted the *Frye* rule, Keenan observed, "it repeatedly has predicated the admissibility of scientific evidence on a finding of reliability." Hypnotically refreshed testimony, Keenan concluded, is simply too unreliable to meet this standard.

Although too unreliable to provide the basis for courtroom testimony, Keenan noted, hypnosis nonetheless can be a valuable technique in the investigation of crime. To protect this application of the technique, the court held that "the mere fact that a witness has been hypnotized does not make that witness incompetent to testify as to all matters related to the hypnosis session." Testimony concerning facts recalled prior to the session still may be admissible, even if discussed during the session, Keenan writes, "so long as the prehypnotic recall has been adequately documented" and the party offering the testimony can show that the information about which the witness will testify was "both recalled and related to someone prior to the hypnotic session." Finally, to ensure the reliability of a witness' testimony with respect to his prehypnotic recall," the court "recommended" that the hypnotic session be conducted pursuant to guidelines set forth in *State v. Hurd*, 432 A.2d 86, 96-97 (1981): (1) the hypnotic session should be conducted by a psychiatrist or psychologist experienced in the use of hypnosis; (2) the hypnotist should be independent of the prosecutor, investigator, and defense; (3) information given to the hypnotist prior to the hypnotic session should be recorded; (4) before the hypnotic session, the hypnotist should obtain from the subject a detailed description of the facts as the subject remembers them (and this inquiry must be made without leading questions); (5) all hypnotic sessions should be recorded, ideally on videotape; and (6) only the hypnotist and the subject should be present during the hypnotic session.

In the Federal Courts

Constitutional right to medical care found for suicidal detainee

Buffington v. Baltimore County, 913 F.2d 113 (4th Cir. 1990).

The United States Court of Appeals for the Fourth Circuit affirmed a district court judgment for the parents of a man who committed suicide while detained in a Maryland county jail at a family member's request. The court held that the state has an affirmative duty to prevent a detainee from committing suicide even when the detainee is not being held for a criminal violation.

The Buffingtons brought suit against Baltimore County, the Chief of Police, and the police officers involved in the incident alleging a violation (under 42 U.S.C. § 1983) of the constitutional right to due process linked to a pre-trial detainee's right to medical care. The jury found for the Buffingtons and awarded $185,000 in damages. The court awarded an additional $430,000 in attorneys' fees and costs.

The incident at issue arose after a family member notified the police upon finding a suicide note from James Buffington. Buffington, although armed with three guns, did not commit suicide because he could not decide which gun to use. The police took Buffington to the jail and notified his family, whose response described a history of emotional problems along with a risk of suicide.

Following standard practice for a suicidal detainee, the police kept Buffington handcuffed to a rail by the booking desk within view of the officers. Meanwhile, the family attempted to have him transferred to the Baltimore Medical Center for an emergency psychiatric evaluation. They agreed to press charges to allow the police to detain Buffington in the event that the hospital could not admit him. After a change in the duty shift, new officers put him in a lock-up cell alone and fully clothed. Fifty minutes later, the police found Buffington hanged by a noose fashioned from his pants.

The county appealed the jury decision arguing that the constitution does not require the state to take steps to prevent a person in its custody from committing suicide if the person is detained by family request and not in violation of the law. The argument was grounded in the Supreme Court's conclusion in *Deshaney* that the state did not have an affirmative duty to protect a child from abuse even when a social worker knew of harm to the child. *DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189 (1989) (See 9 ***Developments in Mental Health Law*** 36, July-December 1989). The court disagreed with this reading of *DeShaney* and stated that an affirmative duty arises when the state takes custody of an individual, and does not depend upon the motive for the assumption of custody. The court reasoned that a pretrial detainee has the right to adequate medical care and that a suicidal detainee has medical needs that must be met. Although the court has refused to impose an affirmative duty upon the police to screen for suicide, the court recognized that indifference to the needs of a suicidal detainee is a violation of the detainee's due process rights. The court refused to draw a line between the case of a detainee who needs medical care and a detainee in need of psychiatric care, and affirmed the district court's finding for the Buffingtons.

Although the court reversed the decision against the county and the Chief of Police based upon specific requirements of section 1983 actions, the decision is likely to have an effect on law enforcement officials. Recognition of an affirmative state duty to provide medical and psychiatric care places additional requirements on law enforcement agencies which should provide greater protection for detainees at risk for suicide.

Fourth Circuit remands patient's claim that he was given antipsychotic drugs against his will

Johnson v. Coto, 924 F.2d 1052 (4th Cir. 1991).

Robert Clifton Johnson, an involuntarily committed psychiatric patient, brought suit against appellees under 42 U.S.C. § 1983 alleging that he had been administered antipsychotic medication against his will. The district court dismissed the action as frivolous noting Johnson's failure to state a claim of deliberate indifference. The Fourth Circuit vacated the decision of the district court and remanded the case for consideration of the due process implications of Johnson's claim.

In a previous suit based upon similar facts, the Fourth Circuit recognized a constitutionally protected freedom from the forced administration of antipsychotic medication and held that the forcible medication of an involuntarily committed psychiatric patient violated due process unless it resulted from the exercise of professional judgment. *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984).

The Supreme Court also recently recognized that an inmate housed in a prison mental health unit possessed a significant liberty interest in avoiding the unwanted administration of antipsychotic medication under the Fourteenth Amendment. Protection against possible due process violations was available, however, through review of the medication decision by a three person committee, provision of notice to the inmate, and the opportunity for the inmate to appear at an adversarial hearing in order to cross-examine those individuals involved with the medication decision. *Washington v. Harper*, 494 U.S. 210 (1990). (See 10 ***Developments in Mental Health Law*** 15, January-June 1990).

Here, Johnson asserted that the medication decision took place in a non-emergency setting, without professional discretion, and without a hearing at which Johnson could voice his concerns. While his allegations were based in current law, the district court's decision to dismiss the case precluded any determination as to their substance.

Finally, had Johnson not been entitled to relief, the judgment of the district court might have been sustained. The court's decision to dismiss the action, however, prevented appellees from establishing an affirmative defense of qualified immunity based upon exercise of professional discretion in the medication decision. Johnson had the right to be free from the forcible administration of antipsychotic medication that was not the product of professional judgment.

Tolling statute applying to medical malpractice claims of minor does not apply to claims of parent

Perez v. Espinola, 749 F. Supp. 732 (E.D.Va. 1990).

The United States District Court for the Eastern District of Virginia dismissed a mother's action that claimed medical expenses incurred in treatment and negligent infliction of emotional distress against an obstetrician who delivered her child. The District Court held that a Virginia law tolling statutes of limitation in cases involving medical malpractice injury to minors did not apply to the mother's claim.

Maria R. Perez became a patient of Dr. Mario E. Espinola, an obstetrician then practicing in Virginia in 1978. During 1979, Perez became pregnant and delivered a daughter on October 31, 1979. The child was born with severe brain damage, cerebral palsy, and limited body functions. The plaintiff notified Dr. Espinola in June 1989 of her claims for medical expenses and negligent infliction of emotional distress associated with the birth of and care for her child. In September 1990, Perez filed her complaint.

The court barred Perez's action as untimely based on Va. Code § 8.01-243(A) which requires that actions for personal injuries be brought within two years of the cause of action, and Va. Code § 8.01-243(B) which states that actions for injury to property, including those brought by parents for medical expenses for a minor child, be brought within five years of the cause of action.

Perez argued, however, that under Va. Code § 8.01-229(A) her claim should be heard. Section 8.01-229(A) includes a tolling provision for disabled persons, including infants and minors, and provides that the time during which an infant remains a minor does not count for limitations purposes. Perez contended that as her claim depended upon the claim of her daughter, she should also benefit from the tolling provision applicable to her child.

The court stated, however, that Perez did not fall within the class of infants, minors, insane persons or convicts entitled to tolling under section 8.01-229(A) nor were her claims brought by or on behalf of the child in accordance with Va. Code § 8.01-243(C).

The court also found that plaintiff's additional arguments for application of the tolling provision were without merit. Although Perez cited Virginia Supreme Court holdings that a parent's claim was wholly derivative of his or her child's claim, the court noted that these decisions involved determination of liability and damages, and did not speak to the statute of limitations.

Similarly, the court differentiated decisions of other state courts allowing parent's claims to benefit from infant tolling provisions. Those decisions, noted the court, arose in different statutory contexts which were overridden by the specific five year limitation set forth in section 8.01-243(B).

Multimillion dollar promissory notes not voided by alleged alcoholism and manic depression

In re Joseph Eugene Wills, 126 B.R. 489 (1991).

In a recent memorandum opinion, the U.S. Bankruptcy Court at Alexandria held that a holder of promissory notes who allegedly was aware of the maker's drinking, divorce, and psychological problems, did not act in bad faith in accepting the notes. Consequently, the holder was found to be holder in due course, and possessed a claim free from all defenses.

Joseph Wills gave two promissory notes valued at more than $2,170,000 to finance a portion of a $4,500,000 land purchase in Loudoun County, Virginia. The seller, soon after the transaction, gave the promissory notes to William Warde as security for a $1,700,000 loan. Within eight months, Wills defaulted on payment of his notes and filed bankruptcy.

When Warde filed a claim with the bankruptcy court as holder of the notes, Wills answered, asserting that the original transfer of property was void since he "was inebriated and had been so for an extended period of time" and was thus incapable of entering into a contract. He also argued that his ill health, intoxication and severe manic depression, as well as a court order restricting the contracts he could enter were facts that Warde, who had known him since adolescence, knew or should have known.

Stating that notice of defenses against an instrument requires looking to the mind of the holder who asserts that he is a holder in due course and not the mind of a reasonably prudent person, the court found that Warde did not have actual knowledge of such facts as would constitute taking the notes dishonestly. His testimony indicated that at the time he took the notes, he had no actual knowledge of the maker's alleged alcohol problems, manic-depressive disorder or a divorce order restricting his capacity to contract.

In granting summary judgment for Warde, the court noted that to have ruled otherwise would have had a chilling effect, requiring every purchaser of an instrument to ask whether he had ever observed the maker intoxicated or had ever heard rumors of the maker's psychological or marital problems. Such a ruling would also have limited the ability of anyone to issue drafts or promissory notes, who was suspected by a prospective purchaser of negotiable paper of having drinking, psychological or marital problems.

Summary suspension of driver's license based on drug addiction withstands due process challenge

Scott v. Williams, 924 F.2d 56 (4th Circuit, 1991).

A Virginia statute that allows for immediate suspension of a driver's license based on a report that the driver is addicted to drugs does not violate the 14th Amendment due process clause, according to a ruling of the United States Court of Appeals for the Fourth Circuit.Ms. G. Scott initially sought voluntary treatment for drug abuse in a Richmond facility, but was transferred as an involuntary patient to Central State Hospital. Upon her eventual release some three months later, a statutorily mandated report was filed with the Department of Motor Vehicles (DMV) by Central State personnel. The report indicated that Ms. Scott was not competent to operate a motor vehicle safely because of her drug addiction. Acting on authority of Va. Code § 46.1-429, the Commissioner of the DMV issued an order suspending her driver's license, and setting forth the criteria to apply for reinstatement.

Scott filed suit under 42 U.S.C. §1983, alleging that failure of the Virginia statute to provide an opportunity for a hearing prior to loss of the license or immediately thereafter denied her due process of law. The district court dismissed the suit on a motion for summary judgment by the state agency, and Scott appealed.

The court of appeals agreed with Scott that a driver's license is a property interest protected by the 14th Amendment. Once issued, it may not be taken away without procedural due process. Nevertheless, the Virginia statutory scheme that allows for prompt reinstatement of suspended licenses following submission of a physician's certification of safety, a $30 fee, and a complete driver's examination, meets constitutional due process requirements, according to the appellate court. Mandating additional procedures such as presuspension hearings would "impede the Commonwealth's interest in removing unsafe drivers as quickly as possible" and add administrative and financial burdens. The court concluded that such burdens were unnecessary in light of the "negligible" risk of erroneous revocation to licensees such as Scott.

Cases from Other States

Capacity of mentally retarded person to consent to sexual relations explored in rape case

State v. Olivio, 123 N.J. 550, 589 A.2d 597 (1991).

The Supreme Court of New Jersey modified and remanded a ruling of the Appellate Division holding that a person is mentally defective if at the time of sexual activity he or she is unable to comprehend the distinctively sexual nature of conduct or is incapable of understanding or exercising the right to refuse to engage in such conduct.

On February 12, 1985, Allan Rios Olivio had sexual relations in his car with sixteen year-old M.R., who had asked him for a ride. An expert for the prosecution testified that M.R. was "mentally defective," as indicated by an I.Q. score of 65 on the Weschler Adult Intelligence Scale (WAIS) and was unable to understand the consequences of her behavior. A school psychologist also testified that a year earlier, M.R. had scored between 40-50 on the Weschler Intelligence Scale for Children (WISC) placing her in the educable mentally retarded range, and that she was functioning on the level of a seven or eight year-old. A defense expert testified, however, that when he administered the Spanish version of the WAIS, M.R. received a score of 86, falling in the dull normal range of intelligence.

The Code of Criminal Justice, [N.J.S.A. 2C:14-2c(2)], criminalizes the sexual penetration of a person who is "mentally defective", and defines the condition as one "in which a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable of understanding the nature of his conduct including but not limited to being incapable of providing consent." [N.J.S.A. 2C:14-1h.] The court noted two issues of concern in applying this definition: the ability to consent and the ability to understand that the conduct was sexual.

The interpretive challenge for the court lay in the degree of sexual knowledge necessary to find a person mentally defective under the statute. The court determined that the knowledge should include an understanding of the physiological and moral implications and consequences of an act. The State argued that this should involve an awareness of the possibility of pregnancy and disease. Olivio responded that such an interpretation was too paternalistic, arguing instead that the court should confine itself to the capacity to consent. To take the definition beyond this issue, argued Olivio, would deprive many individuals of legitimate sexual expression and infringe upon the basic right of procreation and contraception.

The court ruled that a person is mentally defective under the statute if at the time of sexual activity, the mental defect renders her unable to comprehend the distinctively sexual nature of the conduct or if she is unable to understand or exercise the right to refuse to engage in such conduct with another. Evidence of the trial court supported the finding that M.R. was mentally defective. However, the trial court's charge failed to provide adequate explanation of the standard for determining "mentally defective" beyond the statutory language itself.

Refusal of medication yields contempt order for Indiana outpatient

In re Tarpley, 566 N.E.2d 71 (Ind. Ct. App. 1991).

