Developments in Mental Health Law

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Housing Discrimination and the Mentally Ill: the Impact of Federal Law

by John Petrila, J.D., LL.M. *

In 1984, the American Psychiatric Association (APA) published a report on housing and the treatment of people who were homeless and mentally ill (Lamb, 1984). The APA report stressed the importance of housing in enabling people with mental illness to live successfully in the community. Prior to the report's publication, many mental health professionals viewed housing as a social welfare issue: important, but not a responsibility of treating professionals. The report effectively eliminated that distinction.

Since then, a number of studies have reaffirmed the critical role that housing plays in community-based treatment (Baker and Douglas, 1990; Fields, 1990; Ridgway and Zipple, 1990). Surveys of primary consumers of mental health services and their families consistently suggest that stable housing is often more important than mental health treatment to successful community residence (Harp, 1993; Tanzman, 1993; Tanzman, Wilson, and Yoe, 1992).

Despite the critical importance of housing, people with mental illness often have difficulty in obtaining access to it. A major obstacle to access is discrimination (Alisky and Iczkowski, 1990; Trute, Tefft, and Segall, 1990) often based on fear of people with disabilities and on concern that property values will decrease if people with mental illness move into a neighborhood (Ellis, 1992; Boydell, Trainor, and Pierri, 1989). State and municipal laws also have created barriers to housing by imposing special requirements and restrictions for the location and operation of housing for people with disabilities; the United States Supreme Court created a legal environment in which at least some restrictions might survive legal challenge by ruling in 1985 that it would review equal protection challenges to such restrictions under the "rational basis" test, the judicial test most likely to result in the upholding of governmental action (City of Cleburne, 1985).

In 1988, Congress enacted the Fair Housing Act Amend-

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ments (FHAA) in an effort to counter such discrimination. The FHAA is one of two major civil rights bills passed by Congress in recent years. The other is the Americans with Disabilities Act (ADA), enacted in 1990 and barring discrimination on the basis of disability in employment, public accommodation, transportation, and telecommunication. These statutes represent a marked philosophic change toward people with disability. The FHAA and the ADA assume that people will be able to live successful lives *despite* a disability. In contrast, the underlying paternalistic stance of traditional social welfare legislation assumes that people will be wards of the state *because* of disability (Morin, 1990).

Congress enacted the FHAA for two reasons. First, it intended to strengthen enforcement of the original Fair Housing Act of 1968, which had prohibited discrimination in housing on the basis of race, color, religion, or national origin. In a typical year, the Department of Housing and Urban Development (HUD) receives fewer than 5,000 complaints alleging housing discrimination, a figure estimated to be less than one percent of the annual incidents of housing discrimination (Recent Developments, 1989). Senator Kennedy, one of the sponsors of the FHAA, referred to the enforcement provisions of the original Fair Housing Act as a "toothless tiger." In response, the FHAA provides HUD and the United States Attorney General's Office with additional enforcement powers.

Second, Congress extended the protections of the Fair Housing Act to people with a "handicap" (the ADA uses the term "disability" rather than "handicap" though the words are given identical definitions in the FHAA and the ADA). Congress had two goals in prohibiting discrimination on the basis of handicap. The first was to enable people with disabilities to gain access to housing in the community of their choice free from discrimination, and the second was to create a "national commitment to end the unnecessary exclusion of persons with handicaps from the American mainstream," using housing as a vehicle for accomplishing this objective (Kushner, 1989; House Report, 1988).

The pertinent question six years after enactment of the FHAA is whether the statute has been implemented in a manner consistent with Congressional intent and expectations. Two recent reviews (Petrila, 1994; Schonfeld and Stein, 1994) of the judicial enforcement of the FHAA suggest that the statute, with some exceptions, has been an effective tool in eliminating certain types of discriminatory treatment. The rest of this article summarizes the emerging caselaw.

Key FHAA Provisions

The FHAA makes it illegal to "discriminate in the sale or rental, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of --(A) that buyer or renter, (B) a person residing in or intending to reside in that dwelling after it is so sold, rented, or made available, or (C) any person associated with that buyer or renter."[1] As this provision suggests, it is illegal not only to discriminate against a person with a handicap, but also against his or her associates, for example, an organization purchasing housing for people with a handicap. The FHAA covers virtually all housing sales or rentals with the exception of a private sale by a seller who owns no more than three single-family homes and sells a home without the assistance of a broker (*Michigan Protection and Advocacy Services, Inc. v. Babin,* 1992).

"Handicap" includes people with (1) a physical or mental impairment which substantially limits one or more...major life activities, (2) a record of having such an impairment, or (3) being regarded as having such an impairment.[2] This definition protects people who might face discrimination because of a past or current mental illness; it also protects people whom others

inaccurately might believe have a handicap, for example, a prospective tenant whom a landlord mistakenly believes has AIDS. Most psychiatric diagnoses would qualify as handicaps under the FHAA if they have a substantial impact on functioning. However, the "current, illegal use of or addiction to a controlled substance" is excluded from coverage, as are a number of sexual conditions.[3] In addition, a person "whose tenancy would constitute a direct threat to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others" is not covered.[4]

The FHAA bars affirmative acts of discrimination in the sale or rental of housing. It also makes it illegal to refuse to make a reasonable accommodation in rules, policies, practices, or services when such accommodation is necessary to afford a person the opportunity to reside in a dwelling of his or her choice.[5] The obligation to make a "reasonable accommodation," which has roots in the Rehabilitation Act of 1973 (and is a core provision of the ADA as well, Mancuso, 1993; Burgdorf, 1991) has become a key element in legal challenges to restrictive practices under the FHAA.

In bringing a case under the FHAA, a person may bring an action either in federal or state court within two years of the discriminatory practice. A party may also file a complaint with HUD, which has independent standing to bring a complaint. A person may file simultaneously with HUD or with a court but if HUD is conducting an administrative hearing into the complaint the judicial proceeding is stayed. In addition, the United States Attorney General may bring an enforcement action.[6] Necessary proof of discrimination is similar to that required generally in civil rights cases. The claimant must show either that there has been intentional discrimination; or that the challenged law, regulation or practice has a disparate impact upon people with a handicap or that there has been a refusal to make a reasonable accommodation. The claimant must also show that he or she falls within the statutory definition of "handicap." To date this has not been a major issue. For example, courts have often assumed that a proposed residence for people with disabilities necessarily is covered by the statute without conducting an individualized inquiry into the "handicapped" status of each of the residents. While this approach has been criticized (Schonfeld and Stein, 1994, 307-310) it appears to be reasonable given that specialized housing for people with particular disabilities will rarely be used for people without disability (an exception might be scattered apartments for people with mental illness located in an apartment complex. To date, however, no litigation under the FHAA has involved such housing).

