Developments in
Mental Health Law

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New Currents in Mental Health Law

By Richard J. Bonnie

According to one of Oliver Wendell Holmes, Jr.'s most quoted aphorisms, "the life of the law has not been logic; it has been experience." By experience, Holmes meant the realities of social life, the "felt necessities of the time."[1] In all aphorisms, the price of cleverness is some loss of accuracy. I would rather say that law is a living tradition, shaped both by the internal logic of ideas embedded in the legal culture and by changing social and technological circumstances.

Mental health law, for example, is given its distinctive texture by the internal logic of two large ideas--liberty and equality of citizenship. I will refer to these two ideas as the libertarian and egalitarian strands of mental health law. "Liberty" refers to the right to be free of unwarranted governmental restraint or intervention. The need to regulate coercive treatment is what distinguishes mental health law from mainstream health law. In this respect, mental health law is analogous to public health law and is analyzed within the same constitutional paradigm. "Equal citizenship" in its thin form refers to the right not to be legally disadvantaged on grounds of mental disability. In a thicker form, this idea encompasses affirmative governmental efforts to counteract the effects of private discrimination.

Mental health law, as we now know it, has developed only over the past 25 years. The libertarian strand of mental health law was rooted in a distrust of discretionary power, and a deepening skepticism about governmental intrusion into people's personal lives. It was in this sense tied to *In re Gault*,[2] which subjected the juvenile court to the rule of law, and *Roe v. Wade*,[3] which substantially restricted governmental interference with a woman's reproductive decision-making. Both of these themes appear prominently in *O'Connor v.*

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

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Donaldson, which is the libertarian font of mental health law. Justice Stewart's opinion is at once a ringing endorsement of what has been called a "right to be different" and a warning about the excesses of the "Therapeutic State:"

> May the state confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? ... May the state fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the state, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.[4]

The libertarian strand of mental health law was rooted in a deepening skepticism about governmental intrusion into people's personal lives.

The egalitarian strand of mental health law was clearly rooted in the same vision of equal opportunity that inspired the civil rights movement of the 1960's, but I think it has a more direct link to the evolving logic of gender equality. The core idea in race discrimination law is that there is no socially relevant difference between people of different races, and that any differential treatment is therefore presumptively irrational and arbitrary. Up to a point, the law of gender discrimination rests on the same premise, but only up to a point. The difference in reproductive capacity between men and women leads to the possibility of rationally differentiated treatment. For example, employers who allow employees to take leave for all sorts of medical reasons might nonetheless disallow maternity leave on the basis of its greater frequency and consequent disruptiveness of such absences to the enterprise. One could say that this policy differentiates not between women and men but rather between pregnant people and non-pregnant people (men and women.) But this response really begs the underlying question: Do the differences between maternity leave and other medical leave justify a distinction in policy which forces pregnant women to choose between job and mothering but which excuses other workers from choosing between job and medical care? Workplace leave practices emerged when the reference point was a male worker whose wife was at home and who therefore did not need maternity leave. The question today is whether employers should be required to adapt leave policies to new social realities.

The additional idea in gender discrimination law is that the significance of the real biological difference between men and women turns on how society is organized, not on any inherent characteristics of pregnancy, childbirth or childrearing. And it goes a step further: traditional workplace leave policies implicitly devalue the special demands of family life such as having a child, or caring for a dying parent. Achievement of equal opportunity therefore requires changes in social practices which are rational but which have the effect of reifying differences between men and women, or--in this context--between people with strong family obligations and people without them.

The disability rights movement represents a continued elaboration of these ideas. A wheelchair-bound person is "disabled" only if buildings have been built without ramps or elevators. More pertinently, the disabling effects of mental disorder are often associated with the way people respond to unusual behaviors rather than with any functional impairment. Also, even if a person has functional impairments, their disabling effects can be minimized by altering working conditions. The logic of these ideas

culminated in the Americans with Disabilities Act (ADA),[5] a remarkable and far-reaching legislative achievement.

But this is not the whole story. As Holmes said, the life of the law has not been logic alone, for it is inevitably shaped by the "felt necessities of the time." And so it has been in the context of mental health law. The libertarian logic of mental health law has been powerfully reinforced by constraints on state mental health budgets which have given states an incentive to move people out of public hospitals and keep them out. De-institutionalization would have occurred even without libertarian developments in constitutional law. Moreover, stigmatization and social intolerance are powerful counterforces to the egalitarian vision of anti-discrimination law. Concerns about the costs of compliance, especially for small businesses, and international competitiveness will inevitably shape judicial practice under the ADA.

This brief review of the evolution of mental health law sets the background for the thesis I want to propose. The face of mental health law is already being shaped, and will be strongly influenced in the coming years, by two important social developments: (1) the escalating fear of violence throughout American society--a fear which is at least partly rooted in an increasing rate of violence; and (2) the impending overhaul of health care financing and the rationing, priority-setting and service reorganization that will be an inevitable part of the new system.

Fear of Violence

The rate of violent crime, which has increased significantly over the last 20 years, has turned markedly upward during the last three years. The escalation in the rate of aggravated assault during the same period has been even more pronounced. All varieties of violence have increased--senseless unprovoked violence, fanatical violence, political and religiously inspired violence, predatory violence. Violence has increased everywhere, it seems: on the streets, in the home, in the workplace. Fear has increased even more. This is evident in patterns of casual conversation in any city with a population over 250,000. It is evident in the phenomenal growth of the private security industry. It is evident in the apparent erosion of the political clout of the National Rifle Association.

Escalating social concern about violence is already having an impact on mental health law.

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Editor
Paul A. Lombardo

Student Contributors
David McConnell
Susan Eisenman

Managing Editor
Bettie Amiss

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In the Supreme Court of Virginia

Breach of Confidentiality by Physician is Malpractice in Virginia

Pierce v. Caday, 244 Va. 285, 422 S.E. 2d. 371 (1992).

The duty of maintaining disclosures made by a patient in confidence presumably applies to all physicians and many other health care providers. Whether breach of that duty gives rise to a legal claim that should be characterized as a tort--rather than a breach of contract--is a critical distinction that can determine the success or failure of a patient's lawsuit when the doctor has failed to honor the expectation of confidentiality. The Virginia Supreme Court recently concluded that even specific agreements by doctors to honor patient secrets should not be considered as special contracts, but as part of the usual duties to patients governed by laws regulating lawsuits for medical malpractice.

Mary Kay Pierce was a hospital employee who complained of sexual harassment by a coworker. Pierce consulted Dr. A.T. Caday, a physician at the hospital, for medical advice and to request a prescription sedative that would allay the emotional distress caused by the incidents of harassment. During her office visit with Caday, Pierce asked that the nurse leave the room so that she could discuss matters that were "highly confidential." According to Pierce, Caday assured her all matters they discussed would remain private. She proceeded to detail her difficulties at work, and Caday responded by verifying her need for medical leave.

Upon returning to work two days later, Pierce learned that an employee of Caday had disclosed the reasons for her medical appointment to several other members of the hospital staff. Pierce eventually filed suit against Caday, arguing that his failure to control his employees amounted to a breach of confidentiality. She demanded payment for emotional distress and physical problems including stress-related ulcers and inability to sleep.

Under Virginia law, actions for malpractice may not be initiated in court before notice has been given to the doctor who is involved. Because Pierce's lawsuit was filed before Caday received formal notice, Caday moved to have it dismissed as violative of the notice provisions of the malpractice act. The trial court refused to accept Pierce's characterization of her claim as one based on a contract with Caday to treat her disclosures confidentially. The case was dismissed.

On appeal to the state supreme court, Pierce asserted that even though Caday is a "health care provider" as described in the malpractice law, her claim was not based on improper treatment, nor did it arise during the time of diagnosis, care or treatment--the time frame regulated by law. Rather, she stated, the complaint "arises from the unauthorized and impermissible dissemination of medical records following the termination of the doctor/patient relationship." Pierce insisted that her suit was not for malpractice, but for breach of the specific promise not to disclose a confidential matter. The breach was clearly wrongful, Pierce claimed, because information that is "acquired in attending, examining or treating the patient in a professional capacity" is protected by a statutory privilege (Va. Code sec. 8.01-399).

The supreme court's analysis of Virginia law began with an examination of the doctor/patient privilege statute. Noting that the law contains only a qualified privilege--it is specifically limited to civil actions--the court recited several other provisions of state law that protect physicians from liability when mandatory disclosures are required by other laws (for example, as the result of a workers compensation examination). Thus, when taken as a whole, Virginia law implies an expectation of confidentiality between doctors and their patients,

the only explicit legislative recognition of the importance of this expectation is in the privilege statute. The legislature has provided that physicians are not required to testify concerning the content of patient communications, but nowhere does state law specifically grant plaintiffs whose confidentiality has been breached a right to sue for damages. The court perceived that Pierce was attempting to "fashion a cause of action for recovery of damages out of what has thus far been recognized merely as a rule of evidence." Many other states do provide a civil remedy for breach of confidentiality, but the court declined expressly to recognize the existence of such a claim in Virginia. Since the parties had presumed that such a remedy was available, no judicial declaration of its existence was necessary.

The only issue for the court to settle was whether the plaintiff's claim was a matter of tort or contract. Pierce attempted to "package her allegations as some sort of special contract . . . [in order] . . . to avoid the requirements of the [malpractice] Act." But, the court concluded, "the duty to honor the implied promise of confidentiality is but another component of the [medical] treatment rendered." A breach of that duty must be judged like a violation of the general standard of care, and dealt with as a tort in a malpractice action.

Even though it is still not entirely clear whether the Virginia Supreme Court would find, in the properly presented case, that breach of confidentiality in the medical context is actionable, it is at least clear that in such a case, the issue must be framed as a tort, not a breach of contract claim.

In the U.S. Supreme Court

Kentucky Statute for Commitment of Mentally Retarded Survives High Court Review

Heller v. Doe, __U.S.__, 61 USLW 4728 (1993).

In a decision endorsed by a bare majority of the Supreme Court's members, Kentucky's statutes regulating residential commitment of the mentally retarded were upheld as constitutional. The majority opinion in the 5 to 4 ruling was authored by Justice Anthony Kennedy and provided the occasion for a pointed dissent from Justice David Souter. The decision ends nearly eight years of litigation that challenged the differences between institutional commitment procedures for mentally retarded adults and parallel, but less restrictive procedures for committing the mentally ill. Though settling the validity of Kentucky law, the Court avoided deciding whether the mentally retarded constitute a constitutionally protected class, and left the continued vitality of past decisions that affect the mentally retarded in doubt. [Most notably, *Cleburne v. Cleburne Living Center,* 473 U.S. 432. See *5 Developments in Mental Health Law 17* (1985). The Cleburne case struck down a Texas city's requirement that group homes for the mentally retarded obtain special use permits when similar housing for other groups faced no such requirement.]

Litigation over Kentucky's statutory procedure for residential placement of the mentally retarded has been in process since the mid-1980's, and has provided the motive for several significant revisions to that state's law. Administrative practices that gave parents of mentally retarded adults a veto over community placement decisions were declared unconstitutional by a federal district court in 1986. [*Doe v. Austin,* 668 F. Supp. 597 (W.D. Ky. 1986). See also"Family Ties and Due Process: Supreme Court to Review Kentucky's Law for Committing Mentally Retarded Adults," 12 *Developments in Mental Health Law* 35 (1992) for a discussion of the history of the Heller litigation.] The Kentucky legislature responded with amendments that effectively abolished judicial hearings prior to commitment of the mentally retarded, but the 6th Circuit Court of Appeals upheld an injunction against applying the new law. [*Doe v. Austin,* 848 F.2d 1386, cert. denied, 288 U.S. 967 (1988).] Kentucky's 1991 amendments to the commitment law formed the focal point for the most recent challenge in a case initially styled as *Doe v. Cowherd* [965 F.2d. 109 (6th Cir. 1992)]. The final appeal of that case left three issues to be addressed by the Supreme Court: 1) May a state adopt a lower standard of proof for commitment of the mentally retarded than it uses for the mentally ill? 2) May guardians and family members of mentally retarded adults participate as parties during commitment hearings? and, 3) Should statutes that appear to discriminate against the mentally retarded be judged under the same constitutional standard that is invoked for laws of more general application?

Justice Kennedy's opinion answered each of those questions in the affirmative. He disposed of the last question first. The plaintiffs asked that the Kentucky law be evaluated not in terms of whether it had any "rational basis," but according to a more searching level of inquiry, a "heightened scrutiny" that might apply to laws discriminating against the mentally retarded. But since the lower court decisions in the case had not addressed this issue, the Supreme Court declined to consider it for the first time on appeal.

This ruling signaled the direction the Court would take with the remaining issues. "Rational basis" review is the least demanding level of inquiry used in cases that question the constitutionality of state law, and it imposes no obligation on states to produce evidence that would demonstrate the rationality of a law. State laws

are initially presumed to be constitutional, and under rational basis review the burden rests on those challenging the law to show that no imaginable set of reasons could justify a statute's enactment. Even under this less-than-rigid test, the standard of rationality "must find some footing in the realities of the subject addressed by the legislature," the Court noted. Kentucky's reasons, according to Justice Kennedy, included "more than adequate justifications for the differences in treatment between the mentally retarded and the mentally ill."

Kennedy then turned to the remaining issues. Kentucky's law allowed the commitment of the mentally retarded based on "clear and convincing evidence" while commitment of the mentally ill required evidence "beyond a reasonable doubt." This disparity, the plaintiffs had argued, violated the equal protection clause of the 14th Amendment. But the majority found ample reasons to support the lower standard of proof for the mentally retarded. Mental retardation is easier to diagnose than mental illness, Justice Kennedy wrote. Because it is "a permanent, relatively static condition" he asserted, "determinations of dangerousness [necessary as a second finding before commitment is authorized] may be made with some accuracy based on previous behavior."

Kentucky's rationale in support of the law making it easier to commit the mentally retarded included the declaration that methods of treatment for them are "much less invasive than are those given the mentally ill." The majority opinion contrasted treatment of the two groups, agreeing with Kentucky that "the mentally ill are subjected to medical and psychiatric treatment which may involve intrusive inquiries into the patient's innermost thoughts . . . and use of psychotropic drugs." Each of these differences--ease of diagnosis, more accurate prediction of dangerousness and nature of the treatment received--provided a reason for the majority to uphold Kentucky's commitment law.