The Court of Appeals of Indiana recently affirmed a trial court's decision to hold a committed patient in contempt for failing to take medication. The opinion stated that ordering the patient to take medication was the least restrictive treatment alternative, and that the contempt holding did not violate the patient's due process rights. The court also held that the trial court was not required to make an express finding that the refusal was a manifestation of the patient's illness since patient's counsel stated that his client's refusal was willful, voluntary, and knowing.

Timothy Tarpley, diagnosed as chronic paranoid schizophrenic, was committed to the Midtown Community Health Center as an outpatient on January 8, 1987. The outpatient commitment was based on the condition that Tarpley continue to take all prescribed medications, attend all clinic sessions, and refrain from abusing drugs or alcohol. After Midtown reported that he was missing clinic appointments, a trial court found that Tarpley was mentally ill and in need of medication. The court determined that the least restrictive treatment alternative was to order Tarpley to continue

taking his medication on an outpatient basis. Tarpley subsequently refused to adhere to the order, and his lawyer affirmed that the refusal was willful, voluntary, and knowing. The court held Tarpley in contempt and he was jailed. Tarpley was released on the condition that he continue his commitment as an outpatient, including the medication.

On appeal, Tarpley argued that although the court could order that medication be forcibly administered, it was not within its purview to order him to take the medication. The court of appeals ruled, however, that once medication was deemed necessary, the court was obligated to choose the least restrictive treatment alternative. Here, those alternatives amounted to a conversion of Tarpley's commitment to inpatient status with forcible administration of medication, an order that Tarpley appear for forcibly administered medication, or an order that Tarpley take his medication or suffer the consequences. As the first alternative was highly restrictive and the second impractical, the court was correct in choosing the third.

Addressing Tarpley's contention that his due process rights were violated in the summary contempt finding, the court of appeals held that regardless of whether the contempt was categorized as civil or criminal, Tarpley was given notice and allowed to defend his noncompliance during his voluntary return to the courtroom. Given that Tarpley's counsel indicated that his decision was willful, voluntary and knowing, the immediate finding of contempt did not violate due process.

Finally, the court noted that an express statement of Tarpley's blameworthiness for contempt was not required from the trial court as Tarpley's conduct was clear from the transcript, and his counsel's admissions. The dissent argued, however, that Tarpley had a qualified right to refuse medication and should have been afforded the opportunity to prepare a defense showing legal or factual justification for his refusal to comply with the court order. Such justification might include proof that his refusal was a product of his mental illness.

Contempt citation invalid absent access to counsel

In re Utley, 565 N.E.2d 1152 (Ind. Ct. App. 1991).

The Court of Appeals of Indiana also recently addressed the appeal of a contempt conviction by an involuntarily committed person, holding that the trial court erred by not inquiring whether he could afford counsel, and by not appointing counsel for him.

Appellant Larry Utley, was diagnosed as a chronic paranoid schizophrenic and was committed to the Midtown Community Health Center as an outpatient in 1987 on the condition that he take all medication and attend all clinical sessions as prescribed. In October of 1989, Midtown reported that Utley was not adhering to these conditions. At a compliance hearing in December, 1989, Utley appeared in court without counsel. The trial court did not advise him of his right to counsel, assess his ability to pay for an attorney, or appoint counsel on his behalf. After some confusion over the status of his commitment and a number of interruptions of the proceedings, the judge held Utley in contempt until he agreed to be evaluated.

Upon appeal, Utley contended that the trial court erred in failing to determine whether he could afford an attorney, and failing to appoint counsel. The appellate court agreed, noting that since the finding of contempt was based on his failure to understand and comply with the trial court' direction, his need for counsel was apparent.

Utley also contended that the trial court erred in failing to determine whether his conduct was the product of his mental illness. The court again agreed, stating that in light of the trial court's finding that Utley was mentally ill, it should have determined whether his conduct was willful or a manifestation of his mental illness. Because civil contempt is coercive in nature, there was no justification for confining Utley on a civil contempt theory if he lacked the ability to comply.

Competency to stand trial found despite .19 alcohol level

Meekins v. State of Arkansas, 34 Ark. App. 67, 806 S.W.2d 9 (1991)

The Arkansas Court of Appeals, sitting *en banc*, denied a rehearing to a criminal defendant whose alcohol level was measured at .19 on the morning of his trial, and who subsequently appealed his conviction on the basis that he was unable to participate effectively in his own defense.

Reynaldo Meekins was brought to trial on a charge of delivery of a controlled substance. He was convicted and sentenced to twenty years in prison as an

habitual offender. Just prior to the trial, the prosecutor advised the court that Meekins might be intoxicated, since he had just undergone a breathalyzer test that yielded a .19 percent blood alcohol level.

The court conducted a brief hearing on Meekins' condition with the two officers who had supervised the breathalyzer test. They both reported that Meekins had been able to recite his name, address, age, and date of birth. They also affirmed that the defendant had been "read his rights" prior to administration of the alcohol test, and that he understood and signed a consent document. Their conclusions were that he "knows what's going on. He's not out of it." Without examining Meekins, the court concluded that he was capable of understanding the proceedings, and refused to grant a request for a continuance.

On appeal, Meekins contended that his condition on the day of trial rendered him incapable of assisting his attorney or of understanding the proceedings. Denial of his motion for a continuance, he argued, violated his 6th Amendment right to counsel. Conceding that a person who is unable to participate in his defense should not be tried, the appellate court denied that characterization to Meekins. Arkansas law, the court observed, specifies that it is illegal to operate an automobile with a blood alcohol level of .10 or more. The law, however "does not declare or imply that a person in such condition is incompetent for any other purpose," the court concluded.

A single judge noted in dissent that since the intoxication of a juror was sufficient cause for dismissing a jury, and the inebriation of a material witness adequate reason to adjourn a trial until the witness became sober, discovery of the drunkenness of "a defendant on trial for his liberty" should provide similar justification for deferring the trial or setting aside a verdict.

Arkansas sterilization law ruled unconstitutional

McKinney v. McKinney, 305 Ark. 13, 805 S.W.2d 66 (1991).

The Supreme Court of Arkansas reviewed that state's statute allowing involuntary sexual sterilization of "mental incompetents" and found an alternative procedure for authorizing sterilization through "direct medical channels" in violation of constitutional due process safeguards. The court quoted commentators who have emphasized that anyone subject to involuntary sterilization is entitled to "the utmost procedural protection."

Arkansas law prescribes two procedures for involuntary sterilization of incompetents. The first allows sterilization following a court order. The second statutory provision outlines a less onerous process, when "obvious hardship and environmental circumstances truly negate the protective measures" contained in judicial procedures. Under that provision, a parent or guardian may initiate sterilization surgery by providing a statement from the operating physician and two psychiatrists who need only certify that the proposed patient is incompetent and that in their opinions, "the sterilization is justified." If the hospital sterilization committee approves, the operation can take place.

A lawsuit was initiated through counsel by an incompetent adult who requested a restraining order against her father to prevent him from invoking "direct medical channels" sterilization. That action was settled via a court order in which the father agreed not to pursue the operation, and to have no further contact with his daughter. Following the trial court's dismissal of the case, an appeal was brought challenging the constitutionality of the "alternative" sterilization procedure. Although the dispute appeared to be moot, the court entertained an appeal to address the policy questions raised by the informal sterilization processes. Noting that the Arkansas Attorney General's office had questioned the validity of the statute in a 1986 opinion, the Supreme Court listed the procedural infirmities of the law. It did not provide for notice to the incompetent patient, an opportunity to be heard or challenge witnesses via cross-examination, nor for the assistance of counsel. The court concluded that the 1971 law "falls short of the minimum requirements of procedural due process," mandated under the 14th Amendment, and declared it unconstitutional.

In the Virginia General Assembly

Recent Amendments and Additions to the Code of Virginia

Attorney's duties to client during involuntary admission and treatment hearings

During commitment hearings pursuant to § 37.1-67.1, the attorney for the person whose admission is sought shall interview his client, the psychiatrist or clinical psychologist appointed to examine his client, and any other relevant material witnesses. Counsel shall also examine all relevant diagnostic and other reports, present evidence and witnesses, and provide active representation on behalf of his client.

Clients must be given adequate notice of the place, date, and time of the commitment hearing according to new provisions of § 37.1-67.3. The subject of the hearing may retain counsel at his own expense, be present during the hearing, testify, and present evidence on his behalf.

[HB 1818; Ch. 636; amending § 37.1-67.3.]

"Terminal condition" redefined relative to the Natural Death Act

A "terminal condition" is now defined by § 54.1.-2982 as a condition caused by injury, disease or illness from which to a reasonable degree of medical probability, (i) there can be no recovery and (ii) death is imminent. The term also means a persistent vegetative state in which a qualified patient has suffered a loss of consciousness, with no behavioral self-awareness or awareness of surroundings in a learned manner, other than reflex activity of muscles and nerves for low level conditioned response, and from which, to a reasonable degree of medical probability, there can be no recovery. (See 10 ***Developments in Mental Health Law*** 28, July-December 1990).

[HB 1615; Ch. 583; amending § 54.1-2982]

Valid statements in written declaration relative to Natural Death Act

Written declarations drafted under provisions of the Natural Death Act, (§ 54.1-2983) may also now include directions regarding sustaining, withdrawing or withholding nutrition or hydration. (See 10 ***Developments in Mental Health Law*** 28, July-December 1990.

[HB 1651; Ch. 583; amending § 54.1-2984.]

Durable power of attorney regarding health care

After determining that an adult, due to mental or physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about a specific medical treatment or course of treatment, a licensed physician may provide for withholding or withdrawal of that treatment from the person.

Reflecting recent amendments to §§ 54.1-2982 and 54.1-2984, withholding or withdrawing treatment may occur only upon authorization of the following persons in order of priority: (i) an attorney-in-fact appointed under a durable power of attorney; (ii) a person designated in a written declaration pursuant to § 54.1-2984 by an adult possessing a "terminal condition" as defined in § 54.1-2982; (iii) a judicially appointed guardian or committee authorized to make such decisions; (iv) the spouse; (v) an adult son or daughter; (vi) a parent; (vii) an adult brother or sister; or (viii) any other relative in descending order of blood relationship.

[HB 1727; Ch. 436; amending § 37.1-134.4.]

Accrual of actions resulting from sexual abuse during infancy or incompetency

In actions for personal injury resulting from sexual abuse occurring during infancy or incompetency, a cause of action accrues when the injury and its causal connection to the sexual abuse is first communicated to the victim by a licensed physician, psychologist, or clinical psychologist. No such action may be brought, however, more than ten years after the later of: (i) the last act by the same perpetrator which was part of a common scheme or plan of abuse or, (ii) the removal of the disability of infancy or incompetency.

"Sexual abuse" is defined in subdivision 6 of § 18.2-67.10 and concerns acts constituting rape, sodomy, inanimate object sexual penetration or sexual battery as defined in Article 7 (§ 18.2-61 *et seq.*) of Chapter 4 of Title 18.2.

[HB 1287; Ch. 674; amending § 8.01-249.]

Provisions for exchange of prisoner's medical and mental health records

New section 53.1-40.10 authorizes the Department of Corrections to exchange medical and mental health information about prisoners.

Administrators of facilities in which prisoners are currently located may receive the information for the sole purpose of maintaining security and safety within the facility.

Members of the Parole Board, probation and parole officers may utilize the records in order to investigate and plan parole and probation, as well as during release and supervision.

Officers of the Department of Corrections may exchange medical and mental health records of prisoners in recommending treatment, rehabilitation, classification, and security and work assignments. The materials may also be used to determine any necessary medical, dental or mental health care.

Medical and mental health facilities, including community services boards may access the records for use in planning and supervising medical and mental health care and treatment programs upon release from the correctional facility.

Substance abuse records subject to federal regulations, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. § 2.11 *et seq*, are not covered by this section. Disclosure of test results for Human Immunodeficiency Virus is also not allowed except as permitted in § 32.1-36.1.

[HB 1912; Ch. 597; adding § 53.1-40.10.]

State Fair Housing Law extended to protect the mentally impaired

Chapter 5.1 of Title 36 now provides for the fair housing of all persons and prohibits discrimination on the basis of race, color, religion, national origin, sex, elderliness, familial status or handicap. Section 36-96.1:1 defines handicap as (i) a physical or mental impairment which substantially limits one or more of such persons major life activities; (ii) a medical or psychological record of having such an impairment; or (iii) being regarded as having such an impairment. The term does not include the current, illegal use of, or addiction to a controlled substance, nor does it apply to an individual solely because that individual is a transvestite.

[HB 1153; Ch. 557; adding §§ 36-96.1 to 96.23.]

1991 House Joint Resolutions

Review of Women's Substance Abuse Programs

House Joint Resolution 389 requests that the Commissioner of Mental Health, Mental Retardation, and Substance Abuse Services scrutinize the implementation of women's programs in Virginia. In particular, the Commissioner is asked to encourage community services boards (CSBs) to develop programming for women who are substance abusers and their children, and if necessary, mandate the CSBs to implement at least one unique program for women by a specific date.

Disability, Special Education Teaching to be Assessed

The Board of Education is directed in House Joint Resolution 420 to review certification requirements and standards for approved teacher education programs. Central to the request is an assessment of the knowledge, skills, and abilities necessary to teach students with disabilities, and the development of recommendations for completion of course work in the area. The Board is similarly asked to scrutinize current recertification regulations, and make recommendations if necessary. HJR 420 also directs the Board to develop guidelines for instruction in the field of special education.

Comprehensive AIDS Plan Called For

Beginning with House Joint Resolution 436, the General Assembly addressed the current AIDS epidemic in the Commonwealth. HJR 436 asks the Secretary of Health and Human Resources to direct the development of a comprehensive plan to ameliorate the current health crisis. The plan is to provide for HIV/AIDS prevention, care, and services in Virginia for the years 1991 to 2000, and address the projected incidence, prevalence, and trends over the period. Also requested is an assessment of current local, state, and federal funding and services as well as those resources available in the private sector. HJR 436 asks for additional analysis of currently available care, financing, information, and early intervention services. Finally, anticipating deficiencies in HIV prevention, care, and services, the Secretary is directed to develop strategies to improve funding, personnel, and facilities.

Continuing the focus on the AIDS epidemic, House Joint Resolution 437 requests the Board of

Education to "strive aggressively to increase the adequacy of AIDS education" in the Commonwealth's schools. The resolution requests an evaluation of current AIDS education programs compliance with existing guidelines and standards and the effectiveness of such programs.