Significant rulings under the FHAA

In deciding disputes brought under the FHAA, the courts generally have been sympathetic to claimants alleging discrimination on the basis of handicap. Judicial decisions have been particularly useful in striking down municipal and state laws which impose special requirements on the construction or location of housing for people with a handicap. The courts have also used the reasonable accommodation requirement of the FHAA to void certain restrictions. At the same time, some courts have upheld ordinances and practices which appear to create barriers to access to housing for people with disabilities but which in the courts' view are "face-neutral" ordinances establishing rules for single family dwellings. Examples of these cases are discussed below.

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In the Virginia Courts

Virginia Supreme Court Allows Malpractice Action Based on Patient/Therapist Sex

Trotter v. Okawa, ---Va---, 1994 WL 248436.

Robert Trotter sued Judy Okawa and George Washington University seeking damages for malpractice alleged to have occurred as a result of a patient/therapist sexual relationship. Trotter received outpatient treatment at the Arlington County Mental Health Center; Okawa was his individual psychotherapist working as an intern under the supervision of a licensed clinical psychologist. The provisional diagnosis of Trotter indicated that he suffered from depression and a dependent personality disorder. Okawa treated Trotter for these problems from January 1991 to June 1991.

Trotter's complaint alleged that during this period, Okawa pursued and promoted a sexual relationship with him. He claimed that she initiated contact during therapy, telephoned him at home to discuss her attraction, repeatedly visited his home, and invited him to her home where they then engaged in sexual intercourse. Trotter asserted that he participated in the sexual activity "as a result of duress, coercion, and the exploitation of his status as a mentally ill patient under the care of the defendants." In addition, Trotter contended that Okawa's supervisors at the University knew of Okawa's actions but failed to investigate, supervise or stop her behavior. Trotter alleged that he suffered severe mental trauma and incurred significant treatment expenses.

The trial court dismissed the lawsuit, characterizing the Trotter/Okawa affair as "fornication," an illegal act under Virginia law. Under Virginia precedent, plaintiffs who participate in illegal acts and are thereby injured are prohibited from later suing others for damages that their illegal conduct caused.

On appeal to the Supreme Court of Virginia, Trotter argued that the general rule of *Zysk v. Zysk* (239 Va. 32, 404 S.E. 2d 721 (1990)), that a party who consensually participates in immoral or illegal acts cannot recover from other participants for the consequences of those acts, did not apply to his case. Trotter claimed that he was the victim of coercion and duress and, therefore, never legally consented to the acts. Okawa responded that Trotter did not properly allege he was legally incompetent to make his own decisions.

The Supreme Court's opinion stated that a proper interpretation of previous decisions does not require that an actor be legally incompetent before his actions can be described as "nonconsensual." The court reinstated the lawsuit, and directed the trial court to reconsider the allegations that Trotter had posed.

Two justices joined a dissenting opinion by Justice Compton questioning the accuracy of describing a therapeutic relationship as the setting for "fraud or duress":

> In the present case, a competent, adult male who claims to have emotional problems, seeks recovery in damages against a woman, who allegedly exploited his status by duress and coercion, because she persuaded him to engage in sexual activity with her. I would hold that this alleged "exploitation," which, given these allegations, is contrary to human experience, does not amount to such "fraud and duress" that will support a cause of action for damages.

In the Federal Courts

Federal District Court Grants Habeas Corpus Petition Claiming Denial of Right to Independent Experts

Tuggle v. Thompson, ---F. Supp.---, 1994 WL 256911 (W.D. Va.).

Since he was first convicted of capital murder in 1984, Lem Tuggle has contended that his conviction was the result of an unfair trial and constitutionally faulty procedures. Challenges to his death sentence have taken him to the Virginia Supreme Court three times and to the United States Supreme Court twice. Despite that court's 1985 order finding the sentence unconstitutional, Tuggle remained on death row. He recently filed his first petition in federal district court and successfully challenged the legality of his sentence.

Tuggle was convicted of rape, sodomy and the use of a firearm in the commission of the murder of Jessie Havens. The murder occurred less than six months after Tuggle was released following a prison term for the rape/murder of a seventeen-year-old girl. [For details of the Tuggle case, see **5 Developments in Mental Health Law 21** (January-June, 1985)]. At trial Tuggle's attorneys filed and the court granted a motion to appoint a mental health professional to evaluate Tuggle's mental condition at the time of the offense and his competence to stand trial. A psychiatrist and a psychologist informed the court that Tuggle was sane and could assist in his own defense. The court was also told that the doctors had formed an opinion concerning Tuggle's "future dangerousness."

Two weeks prior to trial, Tuggle's lawyers received a copy of the expert report. They immediately requested the appointment of an independent psychiatrist to assist the defense. The request was denied. The lawyers offered to pay for a psychiatric examination with their own funds; they also requested that Tuggle be transferred to a county jail in the community where their expert was located. These requests were denied, along with requests for an independent pathologist, serologist, ballistics expert, and forensic dentist to counter prosecution experts. Following trial, the jury delivered a guilty verdict and the state's psychologist testified in the sentencing phase of the trial, over the objections of Tuggle's counsel. At sentencing, the jury found two aggravating factors: Tuggle was susceptible to "future dangerousness" and his crime had been unusually vile. He was sentenced to death.

Tuggle appealed to the Virginia Supreme Court. While this first appeal was pending, Tuggle and five other men on Virginia's death row escaped from prison. He was recaptured before the court decided his case and affirmed the findings of the trial court. He then petitioned the United States Supreme Court for review. The Court vacated his sentence in light of its holding in *Ake v. Oklahoma*, 470 U.S. 68 (1985), and returned the case to the Virginia Supreme Court. *Ake* established a due process right for those convicted of capital crimes when evidence of future dangerousness has been submitted by the prosecution. In such cases, due process requires that expert mental health assistance be available to a defendant in preparation for sentencing.

Upon a second review, the Virginia Supreme Court attended to the *Ake* requirement by discarding the finding of future dangerousness. It nevertheless upheld the death sentence on account of "vileness" alone. This decision was rendered in spite of a concession by the Attorney General of Virginia that Tuggle was constitutionally entitled to resentencing. Tuggle's petition

for rehearing by the Virginia Supreme Court was denied. A subsequent petition for a writ of habeas corpus in the Circuit Court of Smyth County, where the crime occurred, was denied without an evidentiary hearing. Later appeals to both the Virginia and United States Supreme Courts also failed.

On a writ of habeas corpus filed in Federal District Court for the Western District of Virginia, Tuggle argued that two constitutional errors taint his conviction and sentence. First, the jury heard unconstitutional evidence about Tuggle's "future dangerousness" that inevitably prejudiced their second finding concerning the "vileness" of the crime. Tuggle's lawyers asserted that the "vileness" finding should not stand as the basis for a death penalty. The state argued that even if one aggravating factor is stricken as unconstitutional, others may stand on their own to validate a death sentence.