The law was also challenged on the ground that it violated procedural due process by giving guardians and family members status as parties during commitment hearings for the mentally retarded. This, the plaintiffs argued, "skewed the balance" against the mentally retarded and created an undue burden on them. Not so, concluded the court. Even if family members may, in some cases, have interests that conflict with those of the person subject to commitment, "these parties will often have valuable information that, if placed before the court, will increase the accuracy of the commitment decision," Kennedy reasoned. Moreover, he said, family members have an interest in the welfare of a mentally retarded person that the state may acknowledge.

> For example, parents who for 18 years or longer have cared for a retarded child can face changed circumstances resulting from their own advanced age, when the physical, emotional, and financial costs of caring for the adult child may become too burdensome for the child's best interests to be served by care in their home.

There is no precedent in our legal tradition, Kennedy concluded, for preferring the judgment of the government over that of families and forcing states to "slam the courthouse door against those interested enough to intervene."

Justice Souter's dissent argued for a different level of review, suggesting that laws affecting the mentally retarded should face the "heightened scrutiny" traditionally afforded protected classes of citizens. He described the provision allowing family members to appear as parties in commitment proceedings as equivalent to imposing "a second prosecutor" to argue against those alleged to be mentally retarded. Souter disparaged the majority opinion which allowed the state of Kentucky

> to draw a distinction that is difficult to see as resting on anything other than the stereotypical assumption that the retarded are "per

> petual children,"an assumption that has historically been taken to justify the disrespect and "grotesque mistreatment" to which the retarded have been subjected.

Souter's most penetrating critique of the majority's decision focused on the assertion that the use of psychotropic medication is generally limited to the mentally ill. Citing the findings of federal courts and several national studies, Souter highlighted data demonstrating that from 30% to 76% of the mentally retarded receive psychoactive drugs as a routine feature of treatment. Additionally, "invasive behavior therapy" often accompanies drug therapy for the retarded, Souter noted. His dissent concluded that the loss of liberty following commitment and the potentially harmful results of aversive treatment and forced medication make the mentally retarded no less needful of procedural protections than the mentally ill.

Justice Thomas' Opinion Equates Competency to Stand Trial, Waive Counsel, and Plead Guilty

Godinez v. Moran, __ U.S. __, 1993 WL 218258.

The 6th Amendment to the U.S. Constitution guarantees criminal defendants the right to be represented by a lawyer. Defendants unable to afford a lawyer are entitled to legal representation at state expense (*Gideon v. Wainwright*, 372 U.S. 335 (1963)). The state, however, ordinarily may not force a defendant to accept the services of a lawyer. In *Faretta v. California*, 422 U.S. 806 (1975), the U.S. Supreme Court decided that defendants may waive the right to representation by counsel and proceed to trial "*pro se*" (i.e., without a lawyer) if competent to do so. The court, however, did not articulate a legal standard for this competency. Some lower courts have interpreted *Faretta* to require an ability to lawyer one's case with reasonable skill (*e.g. People v. Burnett*, 188 Cal. App. 3d 1314 (1987)). Other courts have viewed the question as one of decisional competency, requiring an ability to make a "reasoned choice" between the alternatives available. Still others have concluded that the defendant need only be competent to stand trial (CST) -- that any defendant who is CST must also be competent to waive the right to counsel and proceed *pro se* and, therefore, no special finding of competency to waive counsel need be made. On June 24, 1993, in it's opinion in *Godinez v. Moran*, the U.S. Supreme Court resolved the matter, siding with those lower courts who had found competency to waive counsel to be subsumed by CST. The standard for competency to waive counsel is neither higher than nor different from the standard for CST, the Court declared. The Court acknowledged that before a trial court may accept a defendant's waiver of counsel, it must find the waiver to be "knowing, voluntary, and intelligent," but it concluded that this requirement was unrelated to the question of the defendant's competency.

Also at issue in *Moran* was whether competency to plead guilty could be inferred from a finding of CST. Consistent with its ruling on the question of waiver of counsel, the Court held that competency to plead guilty is part and parcel of CST and thus a finding that a defendant is CST obviates the need to inquire specifically with regard to competency to plead guilty. Again, however, the Court noted that the defendant's decision (here, to plead guilty) must be knowing, voluntary, and intelligent.

The defendant in this case, Richard Moran, was charged with three counts of capital murder for shooting two men in a bar to death and then nine days later killing his former wife. After shooting his wife, Moran turned the gun on himself in an unsuccessful attempt to commit suicide.

Initially, Moran pled not guilty to the charges. The trial court ordered Moran examined by two psychiatrists, both of whom described Moran as depressed but concluded that he was CST. Subsequently, the prosecution announced its

intention to seek the death penalty. Sometime later, Moran advised the court that he wished to discharge his attorneys and change his pleas to guilty. He indicated that he wanted to prevent the presentation of mitigating evidence at his sentencing hearing. On the basis of the reports provided by the psychiatrists who had examined Moran's CST, the court found that Moran knew the consequences of pleading guilty and that he could knowingly and intelligently waive his constitutional right to counsel. Accordingly, the court discharged Moran's attorneys and accepted his plea of guilty. A three-judge court sentenced Moran to death.

Two years later, while on death row, Moran petitioned for post-conviction relief. The 9th Circuit Court of Appeals reversed Moran's conviction, finding that the trial court should have conducted a hearing to evaluate and determine Moran's competency before accepting his decision to discharge counsel and plead guilty. Observing that "competency to waive constitutional rights requires a higher level of mental functioning than that required to stand trial," the 9th Circuit ruled that the trial court's determination that Moran was CST provided an insufficient basis for determining his competence to waive counsel and plead guilty. While a defendant may be CST if he or she has a rational and factual understanding of the proceedings and is capable of assisting his or her attorney, "a defendant is competent to waive counsel or plead guilty only if he has the capacity for 'reasoned choice' among the alternatives available to him," the court declared.

The state appealed the 9th Circuit's decision, and the U.S. Supreme Court reversed. Writing for a seven-justice majority, Justice Clarence Thomas noted that to be CST a defendant must have a range of decision-making abilities. Indeed, Justice Thomas observed, the defendant may be faced with a series of waiver decisions in the course of standing trial: whether to waive the right to a jury (and accept a bench trial); whether to waive the right to confront one's accusers (by foregoing cross-examination of opposing witnesses); and whether to waive the privilege against self-incrimination (by taking the witness stand). "[W]hile the decision to plead guilty is undeniably a profound one, it is no more complicated than the sum total of the decisions that a defendant may be called upon to make during the course of a trial .... If the *Dusky* standard [for determining CST] is adequate for defendants who plead not guilty, it is necessarily adequate for those who plead guilty."

With respect to waiver of counsel, the Court made clear that the ability to lawyer one's case is an irrelevant consideration. "[T]he competence that is required of a defendant seeking to waive his right to counsel is the competence to waive the right, not the competence to represent himself," Justice Thomas declared.

Whether the defendant who is CST with a lawyer might be considered incompetent to stand trial without a lawyer is not clearly resolved in Justice Thomas' opinion. Justice Thomas does make clear that no greater competency than that which is required for CST is necessary for choosing self-representation, but he dodges the question posed in briefs for the defendant whether the calculus for CST may vary depending on whether or not the defendant is represented. Thus, if it is true, as Grisso and others have written (Grisso, T. *Evaluating Competencies* (New York: Plenum Press, 1986)), that CST is context-dependent, it may be possible, even after *Moran*, for a defendant previously found to be CST with a lawyer subsequently to be found to be incompetent to stand trial in the changed context of trial without a lawyer.

While Justice Thomas insists that defendants who are CST necessarily are competent to waive the right to counsel and plead guilty, it is noteworthy that he recognizes nonetheless that the defendant's choices in this regard must be knowing, voluntary and intelligent. Justice Thomas concedes, "[i]n this sense there is a 'heightened' standard for pleading guilty and for waiving the right to counsel, but," he insists, "it is not a heightened standard of competence." That mental disorder might provide the basis for

finding an otherwise competent defendant unable to make a knowing, voluntary, and intelligent decision to plead or to waive counsel is not a question Justice Thomas considers.

In a dissenting opinion in which he was joined by Justice Stevens, Justice Blackmun took issue with the majority's one-size-fits-all view of competency. "[T]he majority cannot isolate the term 'competent' and apply it in a vacuum, divorced from its specific context. A person who is 'competent' to play basketball is not thereby 'competent' to play the violin." Justice Blackmun also took issue with the majority's assertion that competence to lawyer one's case is unrelated to the question of competence to waive the right to counsel. "[A] defendant who is utterly incapable of conducting his own defense cannot be considered 'competent' to make such a decision, any more than a person who chooses to leap out of a window in the belief that he can fly be considered 'competent' to make such a choice." Noting that at the time Moran discharged his lawyers and pled guilty he was diagnosed as depressed and was taking four different prescribed medications (including an antidepressant and a medication to control seizures), and reflecting on the difficulty Moran had responding appropriately to questions the
trial court posed before accepting his waiver and plea, Justice Blackmun concluded, "[t]o try, convict, and punish one so helpless to defend himself contravenes fundamental principles of fairness and impugns the integrity of our criminal justice system."

- by Larry Fitch

Disability Software Available

The American Bar Association recently released a computer package entitled *autoBOOK: ADA Disability Law Software.* The software includes the text of the Americans with Disabilities Act, Technical Assistance Manuals, pertinent regulations, case summaries and articles on the ADA that have appeared in the *Mental and Physical Disability Law Reporter.* The software is designed to allow instant searches of the statutory text and other material, downloading or fax transmission of relevant sections, as well as numerous word-processing applications. For further information contact:

The Commission on Mental and Physical Disability Law
American Bar Association
1800 M. Street, N.W.
Suite 200 South
Washington, D.C. 20036
(phone) 202/331-2240
(fax) 202/331-2220

In the Federal Courts

Multiple Choice Tests OK for Dyslexic Medical Student under Federal Rehabilitation Act

Wynne v. Tufts University School of Medicine, 976 F.2d 791, cert. denied, 113 S. Ct. 1845 (1993).

The United States Supreme Court has decided to leave undisturbed a federal appellate decision exonerating Tufts University of discrimination against a medical student who requested educational accommodation of his cognitive deficits. Though the case ultimately focused on the decision of the school not to vary its requirement of multiple-choice exams, it also explored the more general issue of how much accommodation is "reasonable" under the prescriptions of the federal Rehabilitation Act.

Steve Wynne entered Tufts University School of Medicine in 1983. By the summer of 1984, he had failed eight of fifteen examinations required of first-year students. While academic performance guidelines prescribed dismissal for students who failed five courses, a special dispensation of Tufts' medical dean allowed Wynne to repeat the year and paid for a neuropsychological examination to help him assess the sources of his academic problems. The diagnostic results suggested that a learning disability made multiple examination tests--the standard testing procedure at Tufts--particularly vexing. Though the evaluation was not conclusive, a reading specialist implied that dyslexia might be a factor contributing to Wynne's performance.

Tufts provided Wynne with tutors, note-taking services, and counselors. At the end of the next year, Wynne passed all but two examinations: biochemistry and pharmacology. Wynne was permitted to retake tests in these subjects. Wynne failed biochemistry for the third time and in September of 1985 was dismissed.

A year later, Wynne filed suit claiming that Tufts' refusal to provide an alternative to multiple-choice examinations in biochemistry constituted discrimination on the basis of his learning disability. The federal district court granted Tufts' motion for summary judgment on the grounds that Wynne was not handicapped as defined by section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794 (1987)). That decision was eventually reversed on appeal by the 1st Circuit Court of Appeals (932 F.2d 19 (1991)(en banc)). The appellate court found that Wynne was learning disabled and entitled to "reasonable accommodation" of his disability under section 504. At trial, Tufts had asserted that it had met its duty of "reasonably accommodating" Wynne, but had submitted a single, conclusory affidavit of the dean to support its position. The Court of Appeals remanded the case to the lower court, refusing to dismiss Wynne's complaint absent a more fully developed record detailing the efforts Tufts had exerted. Tufts was invited to offer evidence that it had considered alternative means, and then to show why additional accommodations were not feasible.

Six affidavits from Tufts and two court appearances later, Wynne's next appeal was heard. His claim was two-fold: that Tufts' refusal to provide tests in a format other than multiple-choice failed to reasonably accommodate him as a matter of law, and that the school's justifications for denying further accommodations were made in bad faith.

The appeals court granted summary judgment for Tufts on both issues. In addressing the question of "reasonable accommodations," the court was deferential to the "professional judgment" reflected in Tufts' affidavits, which contained claims that changing the multiple-choice test format would require significant program

alterations, lower academic standards and devalue a medical degree from Tufts. It refused to consider Wynne's evidence that other schools had substituted alternative testing methods, but relied without question on the University's statement that the multiple choice test was the most fair way to test a student's ability in biochemistry.

In dismissing the second claim, the court found insufficient evidence that the fears of academic erosion Tufts voiced were a mere pretext for discrimination. The school "neither ignored Wynne nor turned a deaf ear to his plight," according to the court. The numerous avenues of assistance offered to Wynne and the unusual flexibility of the faculty in affording him second and third chances to succeed convinced the court of the school's good intentions. The absence of an offer to provide an oral biochemistry test, which not incidentally, Wynne neglected to ask for until after his expulsion, was inadequate evidence upon which to base a claim of pretext. Wynne's successful performance on multiple-choice exams in other subjects also undercut his appeal. The court was careful to point out that this decision should not be read to rule out the possibility that alternative examinations will never be required for clearly diagnosed and timely identified dyslexic medical students. The opinion was specifically limited to the idiosyncratic facts of Wynne's situation and the court reiterated its earlier conclusion that an academic institution has an obligation to consider available means to accommodate disabled students. When seeking a court's summary judgement of discrimination suits, the institution must "produce a factual record documenting its scrupulous attention to this obligation."

Seventh Circuit Sees No Constitutional Right To Refuse Treatment With Antipsychotic Drugs

Sherman v. Four County Counseling Center, 987 F.2d 397 (7th Cir., 1993).