Finally, House Joint Resolution 438 provides for the continuation of the Joint Subcommittee Studying Human Immunodeficiency Virus as the Joint Subcommittee Studying the Issues, Policies and Programs Relating to Infection with Human Immunodeficiency Viruses.

Attention Deficit Disorder

Addressing current concern over Attention Deficit Hyperactivity Disorder (ADHD), House Joint Resolution 455 requests the Department of Education to encourage local schools to make personnel available in every public schools to administer medications, including recording observable reactions and other appropriate information associated with medication used to treat ADHD.

From the Office of the Attorney General

Probable cause concerns surrounding temporary detention orders

In an opinion letter dated June 7, 1991, the Attorney General's Office addressed a number of concerns surrounding temporary detaining orders (TDOs) issued after telephone conversations with mental health professionals. Citing Virginia Code § 37.1-67.1, the opinion noted that there is no requirement that a mental health professional personally appear before a magistrate to offer advice regarding the mental health of an individual. Rather, a telephone conversation with a person skilled in the diagnosis and treatment of mental illness may provide enough probable cause for issuance of the TDO.

During such a telephone conversation, the magistrate may employ any method necessary to authenticate the identity of the caller and determine that probable cause exists. However, if the caller is not personally known to the magistrate or if the magistrate cannot establish a reasonable belief in the reliability of the caller, a personal appearance may be required prior to issuing the TDO.

New Law for the Commitment and Release of Insanity Acquittees

In 1990, the Virginia General Assembly passed a resolution (House Joint Resolution 68) directing the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to study the commitment, management, and release of persons found not guilty by reason of insanity (NGRI) of criminal offenses in Virginia. Russell C. Petrella, Ph.D., DMHMRSAS Director of Mental Health Services assembled an interdisciplinary committee to conduct the study. Committee members included representatives of the judiciary, the Commonwealth's Attorneys Association, the Defense Bar, the Parole Board, and several community services boards (CSBs) and state hospitals. The study resulted in a proposal to alter radically Virginia's law governing the disposition of insanity acquittees. Legislation drafted by the study committee was passed virtually intact by the General Assembly in 1991, to become effective July 1, 1992. [HB 1558; Ch. 427; adding §§ 19.2-182.2 to 19.2-182.13.]

Designed to promote the treatment of insanity acquittees in the least restrictive setting consistent with public safety, the new law features an elaborate plan for the conditional release of NGRIs no longer requiring inpatient care. CSB personnel will assume a significant role in the management of NGRIs on conditional release. Training on the implementation of the new law will be offered by the DMHMRSAS and the Institute of Law, Psychiatry and Public Policy this winter and next spring.

The following is a brief synopsis of some of the law's most significant provisions.

Initial Commitment

Persons acquitted by reason of insanity will be subject to commitment on a finding by the court in which the criminal case was tried that the acquittee is currently "in need of inpatient hospitalization . . . [considering] (1) whether and to what extent the acquittee is mentally ill or mentally retarded . . ., (2) the likelihood that the acquittee will engage in conduct presenting a substantial risk of bodily harm to others or to himself in the foreseeable future, (3) the likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis, and (4) such other factors as the court deems relevant. The

law expressly provides that an acquittee no longer in need of inpatient care "solely because of treatment or habilitation he is currently receiving" may be retained in the hospital unless the court is persuaded that the acquittee will continue to receive such treatment or habilitation on an outpatient basis. Current Virginia law provides for the commitment of NGRIs found to be either mentally disordered (insane or mentally retarded) or dangerous. The United States Supreme Court has indicated that it will address whether commitment of NGRIs on the basis of dangerousness alone is constitutional during its next term.

Periodic Review

Under the new law, review hearings before the original committee in court must be held annually during the first five years, and biannually thereafter. Current law provides for review hearings on request of the patient, annually beginning six months after the initial commitment. As in current law, the commissioner (of the DMHMRSAS) may request the patient's release at any time. In every case, however, release decisions must be made by the court.

Conditional Release

The court at any time may place the acquittee on conditional release if it finds: "(i) . . . the acquittee . . . does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization; (ii) appropriate outpatient supervision and treatment are reasonably available; (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and (iv) conditional release would not present an undue risk to public safety." Before ordering conditional release, the court must approve a discharge plan prepared jointly by the hospital in which the acquittee is a patient and the "appropriate community services board." The CSB serving the locality in which the acquittee will reside on conditional release is responsible for implementing the court's release orders and must submit written reports to the court "on the acquittee's progress and adjustment in the community" at least every six months.

Conditional release may be revoked on a finding that the acquittee either has violated the conditions of his or her release or is no longer a proper subject for conditional release and requires inpatient hospitalization. The committing court may conduct a hearing whenever it finds reasonable grounds to believe that the acquittee should be returned to the hospital. Provision also is made for emergency custody of conditionally released acquittees on a finding by a judge, special justice, or court magistrate that there is probable cause to believe that the acquittee either has violated the conditions of his or her release or is no longer a proper subject for conditional release and requires inpatient hospitalization. The procedures prescribed by the law closely follow procedures appearing in the civil commitment law for emergency custody.

Although the law provides for neither a maximum term of conditional release nor automatic review, the acquittee may petition for a modification or removal of conditions annually beginning six months after the conditional release order is issued. The CSB and the Commonwealth's Attorney may petition at any time. On such a petition, the court must give notice to the acquittee, the Commonwealth's Attorney, and the CSB; if no one objects within ten days, the court may issue an order modifying or removing conditions. If an objection is filed, a hearing must be held.

—W. Lawrence Fitch, J. D.

. . . Outpatient commitment

-continued from page 3 -

obtained employment in the community while on our open ward, participated in Alcoholics Anonymous, and used his time in therapy to work on issues of the murder, his illness, remorse, and his need for sobriety. For the first year after his conditional release, Joe appeared to do well. Yet, by the end of the year he began to miss clinic appointments. A check with both Joe and his alcoholism counselor led us to believe that he might again be drinking. His participation in the alcoholism group had also been sporadic over the prior month.

As a result of these inquiries and the information received, the aftercare office prepared a revocation order, notified the local State's Attorney and set the wheels turning for Joe's return. We lacked clinical evidence that Joe's mental condition had deteriorated, but sought revocation based upon the condition of his release prohibiting the use of alcohol. The aftercare office documented repeated efforts over the next four months to persuade the State's Attorney to take Joe into custody as authorized by statute. He repeatedly assured the aftercare office that he was working on it, but he chose not to act. We soon heard of Joe's death in another city. He had been shot by the police after he had committed another murder.

The aftercare office had on file detailed records of the attempts to revoke Joe's release, the court orders sent, and detailed logs of the phone contacts with county officials during the four fruitless months. This tragic story highlights the seriousness of a mandate to provide outpatient supervision. The department was protected from liability by the thoroughness of the documentation of its efforts; the State's Attorneys now respond with no delay. None of us predicted the urgency of need for Joe's re-hospitalization, but we have all learned to respond vigorously to lapses in a patient's conditional release compliance.

We built the fourth problem for ourselves. The insanity defense statute in the seventies called for five years of conditional release. But, after *Hinckley*, we looked at the general experience in Maryland since the beginning of conditional release and found that many offenses occurred after the end of the five years of mandated follow-up. These findings led to our incorporation in the 1984 revised law of the ability to extend conditional release beyond five years upon application by the department. While this made perfect sense at the time we were drafting law, we didn't think about how we would know whether to ask for these extensions.

Usually, by five years, the clinic sessions were less frequent. The therapist following the patient had often forgotten the original court connection. It is easy to decide you want to supervise a newly discharged felony insanity acquittee, but how do you decide when you should stop? We didn't deal with this issue in statute, but gradually it occurred to me as we began to live under the new law that we had an obligation to make an assessment of the patient's clinical condition before permitting a conditional release simply to lapse. We now had an option to extend the period of supervision. I recognized that we had created a duty to do so if the patient's condition was not stable.

We chose to perform an independent evaluation of each felony insanity acquittee several months before the termination of their conditional release. As you may have already anticipated, the silence of the statute afforded attorneys for the clients a basis to challenge our right to subject the patient to an evaluation not agreed upon in the original conditional release, to apply an option to extend not explicitly permitted in the law under which the original commitment occurred. Although we overcame these challenges, we still lacked established criteria or protocols by which to recommend whether mandatory continued monitoring was necessary or for how long.

In retrospect, I believe we should have thought of all these issues before we agreed to the extension option. Yet, at the time, we all were pleased with making law logically, basing public policy upon scholarly research findings, acting with maturity in Annapolis. The law of unforeseen consequences, however, usually presents some surprises when we try a new approach, especially one which seemed such a trivial change at the time. We are currently institutionalizing the protocols for these reevaluations. As director, I now must provide resources to pay for these rather comprehensive and important evaluations that may bind us for many years of professional responsibility.

The fifth area of difficulty is one we have discovered over the past five years as we have engaged increasingly in research on outcome. We have been concerned about the recidivism of insanity acquittees

not only during their period of conditional release, but also after their conditional release expired. Our earliest data came from quality assurance audits carried out on the half-way house population. Records on patients were kept by the hospital social work department and based on interaction with the patients in clinic and information sought from family when appointments were missed. From these data, we found surprisingly few rearrests.

In subsequent studies, we examined additional data from local court records and FBI rap sheets. We discovered that many patients whom we followed had sustained arrests and convictions about which their therapists were unaware. Fifty-four percent of 127 discharged insanity acquittees were rearrested within five years of their release from inpatient care. While most of the rearrests were on trivial charges, the issue of interest here is the difficulty clinicians had in learning of their patients' scrapes with the law. Perhaps the difficulty was in asking the right questions.

We have subsequently connected our aftercare office with the state's criminal justice information system computer and can obtain arrest data on-line. We have had to set up procedures to ensure that we are monitoring this information appropriately. We have created another area where our performance is measurable on the record.

The original law allowed immediate discharge of a defendant to conditional release from the courtroom upon a finding of insanity. This immediate return to the community was possible if the judge had received a psychiatric report after verdict which assessed dangerousness and suggested outpatient management. Needless to say, virtually no serious offenders were discharged in this manner. Nonetheless, many misdemeanants were. Often the regional hospital recommended these releases. This was especially true if a time delay occurred between the patient's admission and the final adjudication, or if a lengthy period of incompetency for trial intervened.

Sometimes, privately retained counsel would arrange for evaluations by local psychiatrists. Many of these conditional releases seemed to be unsuccessful. The staff at Perkins has concluded that the success of a conditional release is built upon the degree of trust and relationship between the patient and aftercare worker as well as the patient's degree of insight into the nature of the illness and its relationship to the criminal behavior. Working through these issues takes time. A premature release undermines the patient's motivation to engage in this effort. Denial wins.

The main value of the court's participation is not to insure a therapeutic relationship, but to provide a mechanism to regain custody of the patient should treatment efforts lose effectiveness. We have since changed the law to minimize the opportunity for ill-planned conditional release.

Patients have the right to challenge their commitment through a variety of legal mechanisms. The most commonly used avenue is an administrative hearing. One potential remedy at hearing is for the judge to order conditional release. Early on, I objected to being ordered to carry out treatment plans with which we did not agree. A confrontation followed between the hospital professional staff and the administrative law judge, the attorney general, the public defender, and the mental hygiene director. I argued that we should not be compelled to provide outpatient treatment if we judged that inpatient care was required. The impasse ultimately was resolved by the judges agreeing not to write their own conditional release protocols and the public defender agreeing to develop alternate plans that did not require the participation of the hospital or its personnel. The public mental health system remained available to provide service, but not Perkins. Many agents can write hypothetical plans, but realistic plans are difficult to find. Commitments to provide therapy for our patients were not easily won. Still, we agreed that the community forensic aftercare office would monitor the compliance of acquittees in outpatient treatment no matter who constructed the plan.

The success of a conditional release is built upon the degree of trust and relationship between the patient and aftercare worker.

All this accountability costs. In Maryland, we are spending resources intensively on a small subset of the mentally ill population, those found not criminally responsible. What I have to this point described illuminates why, when I first heard the idea of outpatient civil commitment proposed in Maryland, I reacted with concern. It seemed like too much process for too little gain while incurring too much liability exposure.

In reflecting on our experience, I recognize that a more coordinated and accountable system of care for forensic patients has resulted in Maryland from the evolution of conditional release. If outpatient commitment takes off for non-forensic patients, much time,

expense and energy will be consumed in managing the growth of a much larger system. If an outpatient commitment statute is created but not widely used, why create such a complex and costly mechanism of responsible enforcement? Are there more effective ways to design services for a non-forensic population which will not discourage their participation in treatment?

To summarize, I have chosen to focus on seven areas in which outpatient commitment as practiced on the forensic side has presented major dilemmas:

1. Worry about the availability of treatment personnel and facilities willing to work with an involuntary and more complicated group of patients. Passing restrictive legislation is always easier than finding the cash and people to carry out the laws meaningfully.

2. Train mental health personnel to deal with the court system respectfully and train criminal justice system personnel to handle the issues of patients with serious mental illness humanely. If, increasingly, we involve mentally ill people with systems designed to process criminals, we must work toward conciliation on goals and methods. We must also inform all participants of our expectations.

3. Develop relatively sophisticated records and data management systems. Monitoring patients in the community is not a traditional mental health discipline. Assertive case management may be a better approach than involuntary outpatient commitment. Case management is a new function; its definition is not settled; training is by apprenticeship; funding streams remain fragile. The technology of documentation is well behind the level of dependability that outpatient commitment will lead the community to expect.

We must not permit ourselves to be trapped into blaming the victim of serious mental illness for the limitations of our own technology or humanity.

4. Beware of unexpected obligations hiding in new procedures. Additional evaluations and court time require funding that may not be available. The new responsibilities will more likely grow without the budgeting of new resources.

5. Make sure that the information sources are adequate for the mental health workers to know what's going on. Are relevant questions being asked? Whenever there is a substitute for commitment to the hospital there will be a need for dependable information about the patient's progress. The time at the clinic appointment may present a misleading slice of the patient's life. When there is a need to return to court for revision of the plan, reliable information will be critical in assuring a responsible disposition.

6. A meaningful therapeutic relationship must be developed with the patient for treatment to succeed. Coercion alone is no substitute. If the relationship can be nurtured, coercion may be avoidable.

7. The responsible clinician must participate in the planning. Few would carry out treatment ordered by a third party that is at odds with their own professional judgment. Be careful who constructs the terms of the outpatient commitment.

Resources, training, careful records, thorough planning, communication, treatment relationship, and professional judgment -- these are issues with which we have wrestled on the forensic side that, in my opinion, are equally critical in the civil context.