The court ruled that an unconstitutional process that yielded an aggravating factor and prejudiced the jury cannot be cured by attempting to guess how the jury would have ruled absent prejudice. The Virginia Supreme Court's second opinion on the Tuggle case failed to mention that Tuggle's jury had heard unconstitutional evidence, that Tuggle had been denied the chance to produce evidence to rebut the psychiatric testimony, or develop his own mitigating evidence through the required psychiatric assistance, or that the prosecution had repeatedly relied on the psychiatric evidence on future dangerousness as an argument for giving Tuggle the death sentence.

Pointing out that the Tuggle case is "apparently the only instance in Virginia legal history where the office of the Attorney General has admitted constitutional error in a reported capital case" the federal court found the violation of constitutional principles outlined in *Ake* serious enough to justify granting the *habeas* petition. The Attorney General's admission had been dismissed by the Virginia Supreme Court in a footnote as " the suggestion of a party concerning a question of law" that was not binding upon the reviewing court.

Tuggle also challenged the constitutional appropriateness of evidence gathered by state mental health examiners when they examined him without notice to his lawyers. He claimed that this procedure violated the Fifth Amendment's protection against self-incrimination since Tuggle was not told that his statements would be used against him, and absence of his lawyer violated the Sixth Amendment guarantee of assistance of counsel. Failure of the trial court to allow questioning of potential jurors on the effect of contacts they had with the prosecution and the press, as well as extensive negative and inaccurate pre-trial publicity were cited as other facts pointing to a violation of Tuggle's Sixth Amendment right to an impartial jury.

The court ruled that since the state mental health examination of Tuggle exceeded the areas ordered by the trial court, defense counsel was given no notice of this examination, and the waiver form Tuggle signed was misrepresented to him, relinquishment of his rights could not have been knowing and voluntary. Additionally, the court found that the evidence available at trial was inadequate as a foundation upon which to base a conviction for rape.

Inaccurate pre-trial publicity concerning Tugggle's previous criminal history and the "public pressure surrounding this notorious case" were cited as the likely explanation for the jury's conclusion on the rape charge. The notoriety of Tuggle's prosecution and the public sentiment it engendered were highlighted in the federal court opinion by this comment:

> Even today, almost nine years after the trial, a framed copy of Tuggle's death warrant is on display on the wall of the Circuit Court Record Room. No orders or pleadings from any other case in Smyth county history are displayed

publicly in the courthouse.

The court concluded that Tuggle's conviction was "inherently unreliable because it is the product of several violations of his constitutional rights." Tuggle's petition for writ of habeas corpus was granted and an order was issued that Tuggle must be retried or released within six months. The Virginia Attorney General's office will appeal the ruling to the 4th Circuit Court of Appeals. All five other inmates who escaped from prison with Tuggle in 1984 have already been executed.

Two Decades of Pennhurst Litigation Yield Contempt Decree for Defendants

Halderman v. Pennhurst State School and Hospital, ---F.R.D.---, 1994 WL 150371 (E.D. Pa. 1994).

A class action lawsuit first filed in 1974 challenging the living conditions at the Pennhurst State School and Hospital has resulted in a contempt decree for the County of Philadelphia and the Commonwealth of Pennsylvania. Since its inception, the litigation has given rise to forty-three published court opinions, over five hundred court orders and has prompted three arguments before the United States Supreme Court. It originally attacked conditions at Pennhurst such as understaffing, overcrowding of facilities, physical abuse and inappropriate medication of residents as well as a generally dehumanizing and unsafe environment.

The district court opinion notes that the litigation is "credited widely for creating a general awareness that retarded persons do have rights." It decries the official blindness to studies that have shown the progress toward self-sufficiency developed by numerous former residents of Pennhurst who are now living and working in the community.

The litigation history spans most of the modern reform era in mental health law. A 1977 trial court ruling *(Halderman v. Pennhurst, 446 F.Supp. 1295(E.D.Pa.1977))* announced that both the Constitutional and statutory rights of Pennhurst residents had been violated. Appeal of that decision was finally settled in a consent decree in 1985 which required state and local officials responsible for Pennhurst to provide "minimally adequate habilitation" including community placement and other living arrangements for members of the plaintiff class. Failure to adhere to provisions of the consent decree led plaintiffs to file multiple actions to enforce compliance including a contempt motion against the defendants in 1987. Several years of additional delay preceded nine days of hearings in December of 1993, resulting in a ruling that the Commonwealth of Pennsylvania and Philadelphia County had "knowingly and deliberately" violated the provisions of the consent decree, and were therefore in contempt of court.

The consent decree had provided that community living arrangements must be organized for members of the Pennhurst class who would benefit from them. These arrangements, in the spirit of "normalization," would move the residents with mental retardation out of an institutional setting and into a community based and less restrictive environment. In addition, all class members were to receive such community services as necessary for minimally adequate habilitation, defined as

> the right not to be abused and mistreated, the right to care and training that will enable retarded persons to develop their capabilities and the right not to be warehoused behind institutional walls.

Each class member was entitled to an Individual Habilitation Plan with a case manager and annual review. Finally, the consent decree mandated that all persons provided with services be afforded: protection from harm, safe conditions, adequate shelter and clothing, medical and dental care, protection from physical and psychological

abuse, neglect or mistreatment, protection from unreasonable restraints and the use of seclusion, and protection from the administration of excessive or unnecessary medication.

The District Court's decision was unequivocal; it announced that the defendants had, "violated nearly every substantive provision of the Court Decree." The court found that at least 33 and as many as 55 members of the class are in large facilities despite professional recommendations, some over a decade old, that these members be placed in the community. Pennsylvania officials had been informed of these failings earlier and had taken no action to remedy the situation.

Of the Philadelphia class members, 32% had no case managers. Monitoring has been poor as well; as many as 176 class members are currently unaccounted for in the system.

Medical and dental care for the former Pennhurst residents has been similarly deficient. Some class members have been heavily medicated. Others have waited years for a visit to the dentist regarding serious dental problems. Medical records for the remaining residents are nonexistent or unintelligible.

The defendants failed to request adequate funding from the legislature to meet the obligations of the decree. Provider agencies were allowed to investigate themselves on charges of abuse or neglect of clients. The agencies have rarely, if ever, identified employees who have abused or neglected class members; this has led to further abuse. All of these deficiencies have been permitted "knowingly and deliberately," in the words of the court.

The court declined to award compensatory damages, stating that the funds would be more effective used by the defendants to properly comply with the court decree. In a separate court order the defendants were required to pay over $820,000 in Attorney's fee for the plaintiffs and expenses for the special master who oversees the consent order.

Seventh Circuit Strikes Down Aviation Agency's No Lithium Rule

Bullwinkel v. Federal Aviation Administration, ---F.3d---, 1994 WL 153613 (7th Cir.).

The Seventh Circuit Court of Appeals affirmed a challenge to a federal agency determination that anyone taking the mood-stabilizing drug lithium was not physically able to pilot an airplane. The challenge was brought in response to a Federal Aviation Administration (FAA) revocation of third class pilot's license held by a man diagnosed with manic-depressive illness.