Paul Sherman, a resident of northern Indiana, was arrested following a dispute over the Bible. Sherman reportedly argued with his minister about the correct version of Scripture to be used in his church. Though he claimed no intent to harm or threaten the minister, Sherman did hold a gun on the elders of his church and on another occasion, he seized the minister from behind and held him. Following the incident with the gun, Sherman was charged with criminal harassment. He paid his bond and was released pending trial.

Immediately after his release, Sherman again visited the church. He threatened the minister and drove repeatedly around the church parking lot. The next morning he was seen in a restaurant publicly crying and lamenting his legal predicament.

Indiana state police officer Gary Boyles was aware of Sherman's arrest and subsequent behavior. Boyles approached a physician and related the details of Sherman's activities and his own concern that Sherman might be suffering from a psychiatric disorder. The physician agreed with Boyles, who subsequently filed the statutorily required application for emergency detention. The application was accompanied by the "Physician's Emergency Statement" also mandated under Indiana law, which asserted that Sherman met the legal standard for detention--mentally ill and dangerous.

A judge, ruling on the application, ordered that Sherman be taken into custody and transported to the Four County Counseling Center (a private facility) where he could be "detained, examined and given such emergency treatment as necessary . . . ." The treatment facility responded six days later with a report that described Sherman's condition as chronic paranoid schizophrenia and recommended continued treatment. The report repeated the conclusion that Sherman was dangerous. The judge thereupon authorized detention until a commitment hearing could be held, and ordered the facility to continue treatment " as necessary and appropriate, with or without the consent of [Sherman]." The following day Sherman was transported to Logansport State Hospital, where

he was held for an additional twelve days until a hearing was convened. The hearing concluded with Sherman's release, the judge having decided that continued detention was not warranted.

Upon release, Sherman asserted that despite his protests he had been given antipsychotic medication against his will at both treatment facilities. He sued the police officer who detained him, the judge, the private facility, the county and the public defender who represented him.

Finding no unreasonable activity on behalf of the police, the public defender or the county, and despite the fact that the judge's detention order was issued for a period beyond the two days specified by statute, the trial court dismissed all those defendants. Each was protected, the court said, by absolute or qualified immunity for actions taken in furtherance of a public role. The court also eventually dismissed the claim against the Four County Counseling Center. Sherman appealed the trial court's ruling only in regard to Officer Boyles and the Counseling Center.

Sherman's appeal focused on two issues. First, he asserted that Boyles acted unreasonably in relying on Indiana's statutory procedure for emergency psychiatric detention. The 4th Amendment requires that a warrant not be issued except following submission of evidence of probable cause supported by sworn statements. Boyles should have known, Sherman claimed, that the procedures he followed did not comport with 4th Amendment requirements for arrests.

The appellate court was not convinced. Boyles had complied with Indiana's prescribed procedures for emergency detention, and in light of all the evidence he had at hand, his conclusion that Sherman was dangerous was not unreasonable. Noting media reports of "bizarre campaigns of threats and harassment" that have concluded with murder, the court said: "[p]olice officers should not be forced by fear of suit to wait for a mentally unstable person to carry out threats before intervening."

The court's analysis of the liability of a private facility carrying out judicially sanctioned treatment conceded the complexity of the issue, but followed the policy it had stated for public officials. According to the court, when the counseling center accepted Sherman as an involuntary patient it

> was fulfilling a public duty. If the actions it took pursuant to a court order subject it to suit, private hospitals might well refuse to accept involuntary patients. This refusal would increase the load on the strained resources of the state's public hospitals. . . . We refuse to give private hospitals the Hobson's choice of obeying a court's order directing discretionary medical treatment, and face liability for the resulting medical judgment, or refusing to make a medical judgment and exposing hospital staff and patients to the risk of harm posed by a potentially violent mental patient.

Even though the order for involuntary medication would not have been valid for an involuntarily *committed* patient under Indiana law, (which requires a judicial hearing before such an order may be issued) Sherman was not committed, but detained in an emergency. More importantly, such an order does not violate any *federal* constitutional rights, the court said. The scope of constitutional due process protections that apply to refusal of antipsychotic medication in an institution "are not clearly established even today." Four County's actions neither exceeded the protections of qualified immunity extended by the lower court, nor the constitutional boundaries of due process protection, said the court.

Cases from Other States

Montana Court Allows Back-to-Back Commitment Hearings

In the Matter of the Mental Health of L.C.B., 830 P.2d 1299 (Mont. 1992).

Does the criminal law exclusionary rule protect people subject to civil commitment? May the doctrine of *res judicata*, which prohibits repetitive suits on the same issue, be used to escape a second civil commitment hearing? The Montana Supreme Court addressed both of those questions in a lawsuit challenging the application of state commitment law and answered both in the negative.

L.C.B., a thirty year old man, was arrested following an automobile accident. Because of his confusion and disorientation, police requested a mental health examination. While he was in custody in the Flathead County Jail, he was visited by a clinical therapist from the regional mental health center. Her evaluation identified symptoms of chronic paranoid schizophrenia, and concluded that he was unable to meet his basic needs and to protect his life and health. L.C.B. was unwilling to receive treatment voluntarily, so the clinician initiated commitment proceedings.

During the commitment hearing, evidence was presented by the clinician concerning the mental state of L.C.B., including her opinion that he was unable to protect his own life and health. The attorney appointed to represent L.C.B. argued that there had been insufficient evidence to support a commitment order, since nothing other than the clinician's speculation was offered to prove "either endangerment or inability to protect his own life and provide for his own needs." Conceding that L.C.B. was indeed, "a very troubled young man," the court nevertheless dismissed the petition for commitment and ordered his release.

A deputy sheriff from the Flathead County Detention Center approached the judge to ask permission to detain L.C.B. until his sister could be contacted, rather than simply releasing him to the street. The judge apparently acquiesced, but the sister was unwilling to assist. Additional efforts revealed that L.C.B. was too ill to be accepted at the local crisis "safe house."

A second petition for commitment was initiated by the mental health professionals who had seen L.C.B. at his first hearing. They testified that he was seriously mentally ill and that commitment to the State Hospital at Warm Springs was the least restrictive alternative for providing treatment that would protect his life and health. Counsel for L.C.B. again called for a dismissal, but the judge ordered transportation to the state hospital.

On appeal to the Montana Supreme Court, L.C.B. argued that the exclusionary rule, derived from the Fourth Amendment prohibition of unreasonable searches and seizures, should block the consideration of all evidence introduced at the second hearing. Since the result of the first hearing had been an order for release, and since he had been detained despite the order, all evidence of L.C.B.'s mental state collected during the illegal detention should have been excluded from his second hearing.

The "core purpose" of the Montana statutory scheme for mental health detention was meant to address "those unfortunate persons who suffer a mental disorder" by making care and treatment available, according to the court. "Suppressing relevant evidence in commitment proceedings would defeat" this statutory purpose, the court asserted. Thus the exclusionary rule was not applied to evidence collected during what was arguably an illegal detention and used at L.C.B.'s second hearing.

The Supreme Court then addressed the issue of *res judicata*. That doctrine normally works to prohibit the reconsideration of questions put

to rest in earlier litigation. Before L.C.B.'s second hearing, his attorney had asked that the commitment petition be dismissed. The first hearing had settled the question of commitability, he said. But rather than dismiss the matter, the judge had limited the evidence that could be admitted to events occurring after the first hearing. The Supreme Court noted that another purpose of *res judicata* is to provide final resolution to controversies. It necessarily applies only to matters that are by their nature final. Such a rule, the court said, cannot fruitfully be applied to civil commitment hearings. "A finding at one time that an individual does not suffer from a serious mental illness is not intended to be a final and irrevocable decision on the individual's mental health." That question may be raised, the court concluded, at any time as long as the necessary statutory criteria are met.

Iowa Psychiatrist Owes No General Duty to Protect Public From Acts of Released Mental Patient

Leonard v. State of Iowa, 491 N.W. 2d 508 (Ia. 1992).

In a case of first impression in Iowa, the state supreme court considered whether a psychiatrist has a duty to protect people who might be harmed by the psychiatrist's patient. The Iowa court followed narrowly focused state precedent that limits the general duty to care, and imposes liability only upon those whose negligence causes harm to foreseeably injured persons.

Henry Parrish was involuntarily committed to the Mental Health Institute (MHI) at Independence, Iowa, in late March of 1987. Upon admission he was diagnosed with "bipolar affective disorder, manic type, with alcohol dependency and suicidal ideation." He was placed on special assault and suicide precautions, which were removed within three days of admission. After two weeks he was allowed home leave for three days, and the leave was extended after telephone consultation an additional three days. He was discharged twenty-four days after commitment because the MHI staff believed that he had achieved "maximum, inpatient psychiatric benefits." It was recommended that he remain an outpatient, and appointments for follow-up treatment were scheduled.

Parrish returned to his job as a demolition contractor. He hired John Leonard to work for him, but rather than going to the work site, the two spent the day drinking. Later in the evening, at Parrish's home, Parrish severely assaulted Leonard and locked him in the house. Parrish was subsequently convicted of attempted murder and kidnapping. Leonard sued the state and MHI for his injuries.

Leonard's suit rested on the claim that the Mental Health Institute was negligent in its treatment of Parrish and that it discharged him prematurely. The claim was framed both as an action for negligence and a separate claim for psychiatric malpractice. In opposition to the state's attempt to have the suit dismissed, Leonard offered evidence that Parrish's criminal record included charges for assault, trespass, criminal mischief and public intoxication, and that he had also endured several involuntary mental commitments stemming from intoxication and violence. The trial court ruled against the state, and the case proceeded to the state supreme court on appeal.

The supreme court combined Leonard's claims, finding "no meaningful distinction between them" since both asserted professional negligence and subsequent personal injury. The issue to be decided was "[d]oes the duty to refrain from negligently releasing dangerous persons from custody run from the custodian to the public at large or only to the reasonably forseeable victims of the patient's dangerous tendencies?"

Under traditional tort doctrine, there is no duty to control the conduct of another, unless a special relationship exists between the actor and some other person. The relationship between a psychiatrist and his or her patient is an example of one such special relationship under this doctrine, and it may give rise to a duty on the part

of the doctor to control the patient. The court determined that MHI and its psychiatric staff did have a duty to control Parrish's conduct or at least not negligently to release him from custody. But this general statement of the law did not immediately lead to a determination of whether Leonard could invoke the duty for his own protection. Before the hiring and unprovoked assault, Leonard was a stranger to Parrish, and Parrish had never voiced any hostility or threats against him to the MHI staff. The court considered Leonard a "member of the general public."

Surveying national trends concerning psychiatric liability for discharge of mental patients, the Iowa court noted that the states "vary widely with respect to the universe of persons to which they will hold the doctor answerable." Some extend a doctor's duty to the public-at-large. Others limit the duty to reasonably foreseeable victims or to victims actually identified by a patient.

Tort law in Iowa reflects, according to the court, "the strong public policy against limitless liability when an individual's decision might affect the general public." Balancing the danger to the public posed by the negligent release of mental patients with the potential remedy of allowing civil suits against psychiatrists for discharge decisions, the court favored the Missouri view of nonliability announced in *Sherrill v. Wilson*, 653 S.W. 2d 661 (Mo. 1983). Increasing liability for mental health facilities and mental health personnel would, according to the Missouri court, force professionals to "indulge every presumption in favor of further [patient] restraint, out of fear of being sued."

Recalling its earlier rulings, the Iowa court noted that "decisions in the realm of mental commitment rest not only on medical judgments but on societal judgments about a community's tolerance for the sometimes deviant behavior of mentally ill persons." The constitutional requirement of treating patients in the least restrictive environment and the integrity of the Iowa civil commitment system would be jeopardized, the court said, if physicians and their prognoses "were subject to second-guessing by any member of the public who might later be injured by [a] patient."

While declining to discuss situations where the victim might have been reasonably foreseeable, the supreme court concluded that, in Iowa, a psychiatrist owes "no duty of care to an individual member of the general public for decisions regarding the treatment and release of mentally ill persons from confinement." Mr. Leonard's claims against the state were dismissed.

Federal Law Protects Substance Abuse Records in North Dakota Lawsuit

Jane H. v. Rothe, 488 N.W. 2D 879 (N.D. 1992).

Laws granting testimonial privileges have been adopted by legislatures in most states to protect confidential communications that occur in the context of some professional relationships. Doctors and patients, lawyers and clients, clergy members and their parishioners are able to avoid compelled testimony in court or the release of confidential records by invoking a privilege. However, a patient or client may consent to disclosure, or may by other behavior waive the right to maintain confidentiality. Bringing a lawsuit in which material normally protected by privilege must be made public to enable a fair adjudication of the case is a common way to waive a privilege.

Jane H., a North Dakota woman, sued two doctors and a Fargo N.D. clinic for medical malpractice following unsatisfactory gynecological surgery. During pretrial discovery, the doctors requested all of Jane's medical records, including records of chemical dependency treatment that had occurred at three separate facilities. These records were considered critical to the defendants' case because Jane had alleged emotional distress and mental anguish as a result of the alleged surgical malpractice. Evidence that her emotional difficulties predated

the surgery might be contained in treatment records, and that evidence would seriously erode any claim that damages were caused by the surgery alone.

North Dakota's privilege statute declares that "there is no privilege . . . as to a communication relevant to any issue of the physical, mental, or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense." Since Jane had put her mental state at issue in the case, the defendants asserted that she had waived the usual privilege protecting medical and mental health records.

Jane sought a protective order from the trial court, arguing that federal law restricted disclosure of patient records and other information by any federally assisted facility that performed drug and alcohol abuse counseling and/or treatment. Jane cited The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and The Drug Abuse Office and Treatment Act of 1972 [42 U.S.C.290dd and 42 U.S.C.290ee (1991)]. The trial court nevertheless ordered disclosure of "complete records" to the defendants, their lawyers and their expert witnesses.

Jane petitioned the Supreme Court of North Dakota for a supervisory writ to avoid the trial court's order. Even if she had waived the protection of state law, she argued, the federal statute still protected her medical records. State law may, the court announced, offer more protection for patient privacy than federal law, but it may not offer less protection. Even though the state lawsuit involved Jane's mental condition, records maintained in connection with a drug abuse prevention program that identify her, her diagnosis, prognosis or treatment may not be disclosed unless a court finds "good cause" under specific guidelines set out in the federal law. The supreme court found that since these guidelines had not been followed by the trial court, its order to compel disclosure of Jane's records was faulty and must be set aside.