When we must provide assurance to the community that once dangerous insanity acquittees may safely return to the community, it is necessary to develop stringent monitoring. For patients who have never shown a propensity for violence, it seems that a less stringent system would suffice. I remain concerned that if any problem arises, accountability will be undiminished.

In Maryland, we are working actively with patients to identify how services can be arranged to reach out effectively to patients whom our clinics have not satisfied or who, because of their terror, have been unwilling to seek help. We seek to minimize the need for involuntary mechanisms in order to conserve the scarce mental health resources available.

I hope that this review of our experiences in Maryland's forensic system will stimulate reflection. How can we use these ideas in designing an effective involuntary outpatient civil commitment process? Should we even try? The reports of some states with this option are somewhat encouraging. It appears that for certain patients, hospital use diminished and tenure in the community was enhanced. The cost consequences are not well analyzed, either in economic terms, or more importantly, in the context of whether these committed outpatients inappropriately displaced others from needed ambulatory services. In attempting to minimize the morbidity in one group, have we aggravated the outcome for others?

My reading of the reports suggests that outpatient commitment may be more useful on the civil side

in preventing hospitalization than in shortening length of stay. I remain troubled that as mental health professionals we must turn to judges to encourage our clients to participate in treatment services. We must not permit ourselves to be trapped into blaming the victim of serious mental illness for the limitations of our own technology or humanity. Those who are persuadable by the court should be reachable by us. Those who are not motivated by the court will be admitted anyway. I've learned that the commitment is not of the patient, but ultimately must be of the provider of care. This means that outpatient civil commitment may really affect provider behavior more significantly than patient behavior. We're not committing the patient, really, but rather the entire mental health community to be more accountable, to do the job well, to find somehow a treatment alliance with the patient. These efforts toward more effective procedures find their value in that context.

This article was developed from a presentation given at the "Symposium on Mental Health and the Law," March 7, 1991 at Richmond, Virginia.

MEMORIAL TRIBUTE TO DELEGATE WARREN G. STAMBAUGH

Delegate Warren Stambaugh served as Arlington County's representative to the Virginia General Assembly from 1974 until his death on November 14, 1990. As a tribute to his involvement in the field of mental health legislation, the 14th Annual Symposium on Mental Health Law was dedicated to his memory. The comments below were excerpted from Richard Bonnie's remarks of dedication.

For almost ten years Warren Stambaugh was *the* legislative authority in the field of mental health law in the Commonwealth of Virginia. He was the primary patron for virtually all of the substantive legislation enacted in the field by the General Assembly over this period -- the Virginians with Disabilities Act, the Inpatient Treatment of Minors Act, the surrogate medical decision-making legislation and various revisions of the civil commitment code (including, of course, some revisions of the civil commitment code that were not enacted).

Warren's legislative accomplishments in this and many other fields only begin to take the measure of the man and his contributions. Warren was regarded as a "liberal" politician. Whether or not this description was accurate in contemporary political terms, I know it was accurate in a more profound and important sense: Warren believed in the worth of the individual and in the society's obligation to respect and promote the dignity of each person. He believed that an affluent society -- even one experiencing the kind of economic dislocations we are now having -- has an affirmative responsibility to promote equal opportunity and equal citizenship for the less fortunate among us.

Many of us share these beliefs, but Warren was special because he sought unstintingly to give them life and texture in the law. When he saw civil commitment hearings for the first time in 1982, and thought them indifferent to human dignity, he was appalled and he said so. And he sought to do something about it. When he visited the homes of persons with mental retardation and mental illness, and he heard of their difficulties in the workplace, he was troubled and he said so. And he sought to do something about it. When he heard the tone of indifference and insensitivity in the legislative debates concerning the Virginians with Disabilities Act, he said so -- quite caustically sometimes -- and he continued to press forward.

Warren believed in liberal ideas and he sought to translate them into public policy. But he was not a starry-eyed idealist; he was a realist -- a hard-headed realist -- and as time went on, he honed his political skills. We see, in Warren's career, how a liberal became so successful, despite all the odds, in a state with such conservative political traditions. This I think is the greatest tribute of all. Warren was an idealist, but he was also a practical man of politics. This is why he achieved so much, why he earned the respect of so many, and why all of us will miss him.

15th Annual Symposium on Mental Health and the Law
March 12 - 13, 1991

HYATT RICHMOND
Richmond, Virginia

Keynote Speaker: Paul Appelbaum, M.D.
Dr. Appelbaum will discuss the expansion of "managed care" in the mental health field and its impact on patients and practitioners.

OTHER TOPICS INCLUDE:
Patient Self-Determination Act
Sexual abuse: clinical obligations and legal changes
Substance abuse and AIDS
Satanism and ritualistic crimes
Workshops for Virginia practitioners

To pre-register please return the postcard included inside.
For Further Information call C. Engelhard at 804/924-5435

Developments in Mental Health Law
Institute of Law, Psychiatry & Public Policy
University of Virginia School of Law
North Grounds
Charlottesville, Virginia 22901

Non-Profit Organization
U.S. Postage
P A I D
Permit No. 160
Charlottesville, VA 22901

Developments in
Mental Health Law
Institute of Law, Psychiatry and Public Policy - The University of Virginia
Volume 11, Number 2
July - December 1991

Creating Community Housing for the Seriously Mentally Ill: Systems Issues

by Glenn Yank M.D.

Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) and network of Community Services Boards (CSBs) are responsible for providing a comprehensive system of care for the seriously mentally ill. Although the DMHMRSAS has endorsed the community support systems model developed by the National Institute of Mental Health as the primary means for providing necessary services for this population, appropriate community-based supported and supervised housing services for the seriously mentally ill, which are key elements of this model, have so far proven difficult to provide on a sufficient and consistent basis in Virginia. This report will describe the origin of the community support systems model, discuss the housing service needs of the seriously mentally ill, and assert that one of the major problems limiting Virginia's ability to provide necessary housing services is the lack of sufficient fiscal and administrative integration of state and community components of our mental health system. Further, this lack of integration can and should be remedied by building upon our current system in a manner guided by the experiences of other states and data about how key administrative and clinical leaders in Virginia view the strengths and weaknesses of our system.

The Community Support Systems Model

The concept of community support systems (CSS) was developed by the National Institute of Mental Health to address perceived inadequacies in the implementation of community mental health centers (CMHCs). The importance of CSS as a concept, and not just a group of services, derives its evolution from knowledge about the nature of serious mental illnesses and their treatment that did not exist when community mental health centers were first conceived during the 1950s and then enabled by the Community Mental Health Centers Act of 1963.

The initial movement toward CMHCs can be traced to the experiences of many psychiatrists in the treatment of traumatic "war neurosis" during World War II and to prevention theory. Psychiatrists treating "war neurosis" learned that these conditions responded most favorably, and had the fewest long-term sequelae, when treatment was initiated promptly and as closely as possible to the site where a person was identified to be in need of treatment. According to Morrissey and Goldman (1984) "the community mental health movement

Glenn Yank, M.D. is Professor of Behavioral Medicine and Psychiatry; University of Virginia School of Medicine

Also in this issue:

was born out of this enthusiasm for brief treatment techniques, which avoided the removal of patients to faraway hospitals." Mental health planners hoped that early intervention in community settings would similarly prevent the development of chronicity in patients who would otherwise be admitted to state mental hospitals. Thus, CMHCs were conceptualized as serving a primary preventive function with regard to serious mental illness.

However, the initial mission and philosophical underpinning of CMHCs did not equally or adequately stress the long-term rehabilitation and support needs of chronically ill patients who were discharged from state mental hospitals. Thus, CMHCs across the United States were ill-prepared to address the hundreds of thousands of patients who were discharged from long-term state mental hospital care as deinstitutionalization progressed. The many problems of deinstitutionalization led to reviews of this process by both the General Accounting Office (1977) and the President's Commission on Mental Health (1978), which called for a national mental health policy to specifically address the needs and problems of the chronically mentally ill.

In addition to the growing concerns about the inadequacies of services delivered to patients who were "deinstitutionalized," impetus for improving community services for the seriously mentally ill came from progress during the 1970s in understanding the nature of serious mental illnesses as brain disorders. Research indicated that these disorders involved significant alterations in brain structure and functioning. The emerging concept of "vulnerability" sought to integrate the genetic and biological factors underlying serious mental disorders with the idea that stressors could trigger a patient's functional decompensation. But vulnerability and alterations in brain structure are enduring traits, and thus require more than a preventive approach to address the problems of chronicity of symptomatic illness and persistence of functional impairment.

In response to the national call for a policy and strategy to better meet the treatment and rehabilitative needs of the seriously mentally ill, the National Institute of Mental Health (NIMH) launched its Community Support Program (CSP). This program was specifically designed to stimulate improvement of services for "one particularly vulnerable patient population - adult psychiatric patients whose disabilities are severe and persistent." Contrasted to the CMHC movement, the community support system model was designed to provide community-based "direct care and rehabilitation for the chronically ill rather than focusing on preventing chronicity."

The NIMH CSP guidelines defined a community support system as "a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community." Although CSS are ideally comprehensive, providing a full array of treatment, rehabilitation and support services, the following discussion will focus on housing services for the seriously mentally ill because housing is the CSS component judged most deficient in Virginia, and clearly illustrates the problems that ensue from inadequate linkage of state and community agencies.

Housing Services for the Seriously Mentally Ill

The current nation-wide scarcity of low-cost housing, the meager incomes and/or entitlement benefits received by patients with serious mental illnesses, and their deficits in community living skills have created major problems for them in finding and successfully living in community housing. During the 1980's, the knowledge base developed by the NIMH Community Support Program in working with states and communities led the CSP to adopt the approach of "supported housing" as the basis of CSP housing efforts. The CSP was instrumental in leading both the NIMH (1987) and the National Association of State Mental Health Program Directors (1987) to adopt position statements calling for the use of supported housing to meet the housing needs of patients with serious mental illnesses.

Supported housing is an evolving approach to both psychiatric rehabilitation and meeting the housing needs of patients with serious mental illnesses. This approach has evolved from studies showing the effectiveness of providing support to patients in community residences through assertive community treatment teams, from research on psychiatric rehabilitation, and as a result of social pressures to address problems caused by deinstitutionalization. Supported housing emphasizes consumer choice among housing alternatives rather than placement

controlled by agency staff. Clients are directed to and supported in normal housing in the community rather than specialized residences for persons with mental illnesses. Ongoing, individualized, and flexible support is provided in permanent settings rather than standard levels of service in "transitional" settings. Normal community roles are emphasized rather than "client" roles, and access to housing does not depend upon participation in treatment.

These concepts represent a significant change from the previous concept of a "continuum" of residential treatment services and may be considered a new paradigm in community-based rehabilitation and housing services. Alternatively, supported housing and residential treatment services may be considered complementary services that ideally benefit patients with different treatment and rehabilitative needs. The residential continuum framework was conceptualized to contain several settings that provided different levels of service and supervision with different levels of restrictiveness. Underlying principles of this framework included providing services in the "least restrictive environment" and providing services and supervision in community settings that otherwise were available only in institutions. Patients were seen as progressing along the continuum, moving from more restrictive and intensely staffed programs to less restrictive and more normalized settings and eventually graduating to independent status, requiring no further services. Residential settings are therefore often thought of as transitional steps, not permanent housing.

Continuum models of residential services differ across communities and range from more institutional settings such as nursing homes and intermediate care facilities, to halfway and quarterway houses, group homes, supervised apartments, foster care homes, board and care homes, and independent living arrangements. Crisis residential services may utilize several of the preceding types of placement, as well as "crisis hostels," and the continuum might also include emergency housing, such as shelters, and drop-in centers. The American Psychiatric Association (1982) delineated a typology of 40 distinct types of community care facilities. However, consistent agreed-upon meanings or licensing requirements for different types of residences were absent. The halfway houses described by one community may closely resemble the group home or licensed home for adults of another.

Despite the practical difficulties of matching patients' individual needs and functional abilities to particular settings and program models, residential continuum models may be of benefit to selected patients. Residential treatment programs provide more than alternate forms of housing. They can provide active treatment alternatives for individuals who would otherwise require hospitalization or other institutional care because of the severity of their behavioral disturbances and need for supervision and can facilitate the transition of mental health systems from dependence upon institutions to community-based systems care.

- continued on page 40 -

Developments in Mental Health Law
is published by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The opinions expressed do not necessarily reflect the official position of either the Institute or the Department.

Developments in Mental Health Law
is distributed free of charge to Virginia residents twice a year, and to out-of-state subscribers at an annual rate of $10. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100, Blue Ridge Hospital, Charlottesville, VA 22901. Change of address requests should include both old and new addresses. Questions about letters, articles or other material to be submitted for publication should be directed to the Editor.

Editor
Paul A. Lombardo

Student Contributors
Jane Kurtz/Peter J. Enko/Allison Ritter

Managing Editor
Carolyn L. Engelhard

Desktop Publisher/Circulation Manager
Irene B. Brenneman

MacArthur Working Papers Available

The Research Network on Mental Health and the Law of the John D. and Catherine T. MacArthur Foundation announces the availability of a Working Paper Series presenting the pre-publication results of the Network's ongoing research activities.

To address the pressing need to broaden and deepen scientific understanding of the empirical bases of mental health law, the Health Program of the MacArthur Foundation created the Research Network on Mental Health and the Law in 1988. The Network is focusing initially on three issues identified as of pivotal importance for the field through the 1990s: (1) the competence of mentally disordered persons to make autonomous decisions; (2) the heightened risk of violence that sometimes accompanies mental disorder; and (3) the coercion inherent in state intervention to redress incompetence or to reduce risk.

Competence. Studies of competence in civil law are addressing competence to make decisions regarding treatment and hospitalization, the stability and generalizability of competence, and the process of clinical judgment in assessing competence. Research on competence in criminal law is addressing the epidemiology of decisionmaking competence in the population of criminal defendants, the development and validation of new competence assessment instruments, and the overlap between criminal and civil competence.

Risk. The Network has developed and pilot-tested an exhaustive battery of potential markers of increased risk of violence by released mental patients. These measures are being applied prospectively to large samples of released patients in civil treatment facilities to validate their predictive value. A study of the public perception of risk of violence by the mentally disordered is also underway.

Coercion. The Network has conducted exploratory research and focus group analysis of the process by which family members, doctors, and judges attempt to influence the decision of a person to be admitted to a mental hospital, and the implications for treatment when a prospective patient perceives these influence attempts as "coercive." A study of perceived coercion among both nominally "voluntary" and "involuntary" patients in civil treatment settings is now in progress.