The Federal Aviation Act requires that all airplane pilots, private or commercial, be "physically able to perform the duties" of their position. Benton Bullwinkel has held a third-class pilot's license since 1987. He received a mandatory medical certification prior to receiving the license, and has applied to renew it every two years since. In 1989, following his first license renewal, Bullwinkel began taking lithium and ritalin as treatment for "concentration problems" and "mild mood swings." He reported this treatment on application for renewal of his license in 1991. The FAA, relying on regulations issued under the authority of the Federal Aviation Act, denied to issue the necessary medical certification.

Bullwinkel petitioned the National Transportation Safety Board (NTSB) for review of his case, and it was assigned to an administrative law judge for a hearing. Evidence at the hearing clarified both the value of lithium in treating bipolar disorder (manic-depression) and the potential failures of the drug during "breakthrough periods" during which symptoms may unexpectedly reoccur and threaten a pilot's ability to handle an aircraft. Experts testifying on behalf of Bullwinkel

asserted that his illness was mild enough that he would not pose a danger in flight, and the judge concurred, ordering the issuance of an unrestricted medical certificate. The NTSB disagreed, and declined to issue the medical certificate or renew Bullwinkel's license.

Bullwinkel sued to challenge the agency determination, arguing that the "no lithium" rule was an impermissible interpretation of regulatory language. The regulation in question specifies that a license applicant may not receive medical certification if he suffers from an "organic, functional or structural disease, defect or limitation that makes him unable to safely perform the duties" prescribed under the license he seeks. Finding no problem with the regulation itself, the 7th Circuit nevertheless noted problems with the "no lithium" interpretation. The rule "addresses a medication, not a condition," the court stated. The "no lithium" rule is irrational because it may suggest "that bipolar disorder treated with lithium may be less acceptable than untreated bi-polar disorder." According to the court the FAA is actually trying to

> diagnose the underlying physical condition from the medication prescribed. In no other situation is this considered acceptable medical logic. This whole area of "disqualifying medication" has created a quagmire of illogical thinking which undermines the FAA's medical credibility.

Two judges on the three judge panel voted to remand the case to the NTSB for reconsideration, despite a third judge's dissent that condemned the conclusion as "simply pettifogging . . . since serious accidents can occur while the rule is reconsidered." The result (no license for Mr. Bullwinkel) will be the same, predicted the dissent, and the NTSB "should not be forced to redraft a rule designed to prevent aircraft tragedies merely to satisfy this Court's sensitivities."

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Cases from Other States

Falsely Accused Parent in Texas Child Abuse Case Has No Claim Against Psychologist

Esther Bird v. W.C.W. 868 S.W.2d 767 (Texas, 1994).

The Supreme Court of Texas has refused to recognize a legal claim that would allow lawsuits against mental health professionals by people other than their patients, when the claim is based on a misdiagnosis of child sexual abuse. The case arose in the context of a parental custody dispute and raised policy questions concerning the duties therapists owe to non-clients, as well as the scope of protection that is available to people who report suspected child abuse.

W.C.W. was successful in winning custody of his son following divorce proceedings with former wife B.W. in 1983. Shortly before W.C.W.'s scheduled departure to another state in 1986, B.W. reported to the child protective agency that Jarrad, the six year old son, had accused his father of sexually assaulting him. B.W. was referred to a crisis management clinic, where an interview was conducted by psychologist Esther Bird. The interview included B.W. (the mother), her common-law husband and Jarrad, the alleged victim.

The evidence presented to the trial court showed that this was the first child abuse case Bird had evaluated, and she spent only ten minutes with the child. She asked him no specific questions and administered no psychological tests. Bird interviewed the mother and her common-law husband for thirty to forty minutes. After these conversations, Bird suspected child abuse by a person called "daddy" but was unsure whether "daddy" meant the father or the mother's common law husband. A week later, and without further contact with the child, Bird's conclusions were incorporated into a sworn affidavit that stated: "I have concluded that Jarrad has been the victim of sexual abuse by his father.... It is my opinion that Jarrad's erratic, violent, and inconsistent behavior as well as outbursts of anger are a direct reaction to the trauma he experienced because of repeated events of sexual abuse by his father [W.C.W.]."

The affidavit, prepared at B.W.'s request, was submitted to the family court in an attempt to terminate the father's custody. The affidavit also became the basis for the criminal charges that were filed against W.C.W. alleging child sexual abuse.

When the criminal charges were dismissed and custody of the boy restored to W.C.W., he filed a lawsuit against Bird and the clinic where she worked. The suit demanded damage payments for past and future mental anguish, injury to reputation, lost earnings and restitution of the costs W.C.W. had incurred defending himself in both criminal court and family court.

The legal basis for W.C.W.'s claim rested on the theory that mental health professionals have a duty to parents to avoid negligently misdiagnosing a child's condition. In cases such as this, W.C.W. argued, therapists can certainly foresee the harm that can flow from a false conclusion following an inadequate examination. W.C.W. characterized Bird's evaluation of the sex abuse allegations as negligent, and offered expert testimony to demonstrate the proper level of diligence to expect from a prudent psychologist.

The Texas Supreme Court conceded that while injury is "almost certain to result" from false allegations of child abuse; it also emphasized that "[p]sychology is an inexact science" which relies on limited information of indeterminate quality. The potential right to sue a mental health professional must, the court noted, be "considered in light of

counter-vailing concerns, including the social utility of eradicating sexual abuse."

Reviewing similar Texas cases, the court could find no analogous circumstance in which a duty to third parties had been established to extend beyond the therapeutic relationship. It concluded that the lower court was correct in dismissing the suit because Bird was under no legal duty that reached directly to W.C.W. The court reasoned that

> [y]oung children's difficulty in communicating sexual abuse heightens the need for experienced mental health professionals to evaluate the child. Because they are dealing with such a sensitive situation, mental health professionals should be allowed to exercise professional judgement in diagnosing sexual abuse of a child without the judicial imposition of a countervailing duty to third parties.

A second theory of recovery advanced by W.C.W. was that Bird's affidavit was not part of her diagnostic duties, and thus constituted a defamatory statement that led to W.C.W.'s damages. But the court disposed of this argument as well, pointing out the strong public policy in favor of reporting child abuse. A judicial privilege protects communications made in the context of court proceedings, and they may not be used as the basis for damage claims, even when they later prove inaccurate.

Two justices of the Texas court concurred in the opinion, but cautioned that the decision "should not be read as conferring a grant of absolute immunity to mental health professionals." They warned that future decisions might not be so forgiving of professional negligence.

> False accusations of child abuse can be devastating: they destroy reputations, relationships, even lives. Our society faces no problem more serious than child abuse. Though we should give mental health workers in this field some latitude and protection in their efforts to eradicate child abuse, commensurate standards of professional discretion should apply, and failure to adhere to such standards could foreseeably result in their judicial recognition and enforcement.