The court listed the particular criteria that must be satisfied by a court in finding "good cause" for disclosure. The court must find that other ways of obtaining the information contained in patient records are not available or would not be effective and the public interest and the need for disclosure must outweigh the potential injury to the patient, the doctor/patient relationship, and the treatment services. Additionally, the court must conduct a private, in-chambers review of the records before issuing an order for release. Even following the *in camera* analysis, disclosure orders must limit release only to those persons whose need for the information is the basis for the order and to parts of the record that are "essential to the objective of the order."

Not only had the trial court neglected to attend to these criteria, it had also ordered Jane to release "complete records" that would presumably include notations on confidential communications that occurred during substance abuse treatment sessions. The North Dakota court pointed out that federal law contains even more stringent rules to protect this type of information. Confidential communications made by a patient in the course of seeking and receiving treatment may not be disclosed even if good cause for releasing records is found. A patient like Jane H. does not waive the confidentiality protection unless during litigation she offers specific testimony concerning the otherwise confidential conversations.

Finally, the supreme court pointed out that federal regulations demand that when a petition for court-ordered disclosure of substance abuse records is heard, both the patient involved and the treatment facilities where the records are kept must be given notice and an opportunity to respond to the petition. Since none of these provisions was satisfied in the case of Jane H., the disclosure order was dismissed and her case was remanded to trial court for further proceedings that would comply with the federal laws on confidentiality.

Books

Out of Mind; Not Out of Sight

A Review of

Madness in the Streets

by Rael Jean Issac and Virginia C. Armat.
(New York: The Free Press, 1990). 436 pp. $24.95

Since before the Revolutionary War, American states have experimented with numerous schemes, both medical and legal, to clear the streets of people whose disheveled appearance, disordered behavior and occasional violence could not be ignored in public places. We have built, filled, and now emptied custodial institutions. We have given to, then taken back power from physicians to confine, restrain, and "treat" (by whatever definition) those unfortunates whom Benjamin Franklin described as "a terror to their neighbours."

Fearful of the paternalism of doctors and aware of the abuses that seem inevitably to creep into institutional life, we near despair at "curing" mental illness, retreating instead into giving patients if not their sanity, at least their rights--to refuse confinement and drugs, perhaps to die a lonely and crazed death.

Today, many of those formerly described by the law as "people of disordered and insane mind" can be found wandering the streets of every major city; in smaller numbers but presenting no less troubling prospect, in most small towns.

This public display of mental illness, particularly among those who do not have or will not accept shelter, is the backdrop behind *Madness in the Streets* by sociologist Rael Isaac and journalist Virginia Armat. The authors launch their diatribe against everything gone wrong with the mental health system by comparing the current "shame of the streets" to the "shame of the states" detailed in Albert Deutsch's 1949 exposé of mental institutions *The Mentally Ill in America*. Their subtitle, "How Psychiatry and the Law Abandoned the Mentally Ill"and the section headings of the book (e.g., "The Law Becomes Deranged") echo the tone of moral indignation that sounds throughout this highly polemic volume.

The roll call of horrors recited in *Madness* is best summarized by reference to the domino theory under which its central chapters are organized. The falling dominoes represent therapies once widely accepted but now all but lost as strategic tools within the psychiatric black bag. Each domino was pushed, we are told, by a legal profession that decided to "arrogate to itself the decision-making power that had belonged to psychiatrists." Former mental patients contributed to the falling dominose by an "emotional rejection of the mental health system."

The authors castigate the conspiracy "to destroy psychiatric authority," which, they say, struck first at psychosurgery. Recalling the lobotomies for which Egas Moniz won the Nobel Prize in 1949 (even while calling them "primitive"), Isaac and Armat applaud the 3500 "operations" later performed by Walter Freeman with icepick, hammer, and homespun technique. Critics of psychosurgery are characterized as part of a "fanatical crusade." More recent professional reluctance to perform psychosurgery coupled with severe legal restrictions on its use led to loss of this weapon against mental illness. It became, the authors claim, the first domino to fall in the "war against treatment."

The second domino was electroconvulsive shock (ECT), the third, neuroleptic (antipsychotic) medication. While ECT and psychoactive drugs are still prescribed extensively, and despite a recitation of many examples of abuse and indiscriminate prescrip-

tion of these therapies, the authors complain that each is now *underused* in treating mental illness.

The content of *Madness in the Streets* is often clouded by the rhetorical exuberance of the authors. Much of their commentary is couched in breathless prose, as if the legal decisions of the 1970s, for example, were hot-off-the-wire news today. Other major stylistic problems include constant *ad hominem* argument and signals of disapproval for anyone who even *leans* to the left of political center. Federal Judge Frank Johnson's attempts to reform Alabama's wretched mental hospital conditions are suspect because he is "widely known for his liberal views." An insider's view of mental hospital abuse including beatings, electroshock torture and rape are reported from the autobiography of actress Frances Farmer, but they are undercut by the irrelevant aside that she was the "mistress of left-wing playwright Clifford Odets." Homeless advocate Mitch Synder's criticism of Ronald Reagan's housing policies are dismissed as "Marxist analysis."

The drugs, sex and rock-and-roll generation wins special blame for the failures of the mental health system. Psychiatry and law are polluted, we are told, by ideas born in the 1960's "counter-culture" and spread by "fashionable Utopian enthusiasts." A "deranged legal system" is controlled by lawyers from the "mental patient liberation bar." The antidote to this "cozy, incestuous, anti-psychiatric universe" is contained, not surprisingly, in the writings of conservative guru Robert Bork.

A major motive for this shrill harangue is discomfort with the visible, in-your-face poverty of America's cities and the part played in this urban tableau by the usually vocal, occasionally aggressive, sometimes psychotic occupants of heating grates and sidewalks. The authors seem most concerned at how "upsetting to the average citizen" the presence of "Bedlam on our streets" is. They describe homelessness as an "enormous social problem destroying the quality of life of [America's] cities."

The concern Isaac and Armat express over the plight of the mentally ill rings hollow alongside sympathy for parents who, out of frustration, murder psychotic family members, or the authors' repetitive invocation of the sufferings of the "average taxpayer" who must endure the upsetting sight of pathology in public places.

Isaac and Armat would like to see an enforcement of "legitimate standards of behavior" and a "civilized ambience" in parks and on sidewalks rather than an emphasis on the rights of the mentally ill. The poor, the homeless and the ill wandering at large apparently clutter the sight lines of their vision of morning in America. And no solution is offered to address the sixty percent or more of people on the streets who they concede are not mentally ill.

Additional funding for research in "biological" psychiatry, relaxed laws on civil commitment, increased use of involuntary hospitalization and medication, and intensive monitoring and guardianship of the mentally ill in the community are proposed as avenues for change. Curiously, no mention is made of the extraordinary costs these changes would generate for the most prominent endangered species of this book, the "average taxpayer."

The problems wrought by de-institutionalization, excessive legal regulation of the mental health system and a lack of coordination within that system are real; so too are the accounts of patient neglect and abuse that legal changes were meant to address. Unfortunately, the ideological posturing with which this book is filled overwhelms even the simplistic solutions the authors propose. It offers little direction to those who wish effectively to confront the twin social problems of mental illness and homelessness.

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

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. . . New Currents in Mental Health Law

-continued from page 3-

Consider the following developments:

*Many states have adopted an incapacitative strategy toward juveniles who have committed violent offenses.

*State legislatures are showing increasing interest in laws authorizing preventive confinement of dangerous sex offenders and "psychopaths." The most publicized example is Washington's violent sexual predator law which authorizes lifetime confinement of a person convicted of a violent sex crime who has already served his sentence if the person is found to have a "mental abnormality" or "personality disorder" which "makes the person likely to engage in predatory acts of sexual violence."[6] Laws of this kind had first appeared as a response to the therapeutic optimism of the 1950's but had been largely repealed and disavowed in the 1970's. The American Bar Association Criminal Justice Mental Health Standards condemned them. Now they are back on purely incapacitative grounds.

*An incapacitative ("mad dog") concept of the death penalty is increasingly evident. In South Carolina, the Supreme Court recently upheld a death sentence against a defendant who had been found Guilty But Mentally Ill. [7]

These laws respond to the violence of strangers. The tragic experience of battered spouses and children has also called increasing attention to the violence within families. And something new has surfaced over the last decade or so--the recognition that we are all at risk of being victimized by a person whom we know in school or on the job. The University of Virginia recently established a Task Force on Campus Violence and sponsored a national colloquium for college administrators and law enforcement authorities on this issue. Violence in the workplace is increasingly seen as a public health problem, one within the regulatory purview of the Occupational Safety and Health Administration. In both contexts, employers and administrators want to take preventive actions without running afoul of the ADA.

In the present context, the ADA has a paradoxical quality because it draws an explicit legal link between mental disorder and violence: a person with a mental disability who is otherwise qualified may nonetheless be dismissed if he or she poses a "direct threat to the safety of others." Dangerousness assessments are becoming a feature of everyday institutional life.

All of this is bound to affect the shape of mental health law, especially in relation to the scope of the state's coercive authority--its police power. How will the courts and legislatures respond? How will these developments alter the libertarian logic of mental health law?

Imagine the following hypothetical situation: Employee DB engages in threatening behavior toward co-workers who become fearful and complain. DB is referred to the Employee Assistance Program for evaluation. He is said to be depressed, hostile and impulsive, but has no diagnosable disorder. Psychotherapy is recommended but he refuses to participate. The next time he behaves in a threatening and hostile manner, the employer reprimands him, DB gets angry, and the employer calls the police. DB is not mentally ill, and has not engaged in any criminal conduct. He has never actually hurt anyone. But he is fired and is committed to a local detention facility for a week of "custodial restraint."

Is this scenario legally plausible? There are only two jurisprudential predicates for confinement in our legal system: (i) arrest and conviction for criminal conduct; and (ii) therapeutic commitment under the mental health system based upon findings of mental illness and imminent dangerousness, and on the presumed connection between the two. Thus,

even though DB may not be able to keep his job, he cannot be restrained because our law does not permit purely preventive confinement outside the criminal justice system. These are the foundational building blocks of our jurisprudence. But can we be so surethat they will not be shaken by the "felt necessities of the time?" In this connection, consider the road almost taken in *Foucha v. Louisiana.*[8]

Foucha was found not guilty by Reason of Insanity (NGRI) for aggravated burglary and was committed. Taking the appellate record at face value, it appears that Foucha was experiencing the symptoms of a drug-induced psychosis at the time of the offense, but that these symptoms had cleared by the time he was committed, so he was not mentally ill. (The staff apparently concluded that he had an antisocial personality but insisted that this condition is not a mental disease and is not treatable. These assertions were taken as given in the subsequent litigation.)

Dangerousness assessments are becoming a feature of everyday institutional life.

Four years later, after a multi-layered review process, the staff recommended conditional discharge, but neither member of the court-appointed "sanity commission" was willing to certify that Foucha would *not* be a danger to himself or other people if he were released. The trial court then ruled that Foucha had not carried his burden of proving that he was not dangerous and refused to discharge him. The Louisiana appellate courts affirmed. So the case came to the Supreme Court raising, quite starkly, the question whether an NGRI commitment could be based on dangerousness alone.

In a 5-4 decision, the Supreme Court said no. In the course of his opinion for the Court, Justice White reaffirmed what I have characterized as the libertarian foundation of mental health jurisprudence:

> A State, pursuant to its police power, may of course imprison convicted criminals for the purposes of deterrence and retribution.... Here, the State has no such punitive interest. As Foucha was not convicted, he may not be punished. The State may also confine a mentally ill person if it shows "by clear and convincing evidence that the individual is mentally ill and dangerous." Here, the State has not carried that burden; indeed, the State does not claim that Foucha is now mentally ill.

So neither of the two traditional jurisprudential bases of confinement could be invoked. But Louisiana had argued that preventive confinement could be constitutionally imposed outside the framework of criminal punishment and therapeutic commitment. In support of this argument, the state invoked *United States v. Salerno*[9] in which the Supreme Court had upheld short-term preventive detention of dangerous offenders awaiting trial. Justice White correctly responded as follows:

> In our society liberty is the norm, and detention prior to trial or without trial is the carefully limited exception. The narrowly focused pretrial detention of arrestees permitted by the Bail Reform Act was found to be one of those carefully limited exceptions permitted by the Due Process Clause. We decline to take a similar view of a law like Louisiana's, which permits the indefinite detention of insanity acquittees who are not mentally ill but who do not prove they would not be dangerous to others.

If Louisiana had prevailed in *Foucha*, the slope would have been very slippery indeed:

*If a person acquitted by reason of insanity can be preventively detained when he or she is no longer mentally ill, there is no apparent reason why a person who has served a criminal sentence could not be preventively detained. As I mentioned earlier, Washington's sexual predator statute is a narrow version of such a law.

*It is the only a short step to a new version of civil commitment which does not require proof of mental illness and which permits preventive restraint of DB for custodial restraint.

Foucha reaffirmed the prevailing logic of mental health law. But will it stand in the face of the escalating fear of violence? As I mentioned, it was a 5-4 decision. Justices Kennedy and Thomas wrote separate dissenting opinions. Justice Kennedy argued, in effect, that an NGRI commitment is really a parallel track of criminal confinement and may be based solely on an incapacitative rationale. This view at least has the virtue of being limited to people found beyond a reasonable doubt to have committed a criminal offense. Justice Thomas' dissent is not so restrained. He denies the very premise of the libertarian strand of mental health law--that freedom from coerced confinement is a fundamental right--and he implies that any scheme of preventive detention should be upheld as long as it is "reasonable." If this view were to prevail, it would wipe away the libertarian jurisprudence of mental health law: *O'Connor v. Donaldson, Addington v. Texas,*[10] and *Jackson v. Indiana,*[11] to mention only a few.

Health Care Financing

Now I want to turn to the other development that is likely to have a major impact on mental health law--this time on its egalitarian strand. The entire structure of health care financing will change. The rationing of care that has long been characteristic of mental health care will become a more prominent feature of the entire system. In general, health care will be broader but thinner.