Members of the Research Network are the Honorable Shirley S. Abrahamson, Paul S. Appelbaum, Richard J. Bonnie, Thomas Grisso, Pamela S. Hyde, John Monahan (Network Director), Stephen J. Morse, Edward P. Mulvey, Loren H. Roth, Paul Slovic, Henry J. Steadman, and David B. Wexler.

Copies of "in press" Working Papers reporting on Network research are available without charge. To be placed on the mailing list, write Lynn Daidone, Network Administrator, 10616 Anita Drive, Lorton, VA 22079. FAX (703) 550-2638.

In the Virginia Courts

Low IQ does not necessarily make a confession involuntary

Yeatts v. Commonwealth, 242 Va. 121, 410 S.E. 2d 254 (1991).

A defendant charged with murder claimed that an IQ of 70 and stress due to intoxication and lack of sleep prior to arrest compromised his ability to make a voluntary confession. The Virginia Supreme Court rejected the claim in light of the defendant's previous encounters with the criminal justice system, his capacity to understand his right to an attorney, and the thorough explanation which he received from the police concerning his right to counsel. The court found that the confession was voluntary and made of the defendant's free will.

On September 23, 1989, Ronald Yeatts accompanied Charles Vernon to the home of seventy year-old Ruby Dodson. While Vernon searched for money in Mrs. Dodson's bedroom, Yeatts used a pocket knife with a three inch blade to slit Mrs. Dodson's throat and to stab her twelve times in the face, neck, and throat to prevent her from identifying him.

Five days after Mrs. Dodson's murder, the Pittsylvania County Police arrested Yeatts. While in jail, Yeatts talked on four occasions to Michael Taylor, the investigator who arrested him. On each occasion, Taylor read Yeatts the *Miranda* warning and asked him whether he had an attorney or wanted one present during the interview. Yeatts did not request an attorney during any of the interviews, and signed forms waiving counsel each time. In the final interview, Yeatts admitted that he killed Ruby Dodson.

A jury found Yeatts guilty of robbery and capital murder in the commission of robbery while armed with a deadly weapon. The jury sentenced Yeatts to twenty years in the penitentiary for robbery and fixed the punishment for capital murder at death. Yeatts appealed his conviction by arguing that his confession to the police was involuntary because of his diminished mental capacity and stress caused by intoxication and lack of sleep.

The test for voluntariness of a confession is whether a statement is "the product of an essentially free and unconstrained choice by its maker, or whether the maker's will has been overborne and his capacity for self-determination critically impaired." In determining whether the maker's will was overborne, the court stated that it must look to the totality of the circumstances including the defendant's background life experiences and the police's conduct.

Although a psychiatrist testified that Yeatts' ability to understand was "compromised," the court found that the doctor's explanation meant that "Yeatts merely had less understanding than the average person." The court noted that because Yeatts had been through the criminal justice system repeatedly (ten felony convictions in ten years), he had an understanding of how the system worked. The psychiatrist conceded that Yeatts had the capacity to understand that a lawyer was available. Further, the court found that the tapes of the interviews revealed a careful and thorough explanation by the police of Yeatts' right to counsel. Based on the totality of the circumstances, the court found that Yeatts made the statements voluntarily.

In the Federal Courts

Administrative Law Judge must validate borderline IQ scores before denying SSI benefits

Johnson v. Sullivan, 1991 W.L. 152413 (W.D.Va.).

A U.S. district court ruled that an Administrative Law Judge (ALJ) had the duty, especially in supplemental security income (SSI) benefits cases, to obtain additional test scores before denying benefits to a claimant with borderline IQ scores.

At the age of 26, Dallas Johnson had a ninth grade education, could not read or write, worked as a laborer for a septic tank service, and suffered from epilepsy. Medication did not control Johnson's epileptic seizures and he could no longer perform his job.

Upon review of Johnson's claim for SSI benefits, the Secretary of Health and Human Services adopted the ALJ's determination that Johnson was not disabled, and denied him benefits. In his decision, the ALJ concluded that while Johnson could not return to his former line of work, he was not so severely disabled as to qualify for benefits. The basis of the ALJ's decision was his rejection of Johnson's IQ scores. Evidence had been presented that Johnson had a verbal IQ of 71, a performance IQ of 69, and a full-scale IQ of 69. The ALJ rejected these scores following testimony that Johnson was malingering on the verbal section of the IQ Test.

IQ scores are significant because federal law classifies an individual as disabled if he has a "valid verbal, performance, or full-scale IQ of 60-69, inclusive, and a physical or other mental impairment imposing additional and significant work-related limitation of function." 20 C.F.R. Pt. 404, Subpt. P. Appendix 1, Section 12.05(C). The regulations provide that the lowest of the IQ scores should be used for the first part of the test for disability. Section 12.05(D). For the second part of the test, courts have held that a claimant's inability to do his previous work establishes a "significant work-related limitation of function."

The ALJ's determination that Johnson could not return to his work as a laborer meant that Johnson met the second requirement of the test. If Johnson's performance IQ score of 69 was valid, he would meet the first requirement of the test also. Given that Johnson met the work-related limitation requirement, and was borderline for the IQ requirement, the court found that the ALJ had a duty to develop the record. The ALJ's duty includes obtaining an additional IQ score before rejecting others in close cases.

Mental disorder not grounds to set aside guilty plea in espionage case

Nesbitt v. United States, 773 F. Supp. 795 (E.D. Va. 1991).

In a recent memorandum opinion, the United States District Court at Alexandria denied a motion to vacate a guilty plea and conviction of transmitting "top secret" national defense information to the Soviet Union.

Frank Nesbitt met with Soviet agents in Bolivia twice in 1989. Following these meetings, Nesbitt flew to Moscow. He provided the Soviets with 60 pages of map, diagrams, and handwritten notes of top secret signal intercept activities of the United States. Nesbitt received $2000 for his services.

Soon thereafter, Nesbitt was arrested and charged with conspiracy to commit espionage and transmission of national defense information to the Soviet Union. Nesbitt pled guilty to transmitting the information and a hearing was held to determine the voluntariness of his plea. During the hearing and while under oath Nesbitt confirmed his plea, stated that he understood the charges and the nature of the proceeding against him, confessed to having committed the crime and related the facts surrounding his association with the Soviets.

Psychiatrists and psychologists who evaluated Nesbitt's mental condition testified that he was suffering from a mental disease and he was subsequently placed in care for the disorder. Following treatment a certificate was issued stating that he had recovered and that he was no longer in need of care or custody for treatment. Consequently, Nesbitt returned to court for sentencing.

At the sentencing hearing, Nesbitt attempted to set aside his guilty plea as involuntary, arguing that he was not mentally competent to understand the nature of the charges or proceedings against him when he initially filed the plea.

The court stated that a defendant must be

mentally able to make the decision to plead guilty and be aware of the consequences of the plea. The transcript of the plea hearing indicated that these conditions were met.

Nesbitt never claimed that his depression or other mental disorder caused him to be so confused during the proceedings that he was unable to understand the nature or consequences of his guilty plea. During the course of the hearing, his comments appeared to be coherent, well organized, and relevant.

Teacher defeats grant of summary judgment in handicap discrimination case

Pandazides v. Virginia Board of Education, 946 F.2d 345 (4th Cir. 1991).

The Fourth Circuit returned a case of handicapped discrimination to the trial court for reconsideration of summary judgement against a school teacher in favor of the school board that dismissed her.

Sophia Pandazides suffers from three learning disabilities. These include an attention deficit disorder affecting her ability to process auditory information at a normal rate, a difficulty in rapidly integrating auditory and visual modalities such that she cannot read quickly, and dysnomia, limiting her ability to succinctly express herself on command. Despite her disabilities, she has been found to be a competent and qualified teacher by psychologists.

After receiving her B.A. in Physical Education, Pandazides applied for professional teacher certification in Virginia. She failed the communications skills portion of the National Teachers Examination (NTE), and consequently was deemed ineligible for certification by the Board. Had Pandazides shown that the severity of her handicap invalidated the test, the test requirement could have been waived .

After taking and failing the communications skills portion of the NTE six times, Pandazides asked for an exemption. The Superintendent of Public Instruction denied the exemption, stating that modifications of certification requirements could only be made in exceptional and justifiable cases. However, Pandazides obtained a partial modification of the exam. She subsequently failed two additional times.

In its opinion, the Fourth Circuit noted that the trial court incorrectly interpreted section 504 of the Rehabilitation Act to mean that Pandazides must meet all of the licensing requirements. The absence of factual details regarding Pandazides' ability to teach compounded the error.

Pandazides' status as "an otherwise qualified" person under section 504 should have involved two factual considerations which the trial court did not make. The court should have determined whether she could perform the essential functions of a school teacher and whether the communications skills portion of the NTE actually measured those functions. Since the court did not determine if the NTE requirements represented the essential functions of the job, whether Pandazides could perform the essential functions of the job, and whether a test waiver was a reasonable accommodation, the court reversed the grant of summary judgment and remanded the case to the trial court.

Fourth Circuit holds Board of Education in violation of the Education of the Handicapped Act

In re Thomas C. Conklin v. Anne Arundel County Board of Education, 946 F. 2d 306 (4th Cir. 1991).

The Fourth Circuit affirmed a U. S. District Court decision that the Anne Arundel County Board of Education did not comply with requirements of the Education of the Handicapped Act (EHA). The Court ordered the Board to supplement a plaintiff's individualized educational program with weekly private tutoring to satisfy the mandate of the federal law.

Thomas Conklin is a 13 year old suffering from dyslexia. During the 1987-88 school year, the Board placed Thomas in a "Level 3" program which provides mainstream classes supplemented by two hours a week of services tailored to the child's disability. In the opinion of an educational consultant hired by Thomas' parents, however, Thomas was in need of a full-time personalized educational program.

During the 1988-89 school year Thomas was placed in a "Level 4" program. The "Level 4" curriculum also places the student in classes along with non-handicapped students but provides an additional 20 hours a week of specially designed services. The Conklins disagreed with this placement as well, arguing that Thomas required a "Level 5" day school program for handicapped students or a "Level 6" full time boarding school. The Conklins

sought administrative review of the individualized program proposed by the Board, as well as reimbursement for the costs of private summer school and individualized tutorial programs Thomas attended. An administrative review panel denied both requests.

Upon review of the administrative decision, the U.S. District Court ruled that the "free and appropriate public education" (FAPE) mandated by the EHA, must include a "Level 4" program and two hours of private tutorials per week. The Court denied reimbursement for summer school programs, but awarded compensation for private tutoring obtained by the Conklins during the school year. Both the Conklins and the Board appealed this decision.

Upon review, the Fourth Circuit noted that the FAPE provision of the EHA existed to enable a handicapped child to achieve a reasonable degree of self-sufficiency. Receiving passing marks and reasonably advancing from grade to grade are factors to be reviewed in determining whether a pupil is being deprived of a free and appropriate public education. These factors alone are not dispositive, rather, the state must comply with procedures set forth in the EHA to assess whether the individualized educational program is reasonably calculated to enable the child to receive educational benefits.

Thomas was able to make a one grade advancement in terms of test scores in the sixth grade. According to the court, this met the requirements of the act. The method of instruction which produced the advancement, a "Level 4" program with two hours of tutoring per week, was appropriate for Thomas. The case, however, was remanded to the district court in order to determine whether Maryland law is more expansive than federal law in requiring a higher substantive standard for the provision of educational services to the handicapped.

Epileptics barred from truck driving by Department of Transportation Rule

Ward v. Skinner, 943 F.2d 157 (1st Cir. 1991).

The First Circuit Court of Appeals affirmed a Department of Transportation (D.O.T.) rule prohibiting epileptics from driving trucks when it dismissed Alden Ward's claim that the rule violated the federal Rehabilitation Act.

Alden Ward is a truck driver suffering from epilepsy. For the past seven years, Ward has taken medication to control epileptic seizures which he has not suffered since 1984. In 1989, upon discovering Ward's condition, Ward's employer suspended him from work by invoking a D.O.T. safety rule disqualifying anyone with a history of epilepsy from driving a truck in interstate commerce.

The rule provides that "[a] person is physically qualified to drive a motor vehicle if that person...[h]as no established medical history or clinical diagnosis of epilepsy...." 49 C.F.R. § 391.41 (b) (8). Since 1977, the D.O.T. has explained the regulation with this statement: "It is the intent [of this section] to permanently disqualify a driver who has a medical history or clinical diagnosis of epilepsy." 42 Fed.Reg. 60082 (1977).

Ward first asked the Secretary of D.O.T. to waive the regulation. His medical records showed that he had experienced no seizures since 1984, and even then they were infrequent, nocturnal, and controlled by medication. His physician attested to the safety of his condition and a national expert on epilepsy concurred. In declining to grant a waiver, D.O.T. relied on a 1988 Medical Task Force report that stated people with epilepsy should be allowed to drive if they had been seizure-free for ten years. Ward had been seizure-free for only six years.

Ward brought suit under the Rehabilitation Act of 1973. He argued that the Act and cases interpreting it require an "individualized inquiry" to determine if people who suffer from handicapping conditions are nevertheless "otherwise qualified" to perform the jobs from which they are barred.

In dismissing Ward's suit, the Court of Appeals concluded that no more "individualized inquiry" than that used by D.O.T. was necessary. The court stated that a government agency may, in adjudicating requests from handicapped persons, use a general rule if: "1) the agency behaves reasonably in doing so; 2) a more individualized inquiry would impose significant additional burdens on the agency; and 3) Congress, as well as the agency, has expressed some kind of approval of the general rule." As the anti-epileptic rule met all three requirements of the test, the court held that it was proper in this case to bar Ward from driving.

Cases from Other States

Reliable hearsay admissible to revoke conditional release

Bergstein v. State, 322 Md. 506, 588 A.2d 779 (1991).

The Court of Appeals of Maryland recently upheld a lower court's decision to terminate a defendant's conditional release from a mental health facility. The release following a plea of not guilty by reason of insanity (NGRI). In its ruling, the court noted that hearsay relied upon at the hearing to revoke conditional release was reliable and admissible.

Defendant Nathan Bergstein was arrested in 1983 for committing assault with a deadly weapon. He pled NGRI and was committed to the Department of Health and Mental Hygiene (DHMH) in Maryland. Following treatment, he was granted a conditional release in February 1985.

In September of 1987, the State filed a petition to revoke Bergstein's conditional release after he claimed he was a secret agent given orders to kill the president of Nicaragua. Although this petition was denied, the court required Bergstein's wife to report regularly on his status. Under the terms of the release, Bergstein was required to reside with his wife, abstain from alcohol, prescription drugs and over-the-counter medications, and report any changes in residence, employment, marital status, family composition, physical and mental health, legal involvement, trips outside the state, and any missed clinic appointments.