Bond With Retarded Mother Must Be Considered in Pennsylvania Parental Rights Case

Appeal of Elizabeth M., 533 PA. 115, 620 A.2d 481 (1994).

Elizabeth M. is the mentally retarded mother of two boys, Louis and Erick. Louis has a learning disability and has been diagnosed with attention deficit disorder. Erick suffers from mental and physical retardation; his abilities both to walk and to speak are impaired.

In 1982 the family came to the attention of Allegheny County Children and Youth Services (CYS) after a report that Elizabeth had been abused by her husband. At the time of the report, Louis was one year old and Erick was two years old. While Elizabeth was living with her sons in a Salvation Army shelter, employees of CYS observed that Elizabeth did not feed her sons properly and often failed to clean the living space to which she had been assigned. She fed her children from dirty bottles of spoiled milk and left dirty diapers in their room for days. Medical care for the children was also neglected.

In 1983, the boys were adjudicated dependent and placed with a foster family. For six years Elizabeth visited her children regularly and attended remedial parenting programs, but failed to show substantial improvement in necessary child-care skills. Having left her husband, Elizabeth and a companion began living together in 1987. The companion expressed a willingness to care for Elizabeth's children but acknowledged the difficulty of raising children with special needs.

In 1989, the foster parents decided to adopt Louis and Erick. To facilitate this process, CYS filed suit to terminate Elizabeth's parental rights.

Testimony at trial included the comments of a psychologist, who testified that the children have a strong bond with their foster mother. While she had not observed the children with their foster father or their natural mother, the psychologist also testified that the children expressed an attachment for their natural mother. The psychologist stressed that evaluations of the interaction between the children and both sets of "mommies and daddies"--as they described the adults--should be conducted before a court decision. However, no further evaluations were conducted, and the trial court terminated Elizabeth's rights of parenthood.

On appeal, the intermediate appellate court affirmed the termination order. Once a parent has been deemed incompetent, the court noted, there is no need to ascertain whether a beneficial bond between parent and child exists.

The Supreme Court of Pennsylvania disagreed. It acknowledged that a finding of parental incapacity could provide adequate grounds for termination, even in the absence of affirmative misconduct. The burden of proof to prove that termination is in the interest of the children, however, is on the party seeking to terminate parental rights. The CYS would have to present clear and convincing evidence that separation of Elizabeth from her children would meet all their interests. The love and emotional bond which may exist with a parent may be an important indicator of a child's needs, and the court determined that this emotional bond had not been sufficiently evaluated. "It is clearly conceivable that a beneficial bonding could exist between a parent and child," said the court, "such that, if the bond were broken, the child would suffer extreme emotional consequences."

While the existence of some bond would not by itself stand in the way of termination, it is a factor that must be explored. The case was remanded to the trial court with orders for further evaluation of the emotional bond between Louis, Erick and their mother.

Delaware Court Orders Accommodation For Bar Examinee With Learning Disability

In re Petition of Kara Rubenstein, 637 A.2d 1131 (Del. Supr. 1994).

The Americans with Disabilities Act (ADA) mandates that no qualified individual may be excluded from the benefits of the services of a public entity by reason of a disability. Title III of the ADA specifies that examinations given for educational, professional, or trade purposes must be made available in a place and manner accessible to people with disabilities. The Department of Justice has adopted the position that Title III covers bar examinations; at least one federal court has agreed.

The Delaware Supreme Court applied similar reasoning in a case that challenged state procedures limiting the number of times an applicant for a law license could sit for the state bar examination.

Kara Rubenstein graduated from Temple University Law School and applied for admission to the Delaware Bar in 1990. The Bar examination consists of two parts: an essay section and the Multistate Bar Examination (MBE). Both sections of the examination must be passed during a single, two day testing session for an applicant to qualify for a law license. Rubenstein failed both parts of the Bar in 1990 and 1991. In 1992, she failed the essay section but passed the MBE.

From 1989 to 1990, Rubenstein clerked for the President Judge of the Delaware Superior Court. She was then granted

limited permission to practice law under a Bar rule that allows non-licensed graduates to participate in certain public programs. Under the auspices of those programs, Rubenstein served as Assistant Deputy Attorney General in Delaware's Department of Justice for two years.

After her third failure to pass the Bar, Rubenstein sought a professional explanation for the seeming inconsistency between her effective performance in court and her inability to pass the examination. An educational psychologist concluded that Rubenstein had a learning disability that affected the rate at which she processed information. Rubenstein's condition was described as linguistic, sequential processing of information and contrasted with the more common simultaneous processing of information--a skill that is of great value to people who take standardized examinations.

Applicants who fail the Delaware Bar three times must appeal to the Bar Examiners to be allowed a fourth attempt. The success of the appeal depends on whether the applicant can prove that physical, mental, or other difficulties existed when at least one of the three attempts was made, and that the difficulty has been resolved.

Rubenstein presented both the psychological evaluation report and letters from former employers as evidence of her competence as a practicing lawyer. The psychological evaluation recommended: "In order to compensate for her disability, unlimited or at least extended time should be granted for the bar examination." The Examiners agreed that Rubenstein's learning disability was a mitigating circumstance contributing to her multiple failures. Since it could not be resolved, they offered to accommodate it. Normally, each of the three essay segments must be completed in three hours--Rubenstein was allowed to use an additional hour to complete each segment. No additional time was allowed for the MBE.

On the fourth attempt, Rubenstein passed the essay portion of the examination, but failed the MBE by two points. She was again rejected for admission to the Bar. She requested certification by the Board, notwithstanding the two-point insufficiency, but her request was denied.

Rubenstein appealed to the Supreme Court of Delaware, which decided that since extra time was allowed for the essay portion of the examination, but not the MBE, the Examiners' procedures were arbitrary and unfair. The psychological evaluation had recommended no distinction between the two parts of the examination. Though the Examiners argued that accommodation was unnecessary--given the fact that Rubenstein had passed the MBE without additional time in 1992--this argument was dismissed as an inappropriate basis for the differential treatment. The court was also influenced by evidence in the form of a standardized application for those requesting accommodation on the MBE. The form was prepared by the Task Force on Disabled Applicants, a group organized by the administrators of the MBE in Delaware. It lists the choices for accommodation granted for the MBE at time and a half, double time, and over double time. In Rubenstein's case, none of these accommodations was offered.

The Delaware court concluded that fairness in this case demanded it to waive the requirement that Rubenstein pass both sections of the Bar during the same test administration. It noted that she had passed the essay section with accommodations and the MBE without accommodations in separate sittings, and that neither her character nor practical abilities were in question.

Though it emphasized that the Examiners had "attempted in good faith to comply with the evolving standards of the ADA," under these "unique and limited circumstances" the waiver operated to correct "the manifest unfairness" of the Examiners' ruling.