Health care reform is likely to have a far-reaching impact on mental health law. For example, the public/private distinction that has been so fundamental to mental health policy and law will be eroded if not eliminated.

Justice Thomas' dissent denies the very premise of the libertarian strand of mental health law.

Federal and state responsibilities will be realigned. Decisions about which mental health services are included in the "basic package" will have a reverberating impact on virtually all features of the law relating to treatment and entitlement, including worker's compensation, social security, disability insurance and the ADA.

In a more speculative vein, I want to highlight an important issue that lies beneath the impending reform. This is an issue that has implications for how we think about mental disorder and distributive justice. In any system of distributing scarce resources, there are several possible allocative principles or criteria. Two of the more common are "need" and "desert" (or responsibility). My message is that we should watch carefully how these considerations play out in the emerging system of health care and social services.

Obviously the dominant distributive principle in a universal health care system will be "need." Inevitably in a capitalistic society, a secondary principle will be wealth. People who can afford to do so will be able to buy more comprehensive coverage. Ordinarily, in a need-based distributive system, we do not ask how the need arose. So, we don't ask how the sick person got heart disease or cancer. We don't ration care according to whether the

person was a smoker or not, or more generally, whether the person was in some way responsible for his own disease. Similarly, we don't ask how a person got AIDS and we don't ration care according to whether the person became infected through voluntary sexual intercourse or through a transfusion of bad blood.

But, this is not to say that notions of responsibility are irrelevant. Consider, for example, the proposed "sin taxes." One of the underlying principles here is that smokers should pay for the costs of their own smoking-related illnesses. Consider also the desert-based distinctions that are inherent in tort and workers compensation systems. There, health care, rehabilitative services and compensation for loss are linked to findings of causation, and in the case of tort, third-party responsibility.

Under worker's compensation laws, for example, the allocative criterion is "need" as long as the injury or illness was incurred in the course of employment. But these laws routinely make an exception for injuries incurred in the course of intentional misconduct (e.g., a head injury from driving 100 MPH or while intoxicated, even if on company business).

Let me bring this closer to home. I think that intuitions about responsibility also shape our ideas about what "need" means in the context of mental disorder. Perhaps the biggest issue to be addressed when mental health benefit plans are structured is determining what "counts" as a covered condition. The developing law under the Rehabilitation Act and the ADA reflects a deep intuition that a person with substance abuse disorders is to some extent responsible for his or her own condition--if not for its onset, at least for failing to do something about it or for failing to comply with treatment conditions. Thus, accommodations are required for an alcoholic under the ADA only if he or she is under treatment. And there is also case law under the ADA holding that persons with severe mental disorders--schizophrenia and bipolar disorder--are not protected by the Act if they have failed to take their medication. In other words, they are sufficiently responsible for their own disorders that accommodations need not be provided.

Intuitions about responsibility for one's own disorder or disability will shape the coverage of mental health benefits under the new health care system.

My prediction is that this general theme concerning intuitions about responsibility for one's own disorder or disability will shape the coverage of mental health benefits under the new health care system and, more generally, will weave its way through the fabric of mental health law in the years ahead.

NOTES

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[1] Holmes Jr., O.W., The Common Law, Mark DeWolfe Howe, ed. (Boston: Little Brown, 1963) p. 5.
[2] *In re Gault*, 387 U.S. 1 (1967).
[3] *Roe v. Wade*, 410 U.S. 113 (1973).
[4] *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
[5] Americans with Disabilities Act, Pub. L. No. 101-336, 104 Stat. 327 (1990).
[6] Revised Code of Washington Ann. (West) 71.09.010 (1990). The constitutionality of this statute was recently upheld by the Washington Supreme Court *In Re Young*, __P.2d.__, 1993 WL 301113 (Wash.).
[7] *South Carolina v. Wilson*, 413 S.E.2d 19, cert. denied, 113 S.Ct. 137 (1993).
[8] *Foucha v. Louisiana*, 112 S.Ct. 1780 (1992).
[9] *United States v. Salerno*, 481 U.S. 739 (1987).
[10] *Addington v. Texas*, 441 U.S. 418 (1979).
[11] *Jackson v. Indiana*, 406 U.S. 715 (1972).

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Inclusion, Motivation and Good Faith: The Morality of Coercion in Mental Hospital Admission

By Nancy S. Bennett, M.A., Charles W. Lidz, Ph.D., John Monahan, Ph.D., Edward P. Mulvey, Ph.D., Steven K. Hoge, M.D., Loren H. Roth, M.D., M.P.H., and William Gardner

Philosophers' accounts of what is coercive, according to Wertheimer (1989), come in two basic varieties. One type of theory maintains that coercion can be described using an essentially amoral behavioral account of phenomena. A second type of theory asserts that coercion is a fundamentally moralized judgement.

> An empirical theory maintains that the truth of a coercion claim rests, at its core, on ordinary facts: Will B be worse off than he now is if he fails to accept A's proposal? [B]y contrast, a moralized theory holds that we cannot determine whether A coerces B without answering the following sorts of questions: Does A have a *right* to make his proposal? *Should* B resist A's proposal? (1989, p. 7).

Wertheimer argues that moralized theories provide the more coherent philosophical account of coercion in general (Wertheimer, 1989), and of coercion in the context of mental hospitalization in particular (Wertheimer, 1993).

Research cannot resolve philosophical debates about the role of morality in mental health law or in any other area (Morse, 1988). One cannot argue from "is" to "ought." That is, even if it is true that patients themselves take moral considerations into account in determining whether an act is coercive (by asking, to use one of Wertheimer's examples, whether another had a right to propose hospitalization), it would not follow that moralized theories of coercion are philosophically superior to empirical ones.

It is also true, however, that patients' experience of coercion is an important empirical factor

Also in this issue:

that mental health law takes into account in determining whether coercive hospitalization is justified (National Center for State Courts, 1986). For example, patients' experience of alienation and disaffection at being, in their view, immorally coerced into hospitalization--and the consequences of this belief for treatment compliance and treatment efficacy--would be a "cost" that the therapeutic "benefits" of hospitalization would have to offset.

Research on the extent to which patients themselves adopt moralized theories of coercion, therefore, while it may not resolve philosophical debates about the nature of coercion, does bear centrally upon an understanding of the experience of coercion, and therefore upon legal debates about the justification of involuntary hospitalization.

The existing literature on coercion in mental hospital admission has virtually ignored patients' perceptions of the morality of the decision making process that resulted in their hospitalization (Monahan *et al.*, under review). In this study, we attend specifically to patients' perceptions of the morality of attempts by others--primarily, family members, friends, and mental health professionals--to influence them to be admitted to the hospital, and of the morality of the process by which those influence attempts resulted in admission.

Methodology

The research reported here was conducted as part of an ongoing effort by the MacArthur Research Network on Mental Health and the Law to understand the role played by coercion in mental hospital admission. The Network's initial exploratory work on this topic is described in Hoge, *et al.* (1993). In the current study, 157 patients were interviewed within the first day after being admitted to a psychiatric hospital. Of those, 105 entered a community based hospital in Pennsylvania, and 52 entered a State Hospital in Virginia. Patients were administered extensive interviews concerning their perceptions of the pressures that came to bear on them surrounding their admissions. Both coerced and uncoerced, legally voluntary and involuntary patients were interviewed. The first part of the interview was open-ended. In it, patients were encouraged to tell us in their own words about their experiences of coming into the hospital. The second part of the interview was composed of structured questions yielding quantitative answers.

All of the 157 semi-structured interviews were audiotaped. However, resources limited us to transcribing only 70: 14 from Virginia, and 56 from Pennsylvania. Cases were selected for transcription based on the recommendations of the interviewers with the intention of providing as wide a range of perceived coercion as possible. We attempted to include both typical and atypical cases from both sites.

This article reports the qualitative analyses that evolved from the first author reading and reviewing the 70 transcripts, the second author reading some of the transcripts and confirming the same general findings, and all the authors discussing segments of these topics as they have emerged during data collection and analysis. The quantitative data from the entire patient sample will be reported in subsequent papers. It is our belief that a complete account of the role of coercion in mental hospital admission will only be achieved by a combination of qualitative and quantitative methods (Hoge *et al., 1993).*

RESULTS

Three morality-related themes emerged in patients' accounts of what they experienced as coercive in the mental hospital admission process:

1. *Inclusion.* Patients believed they have a right to be included as much as they wished to be in the process of determining whether they would be admitted to the hospital.
2. *Beneficient Motivation.* Patients believed that those involved in the admission process should be motivated by an appropriate degree of concern for the patient's well-being.
3. *Good Faith.* Patients believed that all persons who became involved in the admission process should behave honestly and openly with them.

We will explore each of these three themes through selections from the transcribed interviews.

I. Theme One: Inclusion

Perhaps the most consistent message given by patients in the selected interviews was the moral importance of their inclusion or participation in the process that resulted in their coming into the hospital.[1] All patients may not have wanted the same degree of participation, but all did believe that whatever their preferred degree of involvement was, they ought to be able to have had it.

The notion of inclusion in the process leading to mental hospital admission subsumed both

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Editor
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Student Contributors
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In the Virginia Courts

Electroshock Damage Claim Allowed Against Psychiatrist by Nurse Anesthetist Despite Workers' Compensation Law

Salih v. Lane, 423 S.E.2d 192 (Va. 1992).

Margaret Lane, a nurse anesthetist, was employed by a group practice responsible for anesthesiology services delivered in Fairfax Hospital. In September of 1988, Lane was assigned to Fairfax Hospital to assist Dr. Hassan Salih, a psychiatrist, in the administration of electroconvulsive therapy (ECT) to one of his patients. According to Lane's testimony, Dr. Salih activated electric current while patient preparation was not complete, and without prior warning to her. While still in the process of anesthetizing the patient, Lane received a shock. She suffered permanent injuries to the nerves in her right arm, and a change in heart beat that may eventually require a pacemaker. Lane subsequently sued Salih for negligence.

At trial, a jury found Dr. Salih guilty of negligence and awarded Lane approximately $ 1.2 million. The doctor appealed the decision on three grounds: (1) that the plaintiff was his employee whose on-the-job damages should be paid exclusively via a claim for workers' compensation; (2) that Lane, not he, was the negligent party; and (3) that the jury's award was excessive. The Supreme Court of Virginia rejected all three of these claims.

The court reviewed the evidence presented at trial and affirmed the jury's decision on the issue of negligence. The record contained credible evidence to show that Salih had failed to maintain the proper standard of care in administering ECT treatments and that Lane's injuries were directly related to this negligence. The court also found the jury's $ 1.2 million award to be appropriate compensation for Lane's injuries, which included irreparable nervous system damage, and permanent loss of wages and corresponding retirement benefits.

Salih's most critical point on appeal concerned the role of a nurse anesthetist in relation to a doctor who provided services to patients as an independent contractor. Under standard principles of workers' compensation law, if an employee sustains an injury that occurs on the job, the employee is prohibited from suing the employer for negligence. Claimants must be satisfied with payments from workers' compensation insurance. According to the trial record, Lane applied for and received workers' compensation benefits from her employer, the anesthesiology practice. But while the workers' compensation scheme provides an exclusive remedy against employers for work-related injury, parties other than an employer are not insulated from claims of negligence. Thus it was critical that the court analyze the roles of Salih and Lane to determine whether they could properly be characterized as employer and employee. A decision that Lane was Salih's employee, or even a subcontractor working under Salih's supervision would protect the doctor from any claim for additional damages.

In determining Lane's scope of employment, the court examined whether assistance with anesthesia was provided "as part of the defendant's [Salih] trade, business or occupation." Since the billing for the anesthesia and the psychiatric treatment were separate, and since Lane did not specialize in any field related to psychiatry, the court found no such connection. Similarly, since Salih was not an anesthesiologist and had no hospital privileges to administer anesthesia, he could not

be considered a supervisor of Lane. He was not Lane's employer under the workers' compensation statute, nor a general contractor responsible for her performance. Consequently, the jury award was allowed to stand.

Court of Appeals Reverses Minor's Conviction for Lack of Independent Psychologist

Anderson v. Commonwealth, 15 Va.App. 261, 421 S.E.2d 900 (1992), aff'd on rehearing en banc ---S.E.2d---, 1993 WL 429694.

The Virginia Court of Appeals, sitting with nine judges *en banc*, endorsed the earlier decision of a three judge panel to reverse the conviction of a juvenile found guilty of malicious wounding. The conviction was the result of a circuit court proceeding in which the sixteen-year-old was tried as an adult. It was an abuse of discretion, according to the appellate court, for the judge of the circuit court to refuse to allow the defendant's competence to be evaluated by a mental health expert not chosen by the prosecution.

During her sixteenth year, Michelle Anderson cut the throat of Roxanne Tucker with a knife. A motion was filed by the prosecutor to transfer her case out of juvenile court. Under Virginia law, children fifteen years of age or older charged with offenses for which an adult could be punished by a term in the penitentiary may be tried in circuit court if several conditions are met. One condition is that "[t]he child is not mentally retarded or criminally insane." Va. Code sec.16.1-269(A)(3)(c).

Accompanying the transfer motion, the prosecutor filed a request that the juvenile judge appoint Dr. Arthur Centor, a private clinical psychologist, to evaluate the mental status of Anderson. Dr. Centor's report concluded that Anderson was competent to stand trial, and functioned above the level of mental retardation. The juvenile judge, however, found that the statutory requirements for transfer had not been met.

The Commonwealth appealed the denial of transfer to the circuit court. At that point, Anderson requested funds for an independent mental health expert, arguing that three earlier psychological evaluations had found her to be mentally retarded. Her request was denied. Following a hearing at which Dr. Centor testified for the Commonwealth, Anderson was tried and convicted as an adult and sentenced to sixteen years in the penitentiary.

Anderson challenged the decision in the Virginia Court of Appeals. She argued that denial of her request for an independent evaluation was equivalent to a failure of due process. While she did not claim a specific right to state-funded psychological assistance of her own choosing, she did contend that fairness would demand that if the state chose its own expert, she should be accorded one as well.