Nearly a year and a half later the state filed another petition to revoke Bergstein's conditional release after a staff member of the community forensic aftercare program received a call from Bergstein's wife. She reported that he had been drinking, had assaulted her, had stolen her credit cards and cash, and had driven away in her car. A circuit court judge concluded that these actions violated his release order and ruled that Bergstein was a danger to himself and others. He ordered Bergstein taken into custody to await a hearing.

At the revocation hearing, the staff member repeated his conversation with Bergstein's wife. When she took the stand, Bergstein motioned to her to be silent. Consequently, she would only testify that she had phoned the after care program. In revoking Bergstein's conditional release, the examiner noted that formal rules of evidence did not apply during the hearing, and that the evidence showed that Bergstein had violated the terms of his release order. The Circuit Court affirmed the decision stating that the hearsay repeated by the staff member was reliable and that due process had been followed.

The Court of Appeals reiterated that formal rules of evidence do not apply to a probation revocation hearing and that the conditional release revocation hearing was similar in nature. The two differed, however, in the punitive nature of the sanctions involved. Conditional release is not a tool of the penal system, but rather is a therapeutic release of a mentally ill individual as part of treatment. Interruption of that individual's liberty by returning him or her to the hospital is not a punishment. In the case at hand, hearsay established that Bergstein had violated the terms of his release. He could have demonstrated that regardless of these violations, he was not a danger to himself or others and should remain on conditional release.

The court concluded that the full panoply of constitutional rights do not apply when the state seeks to terminate the conditional liberty of an outpatient.

Failure to request competency evaluation not deficient performance of counsel

Groover v. Florida, 574 So.2d 97 (Fla. Sup. Ct. 1991).

Florida's Supreme Court denied Tommy Groover's motion to vacate his three murder convictions and death sentence following a trial court hearing on Groover's assertion that deficient performance of counsel led to his conviction.

Prison physicians medicated Groover in response to his complaints of insomnia and other symptoms indicating depression. According to the prosecution, high doses of drugs were required due to Groover's increased tolerance to medication and addiction to other drugs.

Groover contended that his lawyers were aware that he was continuously medicated with Mellaril prior to, during, and following trial, but failed to request a psychiatric evaluation to assess his competence. No evidence was presented to demonstrate

that trial counsel should have concluded that Groover was insane or suffering from diminished mental capacity related to the administration of the drug. To the contrary, an abundance of evidence in the record showed "a lucid, oriented and conniving person."

The court affirmed the hearing's conclusion that defense counsel's failure to explore the possibility that Groover was incompetent to stand trial and request an evaluation did not constitute deficient performance, describing the attorneys' behavior as "conscious tactical choices" made in light of "meticulous preparation".

Possibility of dangerousness without medication not clear and convincing in North Dakota

In re M.B., 467 N.W.2d 902 (N.D. Sup.Ct. 1991).

The North Dakota Supreme Court overruled a trial court decision to impose involuntary commitment based solely upon a psychiatrist's testimony that the patient could become dangerous if not medicated.

M.B. was brought to an emergency room by the police where doctors applied for an involuntary commitment. Following commitment to a 14 day hospital stay, a second hearing extended M.B.'s commitment time to 90 days. A psychiatrist's speculation that M.B. could become dangerous if not forcibly medicated formed the basis of the extended commitment. Upon review, the North Dakota Supreme Court examined the psychiatrist's testimony and determined that it was so generalized that it failed to constitute "clear and convincing evidence of a substantial likelihood of substantial deterioration" in M.B.'s mental health -- the standard for commitment required by statute. The commitment order was thus dismissed.

Severe memory loss invalidated mental capacity to marry in Texas

Kerckhoff v. Kerckhoff, 805 S.W.2d 937 (Tx. Ct. App. 1991).

A Texas appellate court affirmed a decision that voided a marriage because of a husband's mental incompetence. In the trial court, a psychiatrist testified that Horace Kerckhoff, the husband, suffered from dementia and severe memory loss. Several lay witnesses supported this testimony, citing incidents during which Kerckhoff did not remember having remarried since the death of his first wife.

No direct evidence of incapacity on the day of the marriage was presented. Post-marriage evidence, specifically the comments of several friends who testified that soon after the wedding ceremony Kerckhoff could not recall the event, was found to constitute a sufficient showing of incapacity.

Books

Mrs. Packard's Revenge

A Review of
The Private War of Mrs. Packard
by Barbara Sapinsley.
(New York: Paragon House, 1991. 220 pages, $19.95)

I.

In May of 1864, Dr. Isaac Ray delivered a report entitled "American Legislation on Insanity" to the Association of Medical Superintendents of American Institutions for the Insane. Ray's report was commissioned by that same association a year earlier, and included model legal provisions for involuntary commitment to "asylums," as mental hospitals were then called. Ray was the logical chairman of the committee to review American law, having published his own treatise ***The Medical Jurisprudence of Insanity*** almost thirty years earlier (1838). By 1864 he was clearly recognized as dean of the fledging corps of American psychiatrists.

Dr. Ray prefaced his committee's proposed law with thirty-five pages of analysis and commentary, surveying the types of illness the law could regulate and noting pitfalls would-be-legislative reformers should avoid. Ray made particularly clear his concern that "repressive laws" not be based simply on "abstract principles."

> ...The prudent legislator will wait for some actual evil requiring redress, before he places a new law in the statute-book. He knows very well that a law which reaches no existing evil is needless, and that one which undertakes to regulate what may as well be left to the unrestricted action of men, is worse than needless.[1]

Families should be left to their own "sense of duty and affection" in determining appropriate care for ill relatives, according to Ray. Nevertheless, he recognized that there are instances where abuse of the familial prerogative might occur.

> ...Even the ties of near relationship are not always sufficient to prevent the intrusion of bad motives, which, under pretence of affording protection, may consign one's own flesh and blood to unnecessary confinement and deprivation.

Admitting to the possibility of relatives who may be "hard-hearted and selfish" or that confinement of those "who have never been insane" has actually happened, Ray concluded that

> ...before legislating for a contingency of very infrequent occurrence, we should be well informed as to the actual facts in the cases....

Ray could not have anticipated how ironic his caveat to lawmakers sounds at this remove, particularly in light of a suit that took place as his study was in progress. That litigation and its aftermath probably had more effect on the content of future mental health law than all the thoroughly deliberated language in the psychiatrist's model legislation. The lawsuit was brought to determine the sanity of a woman confined by her husband. The case and her version of the "actual facts" of her captivity--both within and outside of an asylum--became the motive force for radical amendment of civil commitment law in Illinois and elsewhere. The woman's name was Elizabeth Parsons Ware Packard and she detailed her story in several books, the first printed as early as 1865.[2] Her travails as an institutional inmate, advocate of legal reform and peripatetic protofeminist are recounted in ***The Private War of Mrs. Packard*** by journalist Barbara Sapinsley.

Elizabeth, or E. P. W. Packard, as she referred to herself, was born the daughter of a successful Massachusetts minister in 1816. By her adolescence, the family had inherited adequate wealth to afford a quality (and for a woman of that time, unusual) education. Her otherwise unremarkable youth was interrupted at age nineteen by an illness described as "brain fever," which led to an involuntary visit to

the Worcester State Hospital, a "lunatic asylum."

According to hospital records, Elizabeth's father requested the commitment, attributing her condition to "too much mental effort" at her teaching job, and her generally intense disposition. She was, he said, "laced too tight." Treatment for her condition consisted of bleeding and medication in the form of

> ***Elizabeth's father requested the commitment. She was, he said, "laced too tight."***

opium and magnesium sulfate. After a stay of six weeks, she was discharged as restored, "her mind free of insanity."

This curious interlude is difficult to decipher through the blurred glass of historical hindsight. It may have indicated mental illness, as the term is understood today. It certainly was used to argue in favor of Elizabeth's commitment a second time twenty-five years later. By then she was a mother of six, and wife to Reverend Theophilus Packard, whose patriarchal Calvinism could not accommodate religious dissent nor marital discord.

II.

Civil commitment legislation--the laws permitting involuntary confinement of the mentally ill--went through significant change in most states between the Revolution and the Civil War. The absence both of institutions and effective treatment for mental illness made such laws unnecessary for many states until the mid-1800's. States that did fund institutional care had a more lengthy record of commitment law.

Virginia was first to sponsor a state-chartered institution and in 1769, even before Independence, had adopted a statute pertaining to admission of "ideots, lunatics and other persons of unsound mind". The founding of a hospital in the colonial capital of Williamsburg was meant to address a social problem that took the form of "several persons of insane and disordered minds [who] have been found wandering in different parts of [the] colony."[3]

The first directors of that hospital included two signers of the Declaration of Independence and the first President of the Continental Congress but no physicians. The absence of medical perspective was also noteworthy in the admission process. Upon learning that a "disordered person is going at large," any magistrate could issue a warrant for the sheriff to detain that person. Joining with two other magistrates, he would then examine the prospective patient. If two of the three agreed that it was both "necessary and expedient," the person would be conveyed before the hospital directors. If the directors concluded that "such person is a proper object" for treatment, they would admit the patient and "pursue such measures as his or her case may require." No doctors, no judge, no jury.

More than seventy years passed before Virginia law directed justices of the peace to summon a physician to provide evidence of mental illness. An 1840 legislative revision[4] also prescribed some sixteen specific questions concerning the cause and nature of the disease, including family, medical and treatment history. These were to be addressed during patient examination and included in the written record of the hearing forwarded to the hospital. The medical model was gaining currency.

Illinois, unlike Virginia, had no asylum until well into the 19th century. Thus, early provisions to care for the mentally ill in that state did not focus on hospital commitment, but on conservatorship. As early as 1823, in only the fifth year of Illinois statehood, legislation was enacted allowing conservators to be appointed for "any idiot, lunatic or distracted person" possessed of property.[5]

The conservator's role required looking after the

> ***"Married women may be received and detained in the hospital on request of the husband . . . without the evidence of insanity"***

estate--the land or belongings--of the "distracted" person. Illinois required no medical testimony to declare a person a "lunatic;" neither did it entrust the job to magistrates or justices of the peace. Instead, the law in Illinois called for a lay jury to ascertain the mental status of citizens.

By mid-century, Illinois established its own insti-

tution to house the mentally ill. Founding legislation for the Illinois State Hospital for the Insane also included a provision for the hospital trustees to "receive and detain in the institution all residents of the state who may be decided to be insane or distracted," and gave county courts jurisdiction to determine that status. But the law allowing institutional confinement contained an interesting exception. Not everyone need be found insane by a court.

> Married women . . . who in the judgment of the medical superintendent are evidently insane or distracted, may be received and detained in the hospital on the request of the husband . . . without the evidence of insanity or distraction required in other cases.[6]

While within two years of its passage, this 1851 law was amended to clarify the right of all *male* hospital patients to a jury determination of their mental condition, the married women's exception remained. Husbands who felt the need to put their wives away were under no obligation to endure public legal procedures. If they could convince a state hospital physician that "insanity or distraction" was present, a wife could be admitted without delay. At least for married women, the physician became the only gatekeeper of the asylum.

III.

Elizabeth Packard learned how Illinois law worked through direct experience. By 1860 her 21 year marriage to Theophilus Packard had reached an impasse. She could not accept the bleak worldview embraced by her husband's gloomy brand of Calvinism. The minister's preachments were especially troubling when they included assertions that her children, through no fault of their own, were subject to eternal perdition. She countered his message of damnation with insights borrowed from other religious perspectives.

In response, he charged that she consorted with "French Catholics, Universalists and such like people." Her flirtation with Spiritualism had included a seance, from which she returned reporting a conversation with her deceased mother. Sharing new religious insights with their children horrified Theophilus, and Elizabeth's refusal to withdraw from participation in a church Bible class convinced him of her instability.

Allusions to her past hospitalization and questionable mental health increased as their conflict ripened. The minister's own rigidity could not tolerate her defiance. "Never before had she so persistently refused my will or wishes," he said, "she seems strangely determined to have her own way, and it must be that she is insane." He attempted to send her away to relatives, demanding that unless she left he would have her taken to the state insane asylum.

A physician at the Illinois State Hospital for the Insane at Jacksonville accepted Reverend Packard's characterization of his wife's behavior as evidence of insanity, and received her as an inmate.

Elizabeth was concerned that constant disagreement over religious doctrine led her husband too often to suggest that she was ill. To forestall any attempt to have her hospitalized, Elizabeth consulted an attorney. His inaccurate assurances that she could not be committed without a jury trial gave rise to further confrontations in the Packard home.

As a final act of defiance, Elizabeth publicly resigned from her husband's congregation. Soon thereafter he attempted to get a court order of commitment. Failing to convince the judge of her insanity, he invoked the husband's prerogative under Illinois law and had her physically carried to the train station. A physician at the Illinois State Hospital for the Insane at Jacksonville accepted Reverend Packard's characterization of his wife's behavior as evidence of insanity, and received her as an inmate. She remained at the asylum for three years, until superintendent Dr. Andrew McFarland, apparently exasperated by her behavior, discharged her as "incurable."

For four months after her release, Elizabeth lived with friends. Her return home in the winter of 1864 was met with predictable resistance by her husband, who, within three weeks had locked her in an upstairs room and nailed the windows shut. She revealed her plight to a visiting neighbor and dropped notes to passing strangers, pleading for deliverance. They in turn contacted a local judge

who issued an order that she be released pending a trial on the issue of her sanity. After five days of trial, a jury required only seven minutes deliberation to declare her sane.

IV.

These details and a plethora of other anecdotes are offered in Barbara Sapinsley's new volume detailing the life of the notorious Mrs. Packard. The author had access to Packard family records, including the private journal and diaries of Theophilus Packard and letters that Elizabeth Packard wrote at various times in her life. Combining these sources with contemporaneous newspaper articles and other public documents, Ms. Sapinsley chronicles Packard's post-asylum career as legislative gadfly, author and crusader for the rights of women and asylum inmates.

The book is the first attempt to write a full-length biography of Elizabeth Packard.

The book contains copies of petitions Mrs. Packard presented to state legislators in Massachusetts and Connecticut to revise commitment laws and the text of the 1867 Illinois "Act for the Protection of Personal Liberty."[7] That law included criminal penalties for asylum directors who admitted any patient not first found insane following trial by jury. It also required that all patients then resident in the Illinois asylum had a right to test their sanity via jury trial. Within ninety days after Packard's bill became law more than fifty trials were held.