Minnesota Supreme Court Finds Statute Allowing Indefinite Commitment For Sex Offenders Constitutional

In re Blodgett, 510 N.W.2d 910 (Minn. 1994).

Can a person deemed a "psychopathic personality" be legally committed to a psychiatric facility for an indefinite period of time? The Minnesota Supreme Court says yes, even though this condition has no accepted medical definition and no proven treatment. The case that raised this issue involved Phillip Jay Blodgett, a twenty-eight year old man with an extensive history of violence, substance abuse and sex crimes.

The *Blodgett* case comes at an important point in the development of statutes dealing with sexual offenders. In 1990, Washington State passed a law that allows for the indefinite commitment of persons found to be "sexual predators" who have been convicted of certain sexual offenses and served their sentences or been found not guilty by reason of insanity or incompetent to stand trial. That law was recently upheld by the Washington Supreme Court [See "Supreme Court of Washington State Finds Sexual Predator Commitment Law Constitutional" **13 Developments in Mental Health Law 35**, 1993]. As of Spring 1994, Wisconsin and Florida had passed similar statutes and legislation mirroring the Washington statute was pending in several other states. Since 1990, Minnesota law has allowed for indefinite commitment of people defined as "psychopathic personalities." An average of two people per month are committed under this legislation.

The Minnesota statute, which contains civil commitment provisions for certain sex offenders, was first enacted in 1939. A psychopathic personality is defined in the law as the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of personal acts, or a combination of any such conditions, as to render such person irresponsible for personal conduct with respect to sexual matters and thereby dangerous to other persons. [Minn. Stat. § 226.10]

The 1939 law was challenged in the United States Supreme Court in the case of *Minnesota ex rel. Pearson v. Probate Court of Ramsey County Minn.*, 309 U.S. 270 (194). The *Pearson* Court limited the statute to apply only to those persons who, by a habitual course of misconduct in sexual matters, have evidenced an utter lack of power to control their sexual impulses and who, as a result are likely to attack or otherwise inflict injury, loss or pain on the subjects of their uncontrolled and uncontrollable desire.

Phillip Jay Blodgett's long history of sexual misconduct and violence began when he was 16 years old. Shortly before the end of his most recent prison term, Blodgett was evaluated pursuant to the Department of Corrections risk assessment and release procedures. Following the evaluation, which stated that Blodgett met the criteria for commitment under the psychopathic personality statute, the Washington County Attorney filed a petition for commitment. Four of the five psychologists who testified at an initial hearing stated that Blodgett met the statutory definition of psychopathic personality. Blodgett subsequently was committed to the Minnesota Security Hospital (MSH). The MSH staff filed an evaluation that Blodgett suffered from antisocial personality disorder but opposed his commitment as a psychopathic personality. At a final hearing, Blodgett moved to dismiss the proceedings on the ground that Minnesota's psychopathic personality statute is unconstitutional.

The trial court found that Blodgett

continued to meet the criteria for commitment as a psychopathic personality and that there was no reasonable, less restrictive alternative to commitment. Affirming the statute's constitutionality, the trial court ordered Blodgett committed to the security hospital for an indeterminate period of time. An appellate court affirmed the ruling. [*In re Blodgett*, 490 N.W.2d 638 (Minn. App. 1992).]

Blodgett petitioned the Minnesota Supreme Court for review. He argued that the Supreme Court's 1992 decision in *Foucha v. Louisiana*, 112 S.CT. 1780 (1992), requiring a current mental illness as justification for holding an insanity acquittee in a psychiatric facility, [See **12 Developments in Mental Health Law 4,** 1992] overruled *Pearson* by limiting the state's discretion to confine individuals under its police power. Although he may be socially maladjusted, Blodgett argued that because he was in no way mentally ill, *Foucha* provided no constitutional basis to further confine him.

The Minnesota Supreme Court disagreed. According to its reading, the *Foucha* Court decided that the state may confine (1) convicted criminals for purpose of deterrence and retribution; (2) persons mentally ill and dangerous; and (3) for a limited time in "certain narrow circumstances, persons who pose a danger to others or to the community." The Minnesota court ruled that the state's psychopathic personality statute is either a sub-set of *Foucha*'s second category (mentally ill and dangerous), or an additional category.

The court reasoned that the psychopathic personality statute was not prohibited by *Foucha* because its conditions for release met the criteria imposed by the United States Supreme Court. When Foucha's insanity (the reason for his confinement) was in remission, Foucha had to be released. Likewise, if Blodgett's sexual disorder was brought under control he would be entitled to release under the Minnesota law. The court admitted that the term "psychopathic personality" is not currently classified as a mental illness but argued that it is an identifiable and documentable violent sexually deviant condition or disorder and not a mere social maladjustment. Furthermore, while not specifically equating the psychopathic personality with a mental illness, the court found that the psychopathic personality statute was enacted with the same measure and concern as the Minnesota statute allowing mentally ill and dangerous persons to be committed. It is noteworthy that the court supported its holding by saying that the psychopathic personality is sometimes equated with the medically recognized "antisocial personality disorder" even though the Court in *Foucha* had clarified that though Foucha was diagnosed as having an antisocial personality disorder he was not suffering from a mental disease or illness that permitted confinement.

Blodgett also argued that because the psychopathic personality condition is untreatable, confinement is equivalent to lifelong preventive detention. Even though the senior staff psychologist at the Minnesota Security Hospital contended that any treatment Blodgett could receive would be "sham" or "placebo," the court said that it is not clear that treatment for the psychopathic personality never works. The court also stated that even when treatment is problematic, so long as civil commitment is programmed to provide treatment and periodic review, due process is provided.

Three justices dissented, providing a differing interpretation of *Foucha* and a discussion of issues concerning commitment and treatability that are relevant in the debate surrounding commitment laws similar to Minnesota's and new laws patterned after Washington State's "sexual predator" law. The *Foucha* ruling, noted the dissent, "compels the conclusion that the Minnesota Psychopathic Personality Statutes . . . are violative of the Fourteenth Amendment and,

therefore, unconstitutional."

The dissent did not recognize either the sub-set to the mentally ill and dangerous category or the additional category that the majority appended to the three allowable means set out by *Foucha* for a state to confine a person. Applying the three categories listed in *Foucha* to Blodgett's case, the dissent argued that Blodgett's commitment does not fit any of them. First, Blodgett's commitment was not a criminal conviction for which a person could be imprisoned. Second, Blodgett is not mentally ill. Finally, because Blodgett's commitment is not limited in duration, nor does the duration of the confinement bear a reasonable relation to the purpose for the commitment, Blodgett's commitment under the Washington psychopathic personality statute is prohibited under *Foucha*.

The dissenters also pointed out that Blodgett bears the burden of proving he is no longer in need of inpatient treatment before he can be released. The psychiatrists charged with treating Blodgett say there is no treatment for an antisocial personality disorder. Blodgett may never be able to meet his burden of proof.