The court of appeals took exception to several of the state's points on appeal, particularly the assertion that the transfer motion was not a "critical stage of the guilt determining process" requiring due process protections. The decision to try a child as an adult, the court noted, determines whether a finding of guilt will result in nonpunitive rehabilitation in the social service sector or a criminal sentence to the correctional system. When the waiver of juvenile jurisdiction is at stake, Virginia law and U.S. Supreme Court jurisprudence demand that juveniles be afforded "a fair hearing" where the proceedings must contain "the essentials of due process and fair treatment."

The court emphasized that since Anderson's transfer to circuit court would turn on the "possibility of eliciting favorable testimony from the expert selected by her adversary," she was placed in an untenable position. The defense burden was under-

lined by evidence that on three previous occasions, I.Q. testing had determined that Anderson was mentally retarded. Those tests were challenged by Dr. Centor, who "testified that his testing technique was superior to the techniques of earlier test givers." The court of appeals concluded that the "prosecution should be denied the advantage of choosing the psychiatrist (sic) whose testimony could be determinative of whether a juvenile is adjudicated an adult or determined to be delinquent." The conviction was reversed.

In response to a petition for rehearing, the full court of appeals reviewed the appellate panel's decision and concurred. Despite a dissent in which three of the nine judges argued that "the fact that a judge chooses an expert suggested by a party does not, standing alone, render the expert biased," the majority agreed that the trial judge erred in refusing independent assistance to Anderson.

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In the U.S. Supreme Court

Supreme Court Orders Reimbursement for Parents of Learning Disabled Child Placed in Private School

Florence County School District v. Carter, --- S.Ct.---, 1993 WL 453609.

The Individuals with Disabilities Education Act (IDEA) requires states to provide disabled children with a "free appropriate public education." In interpreting this law, (formerly known as the Education of the Handicapped Act) the Supreme Court has allowed a retrospective remedy for parents who judge public school education to be inappropriate. In *Burlington School Committee v. Massachusetts Department of Education* (471 U.S. 359 (1988)) the Court approved payments for tuition and expenses to parents who unilaterally placed their child in a private school after the public school system failed to comply with its statutory duties and the private school program was judged to be appropriate. In a case arising out of the Fourth Circuit Court of Appeals, the Supreme Court has extended the right to recover the costs of private school placement to cases where the private school has not been approved by the state educational agency.

Shannon Carter attended a public school in Florence County, South Carolina for the seventh, eighth and ninth grades. Despite performing several psychological assessments, from 1982-1985 the school failed to recognize Shannon's severe learning disability. When the disability was diagnosed following the 1985 academic year, the school district proposed an individualized educational program for Shannon, as required by the IDEA.

The individualized education plan (IEP) is a critical feature among measures school systems are required to take to meet the mandates of the IDEA. An IEP is to be developed by school officials and parents and must contain a current evaluation of the student's performance, goals for educational advancement, lists of specific services the school will provide to the student and evaluation criteria by which to judge the accomplishment of educational objectives. Every disabled child must have an IEP, and it must be reviewed annually.

Shannon's proposed IEP included three periods of individualized instruction per week, with the remainder of her week to be spent in regular classes. The plan included goals of four months progress in reading and mathematics within the entire school year. Dissatisfied with these projections, Shannon's parents requested a hearing to challenge the appropriateness of the plan. When both local and state education hearing officers approved the IEP, Shannon's parents removed her from the public school and placed her in the Trident Academy, a private school specializing in educating children with disabilities.

Shannon attended Trident from the fall of 1985 until graduation in the spring of 1988. Her parents filed suit in 1986, asking the federal district court to order retroactive reimbursement for tuition costs at Trident. The court found that the public school plan was inadequate as a matter of law, and contrasted the actual progress Shannon had demonstrated at Trident --more than three years progress in reading scores in only three years of schooling--with the very modest projections contained in the IEP. The court also determined that Trident's program, though not officially approved by the state,

afforded Shannon an excellent education that substantially complied with all the requirements of the IDEA. The court concluded that the Carters were entitled to reimbursement from the school district for tuition and fees, room and board, mileage to school and four trips home per year--a total of $35,716 plus interest.

The school district appealed, but was also rebuffed by the Fourth Circuit Court of Appeals. The appellate court rejected the school system's argument that placement is never appropriate in a private school that has not been selected by the state and has not complied with all the procedural requirements of the IDEA. The U.S. Supreme Court accepted the case for review on the single issue of whether a parental placement such as the Shannon's must meet all the specific procedural requirements of the IDEA in order for reimbursement to be proper.

The school district's argument before the Supreme Court relied on language in the IDEA specifying that education be provided "under public supervision and direction," that an IEP must be designed by "a representative of the local education agency," and that the IEP must be "revised and reviewed" by the agency. Another key deficiency of the Trident placement, according to the public school district, was that two Trident faculty members were not state-certified.

The Supreme Court's unanimous ruling dismissed all these objections. Echoing the Fourth Circuit, the opinion by Justice O'Connor underlined the inconsistency of forbidding parents from sending children to a school "that provides an appropriate education simply because that school lacks the stamp of approval of the same public school system that failed to meet the child's needs in the first place." Similarly inconsistent would be the expectation that public school officials, having prepared and steadfastly endorsed their own IEP, would cooperate in supervising and monitoring an IEP at a school they had not chosen. The procedural requirements of the IDEA "cannot be read as applying to parental placements."

In response to the concern that retrospective relief for parents would place school systems in the position of paying unbudgeted private school costs, Justice O'Connor noted that "[t]otal reimbursement will not be appropriate if the court determines that the cost of private education was unreasonable."

In the Federal Courts

Special Master Appointed to Direct Mental Health Services In District of Columbia

Dixon v. Kelly,---F.Supp.---, 1993 U.S. Dist. Lexis 6511

A U.S. District Court Judge recently appointed a special master to oversee the creation of an outpatient mental health network in the District of Columbia. Judge Aubrey Robinson found that the District had failed to provide a "cohesive, organized system for the delivery of psychiatric services . . . in the least restrictive environment possible."

This most recent court intervention can be traced to a class-action lawsuit brought eighteen years ago [*Dixon v. Weinberger,* 405 F. Supp. 974 (D.D.C 1975)] on behalf of patients confined in St. Elizabeth's Hospital, which was a federally administered institution in Southeast Washington, D.C. In that case the same Judge Robinson found that provisions of the District of Columbia Code gave patients confined in the hospital a statutory right to treatment under the least restrictive conditions attainable. He found further that the District of Columbia and the federal government had a joint responsibility to provide these services; neither entity had performed its duty, and both governments were ordered to develop "suitable alternative placement facilities" as soon as possible.

A consent order and plan to implement the 1975 decision were approved by the court in 1980, with a targeted completion date of 1986. Since the entry of the order and the plan, the defendants were " consistently unable to meet their obligations, forcing the plaintiffs to seek . . . findings of contempt and the appointment of a special master." The federal government was dismissed from the suit in 1987, when the District assumed full control of St. Elizabeth's Hospital. In order to avoid further litigation, the remaining parties conducted extended negotiations which resulted in a new plan, approved by the court in January of 1992.

Under terms of the revised plan, the District agreed to provide new housing, intensive care management, family support, emergency services, personal care services, social activities, vocational services, and mobile community outreach and treatment teams for present and former patients of St. Elizabeth's. This "Dixon class" includes about 2,500 homeless people with chronic mental illness.

On May 14, 1993, Judge Robinson found that the District had once again failed to comply with the provisions of the agreement. He "declare[d] emphatically that twelve years is long enough for the District to perfect and effectuate a system which protects the legal rights and lives of the mentally ill in the community consistent with its statutory mandate and the judgement of this court." He appointed Dr. Danna Mauch as Special Master of mental health services in the District of Columbia for a one-year term effective on June 1, 1994.

Challenge by Substance Abuse Group Home to Virginia Beach Zoning Ordinance Dismissed

Oxford House Inc. v. City of Virginia Beach, 825 F.Supp. 1251 (E.D. Va. 1993).

Oxford House Inc. is a not-for-profit corporation that provides programs and

housing assistance for recovering substance abusers. Approximately four hundred households nationally are chartered as "Oxford Houses" and up to fifteen persons live in each of those houses run as self-governing units. Four such houses are located in the Virginia Beach, Virginia, area.

A zoning ordinance of the City of Virginia Beach restricts the use of residential districts to "families"--defined to include groups of no more than four people unrelated by blood or marriage, but allows group homes to operate if they obtain a conditional use permit. The permit process requires an application to be filed with the city planning director, review by the planning commission, and approval by city council. The procedure includes public notice when permits are considered, and a public hearing before the planning commission and the city council.

In 1991, zoning officials visited one of the Oxford House locations and subsequently issued a notice of violation. The notice cited the impermissible number of unrelated persons living in the house. Oxford House responded by complaining to the U.S. Department of Housing and Urban Development (HUD) that the zoning ordinance violated the Fair Housing Act by discriminating against the handicapped. After an investigation, HUD found no violation of the Act because the restriction on living arrangements was written to apply to all "unrelated persons" whether or not they are handicapped.

The city then threatened legal action, giving the four Oxford Houses the option of reducing the number of residents to no more than four per house or applying for a conditional use permit. Oxford House responded by filing suit in federal court, alleging that the zoning ordinance violated the Fair Housing Act by discriminating against the handicapped, that a public hearing on the zoning permit would expose residents to "unrestricted public scrutiny," and that the city's unwillingness to waive the permit process constituted a failure to make "reasonable accommodations" in violation of the Rehabilitation Act and the Americans with Disabilities Act.

After oral arguments and briefs from both the city and Oxford House the case was dismissed. The court found that cities do have a great deal of discretion in fashioning nondiscriminatory housing plans, and that the concept of "reasonable accommodation" could not be tested outside of the specific context in which that discretion is exercised. In this case, the opportunity for the city to make an accommodation would occur during consideration of the conditional use permit, and "facts are collected and interests balanced" by zoning authorities in the zoning permit process.

Because Oxford House had not yet gone through the permit process, the court concluded it was premature to judge the claims of discrimination and failure to make reasonable accommodations. Oxford House's concern that residents would be exposed to public scrutiny was misplaced, according to the court, because there was no allegation in the complaint that residents would have to appear at hearings. The usual practice would have applicant's interests represented by lawyers, experts and other advocates. Finally, the court concluded that the Fair Housing Act and other federal laws were intended to integrate handicapped citizens into places and processes available to other citizens. Those laws, it said, do not "insulate [the disabled] from legitimate inquiries designed to enable local authorities to make informed decisions" on zoning or other matters.

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Cases from Other States

Supreme Court of Washington State Finds Sexual Predator Commitment Law Constitutional

In re the Personal Restraint Petition of Andre Brigham Young, 857 P.2d. 989, 122 Wash.2d. 1 (1993).

In American jurisprudence, there are few acceptable justifications for the use of the coercive power of government to deprive a person of liberty. The "police power" rationale is most common, invoked in the criminal context for the purposes of public safety to arrest and detain those suspected of or found guilty of crimes. Mental health law contains a second principle, the benevolent "parens patriae" or paternalistic motive. The parens patriae is the justification for detention and confinement of the dangerously mentally ill, who are taken out of the community both for their own benefit as well as for protection of the community. Recent Supreme Court opinions have confirmed that neither criminals who have served their sentences, nor other arguably dangerous people who are no longer mentally ill may be subjected to indeterminate "preventive detention" simply to incapacitate them in an attempt to allay public concern over their potential for violence. (*See Foucha v. Louisiana,---U.S.---, 112 S.Ct 1780. 12 Developments in Mental Health Law 4 (1992)).* The police power does not reach far enough to prevent free citizens, even those formerly punished for their crimes, from voluntarily offending again.

Random, repetitive rape is unique among violent crimes in evoking community fear and giving rise to calls for creative solutions from all agencies of law enforcement. In an attempt to address growing concerns about men who rape repeatedly, Washington State passed the Community Protection Act of 1990. The act allowed for the continued confinement, under a mental health rationale, of "sexually violent predators" who had served criminal sentences, but who arguably were so likely to re-offend because of their psychological make-up that freeing them could not be risked. The legal challenge to the constitutionality of the "sexual predator" law reached the Washington Supreme Court this year. Despite assertions by plaintiffs that the law was nothing more than a scheme to allow indeterminate confinement of criminals who had already endured the term of punishment accompanying their convictions, the Washington court upheld its validity.

Andre Brigham Young (whose appeal was heard along with another repeat rapist) has been convicted of the rapes of six women. The rapes occurred at various times over the past 31 years during "the intermittent periods when Young was not in custody." His last offense took place in 1985. Young broke into an apartment and raped his victim in the presence of three small children. When Young qualified for release from prison in 1990, the continuing confinement provisions of the Community Protection Act were put into motion to commit him to a mental health facility as a "sexually violent predator."

The Community Protection Act contains a variety of provisions ranging from victim compensation to registration of sex offenders to increased criminal penalties for violent criminals. The specific part of the law applied to Young, however, is entitled "Civil Commitment" and allows for the involuntary commitment of "sexually violent predators" who have completed criminal sentences. The law defines a "sexually violent predator" as someone " who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person

likely to engage in predatory acts of sexual violence." The term "personality disorder" is not defined in the statute. "Predatory acts" are qualified as those directed toward strangers or persons specifically chosen by the predator as a victim. "Mental abnormality" is defined as a "condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts."

The act establishes a series of procedures that afford due process rights to one accused of being a "sexual predator," including a probable cause hearing, the right to counsel, the right to independent mental health evaluation, and the right to trial by jury to determine whether the person charged meets the statutory definition of a "sexual predator." Following a trial on that issue, commitment may be ordered "for care, control and treatment" of sexual predators until they are considered "safe to be at large." Commitment is available only to mental health departments within correctional facilities, and an annual examination and hearing is available to the detainee to challenge his continued commitment.

Andre Brigham Young's challenge to his impending commitment under the sexual predator law raised several constitutional issues. First, Young claimed that the law violated the *ex post facto* clause and the prohibition against double jeopardy. Second, he argued that substantive due process was violated because the state lacked sufficient justification for depriving people like Young of liberty during what was characterized as "preventive detention." He also asserted that the absence of a requirement to prove a recent overt act of violence was inconsistent with the evidentiary burden for proving dangerousness. Finally, along with several other evidentiary issues, the appeal claimed that the statutory proceeding, by forcing participation of the accused in a psychiatric evaluation, denied Young his Fifth Amendment right to remain silent.