Among Packard's other achievements were the instigation of a seven month long legislative inquest into the management of the Illinois hospital where she had been held, publication of four books, and authorship of a prescient but unsuccessful bill presented to the U.S. Congress to secure postal privileges for all institutionalized patients in the country. In the midst of these labors, she traveled to more than thirty states in her crusade to reform commitment laws. Sapinsley's account takes us through Packard's campaigning years to the time of her death at age 81.

The book is the first attempt to write a full-length biography of Elizabeth Packard, whose impact on mental health law has long been known but never explained in adequate detail. Though the subject justifies the attempt, and the documents to which Sapinsley had access shed light on many sides of a fascinating story, she ultimately fails to deliver the "real" E.P.W. Packard.

Part of the problem is Sapinsley's point of view. She plays the role of omniscient narrator, reveling in the arrogance of Theophilus Packard or the limited diagnostic range of Dr. McFarland, as if they should be faulted for living in the 1800s. But these men did not invent the attitudes, social or professional, that they sometimes exhibited. However retrograde their rationalizations, they should not be taken to task for lacking political correctness by 1990s standards. Sapinsley is also too quick to condemn those who found Mrs. Packard's often bizarre behavior a sign of "insanity," without addressing the possibility that although she may not have qualified as committable by today's legal standards, even now her behavior would prompt a serious inquiry into potential mental disorder.

Sapinsley's greatest fault is an attempt to categorize all inter-gender relationships, both professional and personal, as products of a corrupting sexism. Certainly the "married woman's" exception in Illinois commitment law reflected attitudes about the subjugation of women; clearly Elizabeth Packard was a victim of those attitudes. But that is an inadequate perspective from which to portray the complexity of Packard's story. Sapinsley allows herself too many morally superior snickers at the expense of the cartoon-sized men she draws as foils to the immortal Ms. Packard. Caricature obscures critique.

V.

But what of Mrs. Packard's impact on the law? The Illinois statute, promising criminal charges for physicians who circumvented the mandatory jury trial, remained to plague the medical profession. In

The Illinois statute, promising criminal charges for physicians who circumvented the mandatory jury trial, remained to plague the medical profession.

1885, British physician D.H. Tuke visited U.S. asylums and published his reflections on American psychiatric jurisprudence and the effect of Mrs. Packard's triumph twenty years earlier. His report of the system in action included a description of the county court on the day known locally as "insane Thursday." After a general account of the proceedings, Tuke sketched the details of two cases.

> One patient was too acutely maniacal to be examined in the Court, out of which he was quickly conveyed, restrained by a leathern muff, into another room, where the jury and the official doctor went and examined him. I followed. The jury, very properly, made short work of the case. In [another] instance, after a careful inquiry into all the circumstances, the man was not found insane, although he was evidently not quite right, and it was agreed that he should go reside with a farmer who was a friend of his. I had an opportunity of conversing with the judge, who told me that he regarded the law under which these trials are conducted as quite satisfactory. "Insane Thursday" is likely, I was told by others, to remain an institution in Illinois, as popular feeling demands jury trial as a right.[8]

Another perspective, from the physician Mrs. Packard numbered among her "persecutors," was also included in Tuke's survey. Dr. Andrew McFarland was superintendent of the Illinois institution where Packard's three years of confinement occurred. His professional reputation suffered significantly following the investigation of his asylum prompted by Packard's accusations. He watched Mary Todd Lincoln publicly declared insane in an 1872 jury trial, required under the law, and considered public trials of insanity both unnecessary and harmful. McFarland reported the peculiarities of Mrs. Packard's case to medical conferences years after she left his asylum but never accepted her contribution to the law. He had this to say of the Illinois "Act for the Protection of Personal Liberty":

> [It] is injurious, odious, barbarous, damnable, and you may add as many more expletives to it as you please, and still not say the truth in regard to its evils . . Every superintendent of an asylum in the State is most eloquently pleading for a change in this detestable system; . . . A Bill is before the Legislature, reported favourably upon; . . . but all, as I fear, will amount to nothing, because there are a few fanatics who raise the hue and cry over an imaginary bugbear.

Illinois law still contains a provision entitling men--and women--to trial by jury before involuntary commitment.

Mrs. Packard's persistence in opposing McFarland's attempts to change the law qualified her as a most successful "fanatic." The legislation she wrote remained intact for years, and Illinois law still contains a provision entitling men--and women--to trial by jury before involuntary commitment.[9]

Packard outlived her psychiatrist by six years. He apparently suffered from depression, and hung himself in 1891. Her final years were devoted to caring for her daughter Elizabeth. Although her child was seriously mentally ill, often to the point of violence, the indomitable Mrs. Packard steadfastly refused to institutionalize her.

by Paul A. Lombardo, Ph.D., J.D.

---

[1] *Journal of Insanity* (July, 1864):21 ("General Law for Determining the Legal Relations of the Insane").

[2] *Great Disclosure of Spiritual Wickedness!! In High Places with An Appeal to the Government to Protect the Inalienable Rights of Married Women,* Reprinted in *Women in America,* Leon Stein and Annette K. Baxter, eds. (New York: Arno Press, 1974).

[3] *Laws of Virginia,* November 1769--10th George III, Chapter XXVIII, in *Hennings Statutes at Large, 1764-1773,* p. 378.

[4] *Laws of Virginia,* 1840-41, p.40, sec. 13.

[5] Act of February 12, 1823, *Revised Laws of Illinois,* 1833, p. 352.

[6] Act of April 18, 1851, *Laws of Illinois,* 1851, p.96.

[7] Act of March 5, 1867, *Illinois Laws,* 1867, p. 139.

[8] D. Hack Tuke, *The Insane in the United States and Canada* (London: H.K. Lewis, 1885). pp. 68-69.

[9] *Smith-Hurd Illinois Annotated Statutes,* ch. 91 1/2, sec. 3-802. (1991).

. . . Community Housing

- continued from page 27 -

The foregoing discussion illustrates that communities must address patients' needs not only for housing, but also support, ongoing treatment and rehabilitation, and supervision. These needs cannot be addressed in isolation from each other. Supported housing allows clinicians to provide individualized levels and forms of support, treatment, and rehabilitation to patients in a variety of community living situations, chosen by the patient. Some patients, however, may still benefit from the specific structure and supervision of a residential treatment program, although they do not require hospitalization. Therefore, it is the treatment component of residential treatment programs that must be emphasized to enable these programs to be considered as complementary to, not competitive with, supported housing.

Economic Issues

Sufficient and appropriate housing services for persons with serious mental illnesses are justified not only on clinical and ethical grounds, but also on economic grounds. Serious mental illnesses, such as affective disorders and schizophrenia, cause extensive and persistent social and vocational disability. They are often lifelong, relapsing illnesses with symptoms and disabilities that can far outlast the duration of most health insurance benefits, and many patients with these illnesses are unable to obtain private health insurance because of their vocational disabilities. Frank and Kamlet (1985) estimated that almost 15% of disabled workers in the United States were disabled because of a mental disorder. Therefore, many patients who suffer from serious mental illnesses are unlikely to obtain coverage for needed services from employment related sources, or to contain their treatment and rehabilitation needs within policy limitations, and thus become dependent on public financing mechanisms for health care such as Medicaid and care delivered by state and community mental health systems.

Public mental health services in the United States consume about $20 billion per year in public funds. However, the total annual direct and indirect costs of serious mental illnesses are considerably higher. The total annual costs of schizophrenia in the United States, including treatment, disability payments, subsidies, and lost incomes and revenues, are estimated to exceed $30 billion dollars. Therefore, the total annual costs for this one illness, in Virginia, can be estimated to be between 800 million and one billion dollars when national figures are adjusted for Virginia's statistics for per capita income and mental health expenditures. When the costs for other illnesses are added, total costs for serious mental illnesses are far higher.

During the 1980s, states continued to spend an average of two-thirds of their mental health budgets on inpatient care, despite the fact that the total census of patients in state and county psychiatric hospitals decreased from almost 559,000 at the end of 1955, to less than 110,000 by 1987. However, a nationwide average per diem cost of state hospital care was $129 in 1983, less than a third of the cost in private psychiatric hospitals at that time. These data do not indicate over-funding of state hospital programs, but rather the lack of funding for community programs needed to address the many demands placed upon them through the process of deinstitutionalization.

Thus, a rational system for treating serious mental illnesses must be cost-effective and clinically effective. The goal of cost-effectiveness requires that a system of care be organized and coordinated to provide each patient with the appropriate services in the most appropriate setting and to minimize unnecessary use of the most costly services and settings, such as hospitalization. Community programs require support and incentives to develop services, particularly housing, that provide more cost-efficient alternatives to hospitalization.

Improving Services for the Seriously Mentally Ill

Despite our growing knowledge of the nature of serious mental illnesses and the technologies that provide effective treatment, rehabilitation and support for the seriously mentally ill, and despite the immense social and fiscal costs of these illnesses, public care of the seriously mentally ill in the United States remains an area of extreme concern. Detailed assessments of the national mental health service

system were performed in response to the Executive Order that established the President's Commission on Mental Health in 1977. The Commission's first priority was an evaluation of the scope of the service system and gaps within it, which revealed severe disorganization and fragmentation of services at both national and state levels. NIMH investigators concluded that "in the absence of any national- or state-level approach for coordinating health/mental health service setting relationships - we are speaking about a largely unorganized and de facto 'system.'" These investigators identified twenty distinct treatment settings that functioned as if in isolation from each other, a state of affairs termed a "nonsystem".

> ***" Patients lost to the system are commonly found in shelters or jails or on the streets. "***

More recently, Talbott (1985) concluded that "Millions of Americans receive very poor quality (services) or none at all." Talbott emphasized that "The most important systems problem is the continuing severe fragmentation of the psychiatric delivery 'nonsystem'... we remain burdened by a plethora of federal, state, and city-county programs and services." Mechanic and Aiken (1987) also emphasized the disorganization of services, stating "The organization of community care for patients with the most severe chronic mental illnesses is seriously deficient. Most of these patients depend exclusively on underfinanced, fragmented, and often inaccessible public services. . . Patients lost to the system are commonly found in shelters or jails or on the streets."

Torrey et al. (1990) reviewed and rated all state mental health programs and concluded that "today, in 1990, services for individuals with serious mental illness in the United States are a disaster by any measure used. Not since the 1820s have so many mentally ill individuals lived untreated in public shelters, on the streets, and in jails." This echoed the commentary that "In the 1840s, Dorothea Lynde Dix found the mentally ill in the streets, in the jails, in the boarding houses of America... over a century later, we find similar conditions" (Butler, 1983).

Many of the problems of the public mental health systems have been attributed to the lack of integration of these systems at the levels of their many funding streams, policy directives, and regulatory authorities. These are among the key reasons "Why can't we do what we know works?" (Talbott, 1987). Since state hospital populations began to decline 35 years ago, "the money has not followed the patients" (Talbott, 1985). Mechanic and Aiken (1989) argue that a major challenge faced by community agencies is obtaining the authority to make financial and economic decisions across the arrays of needed services and potential funding streams, and state "It is not unusual for an agency caring for these patients to have as many as thirty funding streams, each with its own eligibility rules, service conditions, and limitations."

Improving the quality of services for the seriously mentally ill will therefore require improving their organization and coordination, by linking the various funding mechanisms of these services to effect better integration of administrative and service responsibilities and developing incentives that drive the public mental health system in the directions of community-based treatment, alternatives to hospitalization, and greater cost-effectiveness. Attempts to improve services through unification or linkage of administrative, funding, and clinical responsibilities have variously been termed consolidation, integration, or capitation. Various forms of budgetary linkage of state hospitals with community care providers are increasingly being adopted by states.

Capitation may be defined as "a method for paying a provider a fixed price per person served for a defined range of services and a specified time period" (Mechanic and Aiken, 1989). Elements include tying payment to specific patients, prepayment of a predetermined, agreed-upon price, and incentives to provide care in a cost-effective manner to maximize revenue potential and minimize the provider's financial risk if expenditures exceed payments. In response to the decision by the Reagan administration in 1981 not to implement the Mental Health Systems Act of 1980, but provide states instead with much reduced block grant funding. Sharfstein (1982) suggested "a planned system of prepaid per capita contracts with local providers to take care of needs of the mentally ill," as a means of utilizing existing resources more productively. In such a system, organizations such as community mental health centers would contract with states to provide services to a targeted or enrolled population. Lehman (1989) states, "Capitation seems to be at the core of several initiatives. By integrating

payments to providers, capitation may stimulate providers to create coordinated, effective, and cost-efficient services." This dovetails with the common observation that mechanisms to capture funds and allow funds to follow patients to community systems of care are crucial elements of efforts to integrate mental health services between state hospitals and community providers, and strengthens the services needed for successful community-based treatment and rehabilitation.

Even small amounts of flexible funds will "prime the pump" of hospital to community fund transfers

Several concepts complement capitation financing in plans to integrate mental health care systems. Performance contracts between state and community agencies may include financial consequences for failure to meet service delivery targets. Utilization review of hospital stays and review of hospital utilization trends compared to established bed targets, coupled with financial penalties for overutilization are other approaches. Regional mental health authorities, responsible for all aspects of service delivery, have also been proposed as a mechanism to effect the financial, administrative, and clinical integration of service delivery systems.

There are many workable variations on the theme of integrated funding for state and local mental health systems. Funding may be routed to community agencies which then "buy" needed services from state hospitals. Alternatively, states may purchase services from community mental health centers. Funding may follow individual patients entirely or may be based on bed day targets and performance contracts for aggregate units of service. Developing a specific model needs to be a collaborative process involving state and community representatives and must take into account the state's historical and political context. States differ markedly in their balance of state-level, regional, and county-and-city-level authority for different functions.

There is one seemingly unavoidable financial pitfall in states' attempts to shift funding from hospital-based care to community-based care. The intent of these efforts is to redirect hospital funds to communities to finance community-based services. However, when patients are discharged, adequate community services must already be in place to prevent patients from relapsing, becoming homeless, finding themselves in substandard "mini-institutions," "drifting" into the criminal justice system, or experiencing the many other problems associated with inadequately planned deinstitutionalization. Funding mechanisms are thus needed to keep hospitals functioning while needed community services are being developed, and to assure that the new community services are targeted for the chronically mentally ill patients who are to be discharged. Although "double-funding" hospital and community services is seldom politically feasible, even small amounts of flexible funds, coupled with strong financial incentives to utilize them to develop services that will allow community support of patients currently in hospitals, will "prime the pump" of hospital to community fund transfers.