The dissent concluded with language from *Reome v. Levine*, 692 F.Supp. 1046, 1051 (D. Minn.1988): "Confinement based on what amounts to a propensity for dangerousness unrelated to mental illness and for which no treatment is required 'is nothing more than preventive detention, a concept foreign to our constitutional order.'" The public safety interest of the state need not tread on constitutional limitations, but may be vindicated by ordinary criminal processes, the use of enhanced sentences for recidivists, and other constitutionally permissible means.

Blodgett raises an important question. If the state can legislatively create a mental illness which has no accepted medical definition nor treatment and then commit dangerous individuals who meet the legislation's criteria, are all potentially dangerous social deviants subject to indefinite incarceration?

by John Kitzmann

. . . *Housing Discrimination*

- continued from page 3 -

Special Rules for Housing for People with Disabilities

Some municipalities have established physical plant requirements for housing for people with disabilities based on the assumption that such requirements are necessary for the safety of residents. For example, the city of Stow, Ohio, would not grant a permit for a home for people with mental retardation until the operator installed special safety doors and lighting, as well as fire walls and flame retardant wall coverings. A federal court of appeals upheld a district court ruling invalidating these requirements because they were based on an assumption that *all* people with a handicap required such protections (*Marbrunak v. City of Stow*, 1992). The court required an individualized assessment of need, noting that the city had not shown that the special requirements were "warranted by the unique and specific abilities" of individual residents. A court reached a similar result in *Cason v. Rochester Housing Authority* (1990). The housing authority required that applicants for public housing who had a mental illness diagnosis be screened in advance by caseworkers to determine their ability to live independently. The court invalidated the requirement and its application to three individuals diagnosed as schizophrenic who had been denied housing after the screening. The court found the requirement had a disparate impact on people with a handicap because no other individual had to undergo screening. The

court characterized the screening as resulting from "unsubstantiated prejudices and fears regarding those with mental and physical disabilities."

Other municipalities and states require public notice and hearing before a permit will be granted for housing for people with disabilities. At least two courts have invalidated such requirements. In *Ardmore v. City of Akron* (1990), a federal court ruled that an ordinance requiring a public hearing before a permit would issue for a home for people with mental retardation was illegal. Similarly, a federal court in Maryland invalidated a notice rule which required the operator of a proposed home to send a written notice to each neighboring property owner, as well as to neighborhood civic organizations (*Potomac Group Home Corporation v. Montgomery County,* 1993). The notice had to describe the proposed home as well as identifying the type of "exceptional person" who would reside there. The court ruled that the requirement was invalid on its face.

A third type of differential treatment involves state laws requiring that residences for people with disability be placed a minimum distance from similar residences. With at least one significant exception, such requirements have been stricken because they are not imposed on other types of residences. For example, in the Ardmore case noted above, the court upheld a challenge to an ordinance requiring that group homes be separated by at least 2,000 feet. In another case (*United States v. Village of Marshall,* 1991), a court ruled that the village as a reasonable accommodation had to permit the siting of two homes that were 1619 feet apart, despite a state law requiring group homes to be at least 2500 feet apart. (See also *Horizon House Development Services, Inc. v. Township of Upper Southampton,* 1993). However, at least one court has upheld denial of a permit to the operator of a home challenging a state law requirement that community residences be separated by at least 1320 feet (*Familystyle of St. Paul, Inc. v. City of St. Paul,* 1991). In this case, the court reasoned that "dispersal legislation" was necessary to avoid the segregation and clustering of homes for people with mental illness. The court also found it significant that the operator already operated 21 group homes in the one and one-half block area in which it proposed to place three more homes. The court's ruling on its face conflicts with the FHAA. However, it may be that the ruling is explicable by the underlying facts of the case, coupled with judicial endorsement of a legislative policy designed to provide integrated rather than segregated housing in furthering deinstitutionalization. Other commentators disagree, arguing that "because persons who are not handicapped are permitted to 'cloister themselves and not interact with the community mainstream,' persons who are handicapped should have the same right." (Schonfeld and Stein, 1994, p. 328-329).

Reasonable Accommodation

The courts have applied the reasonable accommodation requirement to cause municipalities to eliminate restrictive ordinances or criteria for obtaining a permit which blocked access to housing for people with disabilities. For example, in the *United States v. Village of Marshall* case referred to earlier, the court directed that a state and municipal rule requiring residences to be a certain distance apart not be applied as a reasonable accommodation when the court found that permitting the challenged residence would further state policies favoring community housing for people with mental illness. In *Parish of Jefferson v. Allied Health Care* (1992), a provider sought to convert two duplexes to a home for six adults. The municipality denied a permit because of a local ordinance permitting only four unrelated adults in a single-family home; the municipality argued that the provider's conversion plan effectively made the two duplexes a single home thereby falling within the ordinance. The court directed that the municipality void application of its ordinance as a reasonable accommodation in this case, in order to permit

people with disability to live in the community.

At the same time, other courts have rejected a reasonable accommodation argument in addressing maximum-occupancy arguments. In *Elliott v. City of Athens, Georgia* (1992), a split federal court of appeals upheld a local ordinance which barred more than four unrelated adults from living in single-family homes near the University of Georgia. The court rejected an argument by a provider wishing to create a home for 12 recovering alcoholics that the ordinance should be waived as a reasonable accommodation.

In a similar case, a federal court in Virginia rejected an argument that a provider wishing to establish a home for more than four unrelated adults should be exempt from a local zoning requirement that a conditional use permit be obtained (*Oxford House, Inc. v. City of Virginia Beach,* 1993). The provider argued that the permit process itself violated the FHAA because its public nature potentially exposed people with a protected handicap to discrimination. The provider also argued that the process should be waived and approval for the home granted as a reasonable accommodation. The court found for the City on the ground that the FHAA did not require the suspension of all face-neutral zoning ordinances, and because in the court's view the plaintiffs had shown neither discriminatory impact nor intent.

The decision in *City of Virginia Beach* has been criticized as "disingenuous and in conflict with the drafters' intentions of the FHAA" (Schonfeld and Stein, 1994, at 324). However, this decision, and that of the court in the *Elliott v. City of Athens, Georgia* case, suggest that at least some courts will be cautious in approaching claims that apparently neutral zoning ordinances inevitably must give way before challenges under the FHAA.

Summary

This brief summary of the FHAA and representative court rulings implementing it to date suggest that the FHAA has become an important tool in challenging restrictions to access to housing for people with disabilities. The reviews by Petrila and by Schonfeld and Stein noted earlier provide more detailed analysis supporting this conclusion. It is worth noting that many of the cases decided under the FHAA address restrictions created by government--municipal safety requirements, maximum occupancy rules, special use permit processes, and notice and hearing requirements all have been subject to challenge. This confirms what many providers of housing for people with disabilities already know; the stereotypes held by individuals are often reinforced in both overt and subtle ways by government action.