The Washington court discarded most of Young's challenge by concluding that even though one feature of the sexual predator law was to incapacitate the former offender, the statute was not punitive in nature, thus not part of the criminal law. The *ex post facto* clause, the provision against double jeopardy and the Fifth Amendment protection against self-incrimination all are limited to the criminal context. Therefore, Young could not invoke their protection. The court's most thorough discussion involved Young's due process rights in light of recent mental health cases decided by the U.S. Supreme Court. Young claimed that the law allowed the state to hold him in civil commitment without requiring a finding of "mentally ill and dangerous." Since the term "mental abnormality" in the law is not included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [DSM-III-R], what Young characterized as a vague and undefined condition was being used justify his custody. Discarding this reliance on the labels of orthodox psychiatry, the court said: "[w]hat is critical for our purposes is that psychiatric and psychological clinicians who testify in good faith as to mental abnormality are able to identify sexual pathologies that are as real and meaningful as other pathologies already listed [in the DSM III-R]."

Though the court commented on several procedural flaws in the application of the sexual predator statute, none of these was significant enough to require reversal of Young's commitment, and he remains in custody under the law endorsed by Washington's highest court as consistent with the federal constitution.

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Colorado Court Affirms Forcible Medication for Criminal Defendant

Donaldson v. District Court for the City and County of Denver, 847 P.2d 632 (Colo. 1993).

The Supreme Court of Colorado affirmed a psychiatric hospital's request to forcibly administer Prolixin to one of its patients, a criminal defendant whose mental incompetence prevented him from standing trial. The medication order was allowed despite the patient's assertion that he was experiencing bad side effects from the drug.

While charges for two criminal offenses were pending, Freddie Donaldson was ordered to submit to a psychiatric examination to determine his competence to stand trial. Donaldson was committed for psychiatric treatment after an evaluation by the Colorado Mental Health Institute during which he was found incompetent. Staff physicians at the Institute prescribed Prolixin, a tranquilizer, to prevent Donaldson's long-term deterioration. He initially refused medication, but later agreed to take the drug twice each day. Following his first two days of medication, Donaldson complained that his tongue contracted, he could not swallow and that his jaw was distorted. The staff recognized these symptoms as evidence of tardive dyskinesia, a potential side effect of Prolixin. They treated Donaldson with an anesthetic to counteract the negative effects of Prolixin. After this incident, Donaldson refused Prolixin, and the hospital sought and received a court order authorizing continued treatment. Donaldson appealed the order to Colorado's Supreme Court.

The Colorado court recognized Donaldson's right to refuse treatment absent a finding of "overriding justification and a determination of medical appropriateness." (Citing *Riggins v. Nevada*, 112 S.Ct. 1810 (1992); See *12 Developments in Mental Health Law 4* (1992). It also noted that Colorado law included a test for justifying forcible administration of antipsychotic medication to a patient if several conditions are met. The court adopted the four-part test from *People v. Medina*, 705 P.2d 961, 967 (Colo. 1985), which requires proof by clear and convincing evidence of four factors. In an adversary proceeding, the petitioning hospital or other party must prove that: (1) the patient is incompetent to effectively participate in a treatment decision; (2) treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient's mental condition or to prevent the likelihood that the patient will cause serious harm to the patient or to others in the institution; (3) a less intrusive treatment alternative is not available; and (4) the patient's need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.

The trial court had applied the four *Medina* factors at a hearing at which the prosecution relied on the over-the-phone testimony of the treating psychiatrist, Dr. Fisher. Fisher testified that Donaldson suffered from paranoid schizophrenia and was a "very dangerous person." He also noted that Donaldson was subject to "extreme anger and hostility" and traced the symptoms of tardive dyskinesia to the extraordinarily high doses of thorazine Donaldson had received in a California psychiatric hospital, rather than the more recently administered Prolixin.

Fisher persuaded the court that dosage management would eliminate the negative side-effects of drug treatment. His most important contention was that the treatment was necessary to improve Donaldson's condition. Fisher's testimony was accepted to satisfy the final three of the *Medina* factors (Donaldson's incompetence had already been conceded). The court allowed the forced medication to proceed.

Two dissenting judges reviewed the trial

court record and concluded that the hospital had not justified compelled treatment with Prolixin. They argued that without further corroboration, Dr. Fisher's testimony did not meet the "clear and convincing" standard of proof. In addition, they cited contradictions between Fisher's opinion that treatment was for Donaldson's benefit and testimony on both direct and cross examination in which he had explained that the hospital's goal was not to "prevent long-term deterioration" of the patient, but to render him competent to stand trial. The dissent also noted confusion at the hospital over whether Donaldson actually suffered from a psychotic illness at all; in his diagnostic notes, Dr. Fisher suggested that the Donaldson might suffer from "anti-social personality disorder" as opposed to a psychotic illness.

The dissent concluded that "when measured against the irreversible and potentially fatal risks involved . . . the state has failed to meet its burden."

Georgia Supreme Court Allows Action on Breach of Psychiatric Privilege to Proceed

Mrozinski v. Pogue, 423 S.E.2d 405 (Ga.App.1992)

Anthony Mrozinski's teenage daughter attended regular therapy sessions with Dr. Robert Pogue. The girl was treated for drug addiction and other mental health problems following removal from her mother's home and a grant of custody to her father. Pogue was the attending psychiatrist during the child's stay at the Ridgeview Institute.

In response to a request from the mother's attorney, Pogue drafted an affidavit and included a discharge summary that described Mrozinski's conduct and reactions during family therapy. The papers included the doctor's criticisms of Mrozinski's behavior and recommended that custody of the child be returned to the mother.

Mrozinski filed suit against Pogue for wrongful disclosure of privileged information and breach of confidential relations. The suit contained three claims: first, that the information Pogue had disclosed about Mrozinski was privileged because of the relationship he had established with the psychiatrist (apart from the psychiatrist's relationship with Mrozinski's daughter); second, that the psychiatrist wrongfully disclosed privileged information in his affidavit; and third, that the psychiatrist had breached confidential relations in giving the daughter's discharge summary to Mrozinski's wife. Pogue countered with the contention that no privilege existed between him and Mrozinski, since any joint therapy sessions were conducted for the benefit of the child. The child, on reaching adulthood, had signed a release for the doctor to release her records, and therefore Mrozinski had no standing to complain of the disclosure, according to Pogue.

The trial court granted the psychiatrist's request to dismiss the lawsuit on a motion for summary judgment that asserted Mrozinski's allegations were inadequate to support his claim.

On appeal, the Georgia Court of Appeals reviewed the facts considered by the lower court. The record demonstrated that occasionally Mrozinski accompanied his daughter during therapy sessions, primarily to support and facilitate her treatment. There was also evidence that Mrozinski consulted Dr. Pogue on his own behalf. Mrozinski alleged that he was encouraged to participate, and was reassured that his input would be confidential. Evidence was submitted that he paid a separate fee when he attended the therapy sessions.

In Georgia, the psychiatrist-patient privilege begins when "the requisite relationship of psychiatrist and patient (exists)...to the extent that treatment was given or contemplated." *Massey v. State*, 177 S.E.2d 79

(1990). While Pogue insisted that his only patient was the daughter, the documents Pogue released contained personal observations of the interaction between Mrozinski and his daughter, and included comments about Mrozinski's need for separate treatment and continued therapy for "his issues."

The court of appeals reversed the trial decision, finding sufficient factual dispute to overturn the summary judgment motion. Addressing the doctor's claim that participation in joint therapy was equivalent to a waiver of privilege, the court clarified that confidentiality is

> particularly important where the psychiatrist, in treating one person and knowing of another's deep concern . . . encourages him to participate in therapy with the original patient. The strongest public policy considerations militate against allowing a psychiatrist to encourage a person to participate in joint therapy, to obtain his trust and extract all confidences and place him in the most vulnerable position, and then abandon him on the trash heap of lost privilege.

The court also dismissed Pogue's claim that Mrozinski lacked standing to sue for the unauthorized release of his daughter's mental health records. Georgia law protects a patient's entire record from disclosure. The only permissible exception is a patient's release of information to the patient's own attorney. Despite the child's verbal consent at the time of release and a written consent upon reaching the age of majority, the court held that release of the records to the mother's, and not the child's attorney, was violative of law. As his daughter's guardian at the time of the unauthorized disclosure, Mrozinski was the only person who could sue for disclosures when she was 14, regardless of whether she approved the action after the fact.

Pogue was denied a reconsideration of the appellate court's decision, and the Georgia Supreme Court refused a petition to hear the case on appeal. The decision to allow Mrozinski's claim to proceed to trial was thus upheld.

. . . Morality of Coercion

(continued from page 27)

the proposition that decisionmakers should be willing to give prospective patients ample opportunity to express and explain themselves (often called "voice" in the literature on the social psychology of procedural justice (e.g., Tyler 1989, 1990)), and the proposition that decisionmakers should seriously consider whatever patients have to say in reaching a final decision regarding admission (often referred to as "validation" in the literature of patient advocacy (e.g., Campbell & Schraiber, 1989)). Not being permitted full participation in the hospitalization decision--or "having no say-so", a phrase which encompasses both voice and validation--was repeatedly cited as the most "coercive" aspect of the experience of entering the hospital. In the following excerpt, the patient complained about his therapist in a manner that illustrates the anger patients felt when they were not included in the admission decision:

> *P: I talked to him this morning. I said, "You...didn't even listen to me. You...call yourself a counselor...Why did you decide to do this instead of...try to listen to me and understand...what I was going through." And he said, "Well, it doesn't matter, you know, you're going away." ...He*

didn't listen to what I had to say...He didn't listen to the situation... He had decided before he ever got to the house...that I was coming up here. Either I come freely or the officers would have to subdue me and bring me in.

Later, the patient revealed that this lack of inclusion had moral significance to him. He compared what actually happened to him to his ideal of what a proper admission process should entail:

P: He [the therapist] had already made up his mind, you know, that I was coming one way or another, and I feel that...if you are to be a qualified counselor, you should be able to sit down and listen to your patients.

Similarly, another patient explained why he thought the hospital staff treated him unfairly:

P: 'Cause they were asking my mother yesterday...They were askin' her what she thought. They didn't ask me what I thought.

One context in which the issue of inclusion often arose was in discussion of "persuasion" by others to come into the hospital. In the structured part of our interview, questions were asked about four types of possible pressures: persuasion, inducements, threats and force. For persuasion, the question was "did anyone try to talk you into going to the hospital or being admitted?" If the answer to this was yes, four followup questions were asked on how hard the persuader was trying to get the patient into the hospital when he or she did that, whether the persuading made the patient want to come into the hospital more, how fair it was for the persuader to try to talk the patient into going to the hospital, and what it was that made it fair or unfair for the persuader to do that.

In answering these questions, not only did patients interpret persuasion positively, they not infrequently complained about its absence.[2] Indeed, efforts by others to persuade sometimes lead patients to report feeling more included or involved in the hospitalization decision by virtue of the fact that someone made the effort to try to persuade them. Attempts at persuasion had the effect of making some patients feel that their opinions and concerns actually mattered in the hospitalization process.

In the following two excerpts, patients were angry because no one tried to persuade them to be admitted to the hospital. Rather, the decisionmaker simply made it clear that the patients had no choice, implying that their internal agreement was irrelevant.

P:... Well, the police said, "Just go up there [to the hospital] and...listen to what they have to say." I wouldn't call that talking me into it, though.
I: You wouldn't?
P: I didn't have no choice.

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I: And that woman that you talked to in the jail...do you feel that she tried to talk you into being admitted into the hospital?
P: No, she just said you're going to the hospital. That's all she said.
I: She didn't try to talk you into it, she just said that this is going to happen?
P: Yeah, she said this was going to happen. She didn't try to give me any choices or any options or nothing. It was wham bam, you know.

I:...you're saying she really didn't persuade you, she just told you this was happening?
P: That's right...there was no persuading, no talking about it, no nothing; you're going to go, period. And I said, "Are you serious?" and she said, "Yes I am, you're going."

While inclusion was morally important for the patients in our sample, it never became an issue for some of them. Some patients wanted a particular outcome, and it did not seem to matter how the decision was made, as long as that outcome resulted. The degree of involvement desired seemed to depend partly on what the situation demanded.

I:... How much did you want to be the one to choose whether to be admitted?
P: It didn't have to be me. But I definitely wanted to be admitted...So that's...I don't know how to answer you.
I: Okay. So you didn't care who chose, as long as you got the right answer?
P: As long as I got in. Just wanted to get in. (pause) You know, I just wanted them to realize, "Yeah, I need help."

Occasionally, a patient actively did *not* want to be included in the decisionmaking process regarding hospitalization. These patients felt that they were not "up to" making the decision about whether they should be hospitalized, and wanted to depend on someone else to make the decision. Making a decision of any sort was more of a responsibility than the patient wished to accept.[3]

I: How much did you want to be the one to choose whether to be admitted?
P: A little. I didn't want the decision on me (laughing).
I: How come?
P: Because if I'd screwed up like at work or something...If I'd lost my job, then I wouldn't have to say, "Oh, it's all my fault." You know, I'll say, "Dr. X made me come in the hospital."...That was mainly the reason why. I was afraid of losing my job.
I:...How is that related to who makes the decision?
P: Well, if the decision isn't on me, then I don't have to pay for the consequences of that...I know it's very immature, but ...

II. Theme Two: Motivation

A second theme to emerge from our interviews was that patients' perceptions of the coerciveness of others' behavior seemed to be strongly influenced by the patient's interpretation of the others' motives. Of particular importance was whether others' involvement was judged to be motivated by an appropriate degree of concern for the patient.

Patients have different expectations of concern for different people, depending upon the role relationship between the patient and the other person.[4] The same behavior, therefore, could be evaluated and responded to quite differently depending upon who the actor was. The transcripts reveal both the patients' expectations for different categories of actors, and how the evaluation of whether those expectations were met affects patients' perceptions further.

A. Evaluation of Others' Motives

One of the most frequently mentioned ways in which others were expected to show their concern was through their willingness to become involved in the process of deciding whether the

patient should come into the hospital, particularly for people whom patients trusted and were close to. Patients might have had different reasons for wanting their family or friends' involvement, such as needing assistance in figuring out how to get help, needing emotional support, or needing approval before being able to ask for help, but whatever form the involvement of these trusted individuals took, it was taken as a sign of caring and was therefore appreciated. Two examples are:

I: How did you feel when your friend...said that he thought it would be a good idea for you to come in today?
P: I thought it was good, I thought he was being concerned.