Improving Services in Virginia

Developing a comprehensive system of care for the seriously mentally ill in Virginia will require building upon the community and hospital resources that currently exist for this population, but will also necessitate ongoing changes in our service delivery system, with continued shifting of the mix of services and settings from institutional to community-based care. Such a system would need to include the elements of a community support system, as elaborated by the NIMH, clearly delineated complementary roles for community-based hospital resources and state hospitals, mechanisms to assure clinical continuity of care, and means to achieve and assure the administrative and financial integration of the system. Developing and implementing a truly unified community-state system will require financial incentives for effective community support systems that allow funds to follow patients. Incentives must foster the creation of supported and supervised community housing alternatives for the estimated 10-20% of patients in our psychiatric hospitals who do not truly need a hospital level of care, but for

10-20% of patients in our psychiatric hospitals do not truly need a hospital level of care

whom no appropriate community alternatives now exist.

Virginia has had experience with state hospital - community incentive funding programs in the form of four pilot projects since the mid-1980s. Projects involving Western State Hospital and the Alexandria and Region X CSBs in 1985-1986, Eastern State Hospital and Chesapeake CSB in 1987-1988, Eastern State Hospital and Western Tidewater CSB in 1989-1990, and Central State Hospital and six of Human Service Area (HSA) IV CSBs have all demonstrated that incentive funding can decrease state hospital utilization rates in Virginia. CSBs participating in the pilot programs all showed decreased use of state hospital beds during the program, even during a period (1986-1990) when the overall adult census in Virginia's state hospitals increased by about 5% per year. However, "back filling" of hospital beds by CSBs not participating in the pilot programs, and the temporary nature of the programs, which made it difficult for CSBs to invest the transferred funds in community resources, have limited the positive effects of these pilot programs.

Virginia has not yet aggressively pursued a policy of financially linking state hospital and community services. "New Initiative" funds made available to communities during the 1988-1990 biennium were not linked to hospital census reduction by either funding mechanisms, or as conditions of performance contracts. Most of the new community service capacity that became operational during the 1988-1990 biennium was used to address unmet needs of patients already living in the communities. The public mental health system in Virginia still directs over 70% of total appropriated funds to inpatient services, more than the national average. Under the current DMHMRSAS financial system, hospitalization is an "off budget" item for CSBs. Thus, there are few incentives built into the current operational structure to decrease bed utilization and enable funding transfer to the communities. There are no enforced limits on CSB utilization of hospital bed days. Current performance contracts between DMHMRSAS and CSBs are more accurately "performance targets" since there are no financial incentives for exceeding performance goals and no penalties for failing to meet them.

Current DMHMRSAS Client Management Guidelines give CSBs control of the admission and discharge process to hospitals, but this is not balanced by incentives to minimize bed utilization. While this policy may have led to relatively fewer of the tragedies endemic to deinstitutionalization than have occurred in other states, it has also led to a 5% annual increase in state hospital adult patient census over the last four years. We cannot currently afford to maintain state hospital budgets at a constant level, let alone increase them by 5% per year. If hospital adult patient census continues to increase and hospital budgets continue to decrease, the ratio of staff to patients in hospitals will decrease significantly, reducing the quality of care provided. Clearly, the Virginia public mental health system has not yet achieved the administrative and financial coordination needed to optimize cost-effectiveness across the system. The quality of the services it provides will deteriorate unless the degree of administrative and financial coordination of state and community services increases.

Survey Results

Planning the future development of our mental health system must realistically address the current status of key dimensions of our "readiness" to further progress toward a unified, community-based system of care. These dimensions include available resources and services, the present degree of hospital-community linkage, attitudes about our present system, the forces that shape it, and the various methods of organizing a unified and comprehensive service system. A survey of key CSB and DMHMRSAS administrative and clinical mental health leaders revealed important findings about their knowledge of and attitudes about these factors.

> ***Resource issues were considered the principal limiting factor on community programs.***

The current degree of integration of hospital, CSB, and central office functions was considered inadequate by the majority of administrative and clinical respondents. Less than 25% of the clinical leaders surveyed considered our system to be clinically integrated, and less than 10% of the administrative leaders considered the system to be adequately integrated. A majority of respondents stated that the current degree of linkage between hospitals and communities does not foster a

community-based system. Over 80% of administrative respondents believed that increasing financial and administrative linkages would improve patient care.

Hospital-community linkages were perceived to be weak in several areas. Less than 10% of clinical respondents thought that hospital and community programs had similar philosophies and models of treatment and less than 20% thought that hospitals adequately prepare patients for participation in community programs. The majority of hospital and central office staff concluded that CSBs do not al-

Over 50% of respondents considered regional mental health authorities likely to improve the system of care.

ways provide adequate follow-up of discharged patients or timely entry of patients into appropriate community programs.

Almost 90% of clinical respondents agreed that more patients should have the chance to live in the community, rather than remain hospitalized, although many hospital and CSB respondents did not agree that communities can now provide the needed levels of service for these patients. Resource issues were considered the principal limiting factor on community programs. Only 10% of respondents considered current agency staffing and financial resources to be adequate for providing effective psychosocial programs.

Some clear differences emerged in respondents' perceptions about different strategies for effecting linkage of the state and community programs, including capitation financing, performance contracts, utilization review, bed targets, and regional mental health authorities. Despite agreeing that linkage mechanisms in general would improve services, CSB respondents, as a group, expressed uncertainty that any of the specific approaches to linkage would be of benefit. Hospital and central office staff were somewhat more optimistic, particularly with regard to regional mental health authorities, the only approach considered likely to help funds follow patients. Over 50% of respondents considered regional mental health authorities likely to improve the system of care. Most CSB respondents did not feel that performance contracts would be beneficial. Most respondents seemed unfamiliar with capitation and this was reflected in uncertainty about its effects.

Findings regarding staff attitudes about linkage mechanisms must be understood in the context of several identified limitations on respondents' understanding of these mechanisms. Attitudes about performance contracts were limited by the general belief that such contracts lack financial penalties if service targets are not met. Attitudes about regional mental health authorities were influenced by some respondents not considering them to have inpatient components. Attitudes about capitation were not considered valid because of respondents uncertainty about the meaning of the term.

The history and current administrative context of mental health management in Virginia have likely affected respondent attitudes, which often seem based on extrapolating from the current organization of the public mental health system rather than on visualizing meaningful alternatives. Virginia's system does not utilize capitation financing mechanisms, uses performance contracts that are really performance agreements, and CSBs generally lack inpatient units. The inherent stresses of managing public mental health services, changes in leadership, and economic uncertainty can combine to create a reactive style of management thinking that has difficulty envisioning solutions that may require significant or radical changes in the organization of the current "system."

Respondents seemed to have more negative attitudes about mechanisms that place limits on agency use of hospitalization, such as utilization review and bed targets, and more accepting attitudes about mechanisms that create incentives for alternatives to hospitalization, such as performance contracts and regional approaches. It will thus be important for future efforts to foster linkages to emphasize developing positive incentives that reward desired outcomes and increase local flexibility to manage patient care. Capitation approaches, perhaps as part of a regional approach, may deserve further consideration after staff have been better educated. Both strengthened performance contracts, with meaningful financial incentives for funds to follow patients, and regional approaches that integrate inpatient and outpatient responsibilities deserve serious consideration as potential approaches to improving the quality of care provided by Virginia's public mental health system.

Survey Implications

What are the implications of these survey findings about our system's readiness to progress toward a unified, community-based system of care that provides meaningful supported and supervised community housing opportunities for our patients? Key clinical and administrative leaders within the Virginia public mental health system consistently expressed frustration with the lack of administrative, financial, and clinical linkages that are needed to unite forty CSBs and eleven psychiatric hospitals into a single system of care. In the words of one respondent, "There's not enough 'system' in the system." In a clinical and management climate where resources are considered inadequate to provide needed, effective programs, an organizational structure that promotes competition for resources will also promote fragmentation of services, unless such competition is based on incentives for efficiency and effectiveness. Such incentives can take a variety of forms, including grants, performance contracts, capitation financing systems, utilization review, managed care, regional authorities, and performance bonuses. These methods are diverse, but have in common the use of financial mechanisms to "drive" the system of care in the directions of effectiveness and efficiency.

Instead, we continue to maintain a system in which incentives promote boundaries between agencies because resource allocations are fixed, service needs are variable, and there are no mechanisms to assure that resources follow patients. Patients who are in hospitals are "off-line" with regard to CSB budgets, allowing an improved resource-to-patient ratio in the CSB as long as patients remain hospitalized, whereas patients in community housing will require services and thus expenditures. Agencies seek to protect their boundaries to keep their resources in and additional service needs out, in order to preserve their already inadequate ratio of resources to tasks. Survey findings reflect dissatisfaction relating to patients crossing the community-hospital boundary in either direction. Unfortunately, this very emphasis on boundary protection, caused by inadequate resources and a lack of fiscal incentives for linkage, only perpetuates the inadequate integration of the total system.

What, then, can we build upon? First, the identification of shared opinions about our system's shortcomings provides a platform of agreement that the "status quo" falls significantly short of both our ideals of an integrated, community-based system of care and the service delivery system that our patients deserve. There are many opportunities for improvement. Second, we have agreement that improving clinical and administrative/financial linkages will improve the quality of patient care. Linkages considered most likely to be beneficial were those emphasizing positive incentives for efficiency and alternatives to hospitalization rather than those consisting mostly of limitations upon hospital use. Effective linkages must increase the range of options, such as housing options for patients and treatment options for clinicians, not decrease them. Third, we have in place, in many communities, many of the core clinical elements of modern community support systems although housing options are limited and the integrative mechanisms to create a total envelope of services and incentives for community based care need to be strengthened.

> ***"There's not enough 'system' in the system."***

Finally, in Virginia we have many dedicated clinicians and administrators who are intensely concerned about both the patients they serve and our service system. As the leaders of the public mental health system, we have the responsibility to our patients, our colleagues, and ourselves, to utilize the information we have learned to develop a vision of what our system could and should be, and to plan a strategy for attaining that vision. But that is only the beginning because we have already suffered a surfeit of plans. Our tasks must therefore include maintaining the constancy of purpose and resolve necessary to implement our plans, learning how to better empower our colleagues to realize the vision that we shape together, and fully participating in the myriad of efforts that will comprise the journey toward fulfilling that vision.

Note: Dr. Yank is staff psychiatrist at the Western State Hospital, Box 2500, Staunton, Va. 24401. This article is excerpted from his report, ***Toward a Comprehensive System of Care for the Seriously Mentally Ill,*** prepared for the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services while Dr. Yank was the Galt visiting Scholar 1989-1990.

Due to space limitations, only direct quotes are referenced. For a full list of references and/or a copy of the Galt Scholar report please contact Dr. Yank.

THE 15TH ANNUAL
SYMPOSIUM ON MENTAL HEALTH AND THE LAW

Thursday, March 12

8:00 a.m.	**Registration and Coffee**
9:00 a.m.	**Welcoming Remarks** King E. Davis, Ph.D. R. Claire Guthrie, J.D. Paul A. Lombardo, Ph.D., J.D.
9:30 a.m.	**Recent Developments in Psychiatric Practice in the Former USSR** Richard J. Bonnie, LL.B.
10:00 a.m.	**The Managed Care Revolution: Legal Consequences for Psychotherapists and Their Patients** Paul S. Appelbaum, M.D.
11:00 a.m.	**Break**
11:15 a.m.	**Response: The Managed Care Revolution** Moderator: Steven K. Hoge, M.D. Discussants: Teresa DiMarco John M. Plewes, M.D.
12:30 p.m.	**Luncheon**
2:00 p.m.	**Patient Self-determination Act: Implications for Mental Health Facilities** Moderator: Paul A. Lombardo, Ph.D., J.D. Discussants: Ronald Forbes, M.D. Ellen Waldman, J.D., LL.M. Susan C. Ward, J.D.
3:15 p.m.	**Break**
3:30 p.m.	**Substance Abuse and AIDS** Moderator: Richard J. Bonnie, LL.B. Discussants: R. J. Canterbury, II, M.D. Glenn Fisher R. Claire Guthrie, J.D.
4:45 p.m.	**Recess**
5:00 p.m.	**Reception (Cash Bar) - Tidewater Room**

MARCH 12-13, 1992
HYATT RICHMOND HOTEL - RICHMOND, VIRGINIA

Friday, March 13

8:15 a.m.	**Coffee and Continental Breakfast**
9:00 a.m.	**Child Sexual Abuse: Changes in the Statute of Limitations** Moderator: W. Lawrence Fitch, J.D. Discussants: Sylvia Clute, J.D. Evelyn Fleming, Ph.D., J.D.
10:15 a.m.	**Break**
10:30 a.m.	**Satanism and Ritualistic Crimes** Janet I. Warren, D.S.W. David G. Bromley, Ph.D. Jeffrey K. Hadden, Ph.D.
Noon	**Adjourn**

UPDATES FOR VIRGINIA PRACTITIONERS

WORKSHOPS

1:30 - 3:00 p.m.	**Americans with Disabilities Act** Gary Hawk, Ph.D. Paul A. Lombardo, Ph.D., J.D. Julie A. Stanley, J.D.
1:30 - 3:00 p.m.	**Attorneys and Incompetent Clients: Ethical Dilemmas** C. Cooper Geraty, J.D., LL.M. Steven K. Hoge, M.D. R. Shawn Majette, J.D.
3:30 - 5:00 p.m.	**Issues in Civil Commitment** W. Lawrence Fitch, J.D. Jane D. Hickey, J.D. Paul A. Lombardo, Ph.D., J.D.

15th Annual Symposium on Mental Health and the Law
March 12 - 13, 1992

HYATT RICHMOND
Richmond, Virginia

Keynote Speaker: Paul Appelbaum, M.D.
Dr. Appelbaum will discuss the expansion of "managed care" in the mental health field and its impact on patients and practitioners.

OTHER TOPICS INCLUDE:
Patient Self-Determination Act
Sexual abuse: clinical obligations and legal changes
Substance abuse and AIDS
Satanism and ritualistic crimes
Americans with Disabilities Act

SEE COMPLETE AGENDA IN THIS ISSUE

FOR REGISTRATION INFORMATION PLEASE CALL 804/924-5435

Developments in Mental Health Law
Institute of Law, Psychiatry & Public Policy
University of Virginia School of Law
North Grounds
Charlottesville, Virginia 22901

Non-Profit Organization
U.S. Postage
P A I D
Permit No. 160
Charlottesville, VA 22901