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I: How did you feel about that? [a friend becoming involved in the hospitalization decision when the patient threatened to hurt herself]
P: I was happy. Because nobody ever cared enough about me to do that...Because he heard what I had to say. He wasn't all right with me attempting to do what I had to do. He told me my life was worth something.

Conversely, when a family member or friend whom a patient thought should be involved in the decision to be hospitalized failed to become so, or did not do so soon enough, patients were often disappointed and angered. Since involvement was taken as a sign of caring, when someone whom the patient expected to care seemed not to, it was interpreted as a breach of moral duty.

P. Sometimes she [the patient's wife] takes it too casually. Like when I'm telling her I'm hearing voices really bad and that, she'll say, "Well, just take your medication and you'll get better in a couple days." Like she don't care.

***

I: How seriously did she [a family member] consider what you had to say?
P: Well, I guess if she didn't really do anything, she didn't take it very seriously at all.
I:...Okay. How about your sister? How seriously did she consider what you had to say?
P: Oh, she must have been awful serious...She must have cared, because she went and talked to the counselor.

Involvement *per se* was less of an issue with mental health professionals, as their involvement was partially determined by their role and therefore not taken entirely as a sign of caring. But they were still expected to be motivated by what was in the patient's best interest, with perhaps a lesser degree of emotional investment being acceptable than with friends or family members.

I:...And how did being admitted to the hospital make you feel? Did it make you feel angry?
P: It made me feel like somebody cared.
I: What made you feel like that?
P: "Cause somebody cared enough to listen and want to help me. I thank the staff...Just for caring.

Indeed, it was difficult for some patients to believe that a professional who did not help them get the care they thought they needed was motivated by an appropriate degree of concern for their welfare.

P: ...I needed to be in the hospital. How come she [a counselor] couldn't make arrangements for me to come to a hospital?...I thought that's what she was there for, you know.

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P: Well, some people I think should...set there and say, "Yeah, you should go in the hospital." Like the psychiatrist, the counselors, and things like that. But they're just the opposite.
I: You wanted them to say you should come to the hospital?
P. Uh-hum (yes).

B. Effects of Evaluation of Others' Motives

Attributing the cause of another's actions to concern or caring had a powerful impact on the patients' moral evaluation of those acts. But patients' evaluations of whether others' involvement was motivated by an appropriate degree of concern also affected both patients' perceptions of the fairness of those others' behavior, and the degree to which those behaviors were likely to influence the patient's point of view regarding admission.

It was almost universally true that when a patient evaluated a family member or friend as acting "fairly," the reason given for that evaluation was that the family member or friend cared about the patient or had the patient's best interests at heart.[5]

I: And could you tell me why you think it's fair for her [the patient's mother] to try to talk you into going [into the hospital]?
P: I guess it's because she cared for me and helped me get out of the trouble I'm in.
I:...Could you tell me how come you think it [the patient's sisters' persuasion] was mostly fair?
P: 'Cause they were all there. And they were all... tryin' to get me to go. They was all tellin' me, "I love you."

The fact that the degree of concern patients expected of mental health professionals was less than that expected of people in close personal relationships with them was demonstrated by patients' apparent willingness to forgive professionals' behavior because it was "just their job." Some patients knew that mental health professionals were morally--and legally--obligated to intervene when a patient might otherwise harm him or herself or someone else, and this awareness allowed the patient to accept whatever the professionals found necessary to do to fulfill that obligation.

I: Did you feel that the [commitment] was pressure?
P: Well,...It's hard to explain because she [the doctor evaluating patient] was concerned for my safety. And I was puttin' her on the spot because if I would've left and...maybe did go out and hurt myself, she would've felt, you know, responsible...So, I...understand where she's comin' from.

Once a patient came to evaluate another's actions as motivated by an appropriate degree of concern, those actions also appeared to be more likely to influence the patient's point of view.

I: And did that [the patient's mother's suggestion] make you want to go to the hospital?
P: Yeah. Because when my mom says it's time for me to get help, then it's definitely time.

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P: That one little nurse, she come in, she even brought me somethin' to eat in the room.

I: Did that make you want to come into the hospital more?
P: Yeah, 'cause they was real nice to me, you know...Seemed like they wanted to help.

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[On why a particular doctor succeeded in influencing the patient:]
P: 'Cause...I was real mean and...I didn't hear nothin' they had to say neither, but...Somethin' about her [the doctor] just...She just like...It's like she felt what I was feelin', some kind of way. I don't know, but she did.

III. Theme Three: Good Faith

The final theme to be revealed in our interviews was that patients' perceptions of coercion appeared to be heavily influenced by their beliefs about whether others acted toward them in "good faith." Good faith was not a term used by the patients, but it seems to capture three related moral notions that were of great importance to the patients: that those who try to exert influence be qualified to do so, that they not be deceitful, and that they treat the patient with equality and respect.

A. Qualifications: Formal and Informal

Patients seemed less likely to find another's actions coercive if they believed that the others were qualified to do what they did. This held true whether the other was a family member or friend who was personally qualified by character and experience to exert influence, or was a mental health professional who was qualified by expertise. When a patient perceived another as unqualified to participate in the process of hospitalization, the patient often felt angry and coerced: someone who is unqualified should not be involved in making decisions about his or her life.

I: Okay. How about your dad? Same question. [What made it unfair for him to make you go?]
P: 'Cause he has a problem himself. He needs a counselor...It's like the pot calling the kettle black.

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P:...(He) [patient's father] actually doesn't help me, even though I probably wouldn't let him. But I just feel like, you know, since he didn't help me...I don't think he should have that right to decide...Because I don't think he fully understands how I feel.

On the other hand, the actions of people who were perceived as qualified to offer help were often accepted. In particular, recognizing a problem that others had not recognized seemed evidence enough that person was qualified to offer help and should be involved in the hospitalization process.

I: Why...do you think it [a sister's involvement] was fair?
P: Oh, she was concerned, I mean, she seen things, you know, that I didn't see.

***

P:...after I had tried to do the pills, he [the patient's father]...just snatched me up, threw my clothes on the bed and said, "Come on, you're going to Western Psych." And brought me here...
I: You didn't perceive that as force?
P: Hm-mm (no).
I: What if you wouldn't have wanted to come?
P: He probably would'a drug me here.
I: How fair do you think it was for your dad to do that though?
P: Very fair (laughing). Instead of me killing myself.
I: Okay, and why do you think it was very fair?
P: "Cause I didn't really want to die. I'm glad...that he did. You know. I could'a had brain damage or anything. I mean, you know if I'd'a took those pills.

The patient accepted his father's actions, as his father's ability to recognize the dangerousness of the situation saved his life.

B. Deceit

Though deceit on the part of others was reported only rarely in our interviews, it evoked strong reactions when it was perceived to have occurred.[6] Deceit apparently fit into no schema for morally appropriate behavior by family members or friends, or by mental health professionals, and was therefore rarely forgiven or perceived as morally legitimate.

P:...So, today she [a hospital staff member] said I was a risk because I wanna kill my husband with a gun or a knife. And they just changed it all around, you know what I mean? That's not what I said...I could've lied and said...but if you...seek a professional's help, you expect...they don't lie to you and you won't lie to them, you know what I mean?

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I: If he [the patient's father] could've...forced you in with the 302 [involuntary hospitalization] without lying, would it still be unfair?
P: Not...if he wasn't lying, no. It wouldn't...be unfair, if he was only trying to help.

A milder version of deceit can be found in cases in which others feign some activity on behalf of the patient, without being willing or able to carry through on what they suggest. In these cases, the actor was aware of the pretense and hoped, incorrectly, that the patient was not. In the first case, a staff member had gone through the motions of trying to talk the patient into coming into the hospital, but then did not wait to hear the patient's response. She immediately left the room to make arrangements for the patient's admission:

I: How fair was it for her to try to talk you into the hospital...?
P: I mean, all she said was her words and she left to make arrangements, you know.

In another case, a promise was made to the patient which was not within the power of the person making the promise to carry out. A father promised to get his son off probation if the son went into the hospital. But the son knew that was not a legitimate offer:

I: Okay. And how fair do you think that was...for him to make that offer?
P: It was...very unfair.

I: And why do you say that?
P: I knew...and I think he even knows, that he couldn't make a promise like that, you know.
I: Okay. He couldn't keep his promise?
P: Right.

C. Respect

The simple notion that patients should be treated by others with respect and, as much as possible, as equals received wide endorsement in our interviews.[7] Patients believed in a version of the Golden Rule: they wanted to be treated by their family members and friends, and by the hospital staff, as these people would wish themselves to be treated in similar circumstances. This patient's complaint was about the evaluating staff:

P:...I think it should have been my decision. And I don't think...that they have to put an order on me like some kind of animal or something. Forced me to do something that I don't really need. I mean I don't think they'd appreciate it if it was forced on them. They would be a little upset too.

Another patient explained how he expected to be treated:

P:...I used to work with the mentally retarded and counselled people. When I'm working with people, I try to step on their level and look through their eyes and see their pain, and then I try to come up with an idea of how to help them. But I think...even the first time I came here, they are too cold, too impersonal, and they turn people off. So if it wasn't involuntary...commitment, I would walk out this door.

In short, patients expected the staff to recognize them, in a morally fundamental way, as being people *just like them*, albeit people in need of help. If staff are free to do otherwise--if disrespectful behavior is seemingly institutionalized--the whole process of hospitalization may be seen as immoral and coercive.

CONCLUSION

A qualitative analysis of the transcripts of interviews with patients shortly after admission to two mental hospitals reveals that patients tend to employ heavily moralized theories of coercion, much as Wertheimer (1989, 1993) urges philosophers to do. Patients believe that they should be included as much as they wish to be in the process of determining whether they will be admitted to the hospital. They believe that those involved in the admission process should be motivated by an appropriate degree of concern for their well-being, and they evaluate the legitimacy of involved persons' actions in light of the motivations they attribute to them. Finally, patients believe that others should act toward them in good faith. The others should be personally or professionally qualified to participate in the admission process, should act without deceit, and should treat the patient with equality and respect.

When the admission process violates these moral norms--when the patient is excluded from participation in the decision about whether he or she should be hospitalized, when the actions of others appear to be selfishly motivated, or when others lack the personal or professional qualifications to intervene, or lie to or disrespect the patient--coercion may be more likely to be perceived, and resented. When these moral norms are adhered to, many apparently coercive acts seem to be accepted by the patient as morally legitimate.

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NOTES

[1] See Barham and Hayward (1991) for more on inclusion and exclusion in the lives of psychiatric patients.

[2] Relatedly, Faden and Beauchamp (1986) posit that, in contrast to coercive influences, persuasion is completely compatible with substantially autonomous action. They place persuasion and coercion at opposite ends of a spectrum of pressures.

[3] See Taylor (1989) for similar findings in the area of accepting responsibility for making medical decisions.

[4] See Dakof and Taylor (1990) for similar findings in medical setting.

[5] See Lind, Kanfer, and Early (1990) on subjective evaluations underlying fairness judgments.

[6] See also Shannon (1976); Linn (1969).

[7] See Barham and Hayward (1991) for similar findings.

REFERENCES

Barham, P., & Hayward, R. (1991). *From the mental patient to the person.* London: Tavistock/Routledge.

Campbell, J., & Schraiber, R. (1989). *In pursuit of wellness: The well-being project* (Vol. 6). Sacramento: California Department of Mental Health.

Dakof, G., & Taylor, S. (1990). Victim's perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology*, 58, 80-89.

Faden, R., & Beauchamp, T. (1986). *A history and theory of informed consent.* New York: Oxford University Press.

Hoge, S., Lidz, C., Mulvey, E., Roth, L., Bennett, N., Siminoff, L., Arnold, R., & Monahan, J. (1993). Patient, family, and staff perceptions of coercion in mental hospital admission: An exploratory study. *Behavioral Sciences and the Law*, 11, 281-293.

Lind, E., Kanfer, R., & Early, P. (1990). Voice, control, and procedural justice: Instrumental and non-instrumental concerns in fairness judgments. *Journal of Personality and Social Psychology*, 59, 952-959.

Linn, L. (1969). Social characteristics and patient expectations toward mental hospitalization. *Archives of General Psychiatry*, 20, 457-469.

Monahan, J., Hoge, S., Lidz, C., Roth, L., Bennett, N., Gardner, W., & Mulvey, E. (1993) Coercion and commitment: Understanding involuntary mental hospital admission. [Manuscript submitted for publication.]

Morse, S. (1988). A preference for liberty: The case against involuntary commitment of the mentally disordered. *California Law Review*, 70, 54-106.

National Center for State Courts (1986). Guidelines for involuntary civil commitment. *Mental and Physical Disability Law Reporter*, 10, 409-415.

Shannon, P. (1976). Coercion and compulsory hospitalization: Some patient attitudes. *Medical Journal of Australia*, 2, 798-800.

Taylor, S. (1989). *Positive illusions: Creative self-deception and the healthy mind.* New York: Basic Books.

Tyler, T. (1989). The psychology of procedural justice. *Journal of Personality and Social Psychology*, 57, 830-838.

Tyler, T. (1990). *Why people obey the law.* New Haven: Yale University Press.

Wertheimer, A. (1989). *Coercion: A working paper.* Unpublished manuscript, MacArthur Research Network on Mental Health and the Law.

Wertheimer, A. (1993). A philosophical examination of coercion for mental health issues. *Behavioral Sciences and the Law.* 11, 239-258.

17th Annual Symposium on Mental Health and the Law
March 31 - April 1, 1994

HYATT RICHMOND
Richmond, Virginia

Featured Speaker: James Ellis

Professor Ellis will discuss the legal impact of the Supreme Court's recent decision in *Heller v. Doe* on the lives of persons with mental retardation.

OTHER TOPICS INCLUDE:

Mental Illness as a Legal Disability:
Discrimination in Housing & Insurance
Mental Health Coverage in the New National Health Plan.

Workshops on:

The Civil Commitment Process
Confidentiality of Drug Abuse Records
Forensic Issues

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

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