The courts have been very receptive to many of these challenges, and have been consistent in voiding rules and requirements that overtly differentiate between people with handicaps and other citizens. One may also anticipate that facially neutral rules and processes will continue to be challenged, with mixed results. However, despite occasional losses, the FHAA and the growing caselaw enforcing it should be known to every provider of housing for people with disability and to every advocacy group. The FHAA represents with the ADA a fundamental change in the legal landscape for people with disabilities, and these statutes will only grow in importance in the future.

NOTES

1. 42 USC Section 3604 (f).
2. 42 USC Section. 3602 (h).
3. 42 USC Section 3602 (h).
4. 42 USC Section 3604 (f) (9).
5. 42 USC section 3604 (f) (3) (B).
6. See generally 42 USC section 3613 (a) (1) (A); 42 USC section 3610 (g) (2) (A)-(C).

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ESSAY

Lorena Bobbitt, "Moral Mistakes" and the Price of Justice

by Richard J. Bonnie, LL.B.

I.

On March 29, 1994, a story appearing in the *Washington Post* began as follows:

INSANITY DEFENSE: NOT A RIGHT
IN MONTANA CASE, JUSTICES GIVE STATES OPTION TO PROHIBIT CLAIM

The Supreme Court yesterday allowed states to prohibit defendants from claiming that they were insane at the time they committed their crime.
The court, without comment from the justices, let stand a ruling from the Montana Supreme Court that said abolishing the insanity defense does not violate the Constitution.

This sounds like an important story. But it wasn't. In fact, the Court's action was hardly newsworthy at all. The Justices simply denied certiorari. In other words, the Court decided not to hear the case. This is not a decision on the merits. The Court did **not** pass on the constitutionality of the Montana statute. In fact, the Court's decision has no precedential value, as even the *Post* article noted in the second paragraph of the story:

While the Court's order does not apply beyond the individual case, other states could follow Montana's lead.

Of course they could. They could have done so since 1979 when the statute was enacted. But only two more states (Idaho and Utah) did.

The *Post* story makes it seem that states were lined up to abolish the insanity defense, just waiting for the Court to say it was O.K. But they weren't. I doubt that there is an abolitionist bill pending anywhere in the country. This "news" is entirely contrived: The Court didn't say anything and no one was listening anyway.

The real story here is why the *Post* treated this non-story as if it were a real story. The *Post* wasn't alone. This non-story made it onto the evening news of CBS and ABC (I didn't watch the others). Maybe the press is confused about the meaning of the Court's decision. The media often make something of denials of certiorari and occasionally a cert denial is newsworthy. But the more likely explanation is that the news media are expressing and reflecting what they perceive to be deep public dissatisfaction with the insanity defense.

And why is the public dissatisfied with the insanity defense or so perceived? You know the answer. It can be found three paragraphs later:

While the defense is rarely invoked, it has arisen in numerous high-profile trials. Most recently, Lorena Bobbitt used the insanity defense to persuade a jury to acquit her of charges related to cutting off her husband's penis.

II.

I did not watch the Bobbitt trial, so I hesitate to express any judgment about the clinical evidence or the verdict. But, based on conversations with my colleagues, I will be bold.

Lorena Bobbitt's trial can be interpreted at two levels. At one level, it can be analyzed as a standard insanity adjudication. This assessment would focus on whether she was mentally ill at the time of the offense and, if so, on how any clinical disorder she had may have affected her conduct. I gather that the experts on both sides agreed that she had been traumatized by her husband's behavior and that she was distraught and depressed. But distress and depression do not provide a clinical basis for an insanity defense. A defense of insanity requires a severe mental disorder with psychotic manifestations. On this issue, the testimony of the experts diverged, with the defense expert supporting the claim that she was psychotic at the time of the offense and the prosecution witnesses rejecting this formulation.

If the case is interpreted at this level, it can be subjected to a fairly standard critique. That is, the questions would be those that should be asked about any contested insanity adjudication: Why did the experts disagree? Was there a reasonable difference of clinical opinion? Was one opinion implausible? In cases of acquittal, did the jury make what I call a "moral mistake"? If so, why?

These are interesting questions, but they are not the ones I want to address here. I want to address the subtext of the Bobbitt adjudication. The case was packaged as an insanity case, but it was really about something else. Beneath the dispute about her mental condition was a story about John Bobbitt's provocation and her rage and, in the final analysis, about whether she can fairly be blamed for retaliating against him.

How one reacts to Lorena Bobbitt's acquittal depends on which story one thinks is the real story. Was the conflict with her husband the situational context for Lorena's mental illness? Or did the evidence of mental illness provide cover for a claim that was about rage and retaliation in a dysfunctional marriage? In my view, the social meaning of Lorena Bobbitt's acquittal can only be understood from this second perspective. From this perspective, her acquittal was a "moral mistake." The law doesn't--and shouldn't--exculpate people who hurt other people because they were enraged, even if they were cruelly provoked. And the law doesn't permit people to strike back at their tormentors unless they need to do so to protect themselves. Perhaps John Bobbitt had it coming but the fact that "he deserved it" is not a defense. From this perspective, Lorena Bobbitt had no legal defense.

But, as the *Post* story said, she was able to "use the insanity defense to persuade the jury to acquit her . . . ." The insanity defense allowed her to put in evidence the history of abuse and, in effect, to put John Bobbitt on trial for a second time. The bottom line is that the insanity defense was used as an instrument of jury nullification.

Lorena Bobbitt's case is unique in many respects, to say the least. But from the perspective of history, it can be assigned to a somewhat larger class of insanity acquittals. I said before that it was used as an instrument of nullification. This shows that I don't agree with the verdict. But I can make the point in a more neutral and temperate way. The insanity defense occasionally serves as a "safety valve" for legally unrecognized claims of situational excuse. The classic cases involve euthanasia.

In one publicized case in New Jersey about twenty years ago, a twenty-three year old man shot his dearly-loved elder brother who had been irreversibly paralyzed in a motorcycle accident. The victim, who was in severe pain, begged his brother to kill him. Three days after the accident, the defendant walked into the hospital and asked his brother if he was still in pain, and

his brother nodded that he was. The defendant then said: "Well, I'm here today to end your pain. Is that all right with you?" His brother nodded and the defendant said: "Close your eyes, George. I'm going to kill you." He then placed a shotgun against his brother's temple and pulled the trigger.

Anglo-American law has never regarded mercy killing as justifiable homicide, although the matter has not been free of moral controversy. The law does not recognize a claim of situational excuse in such a case. So what did the defendant do? He pleaded insanity. And what did the jury do? They acquitted by reason of insanity.

An outlet for nullification is not such a bad thing, as long as it doesn't happen too often, and as long as juries don't stray too far outside the moral boundaries of the criminal law. But there is a danger of this, especially if the idea catches on that cases of rage and retaliation can be repackaged as claims of mental disorder.

Is the danger of moral mistake and of nullification so great enough that we should abolish the insanity defense? Emphatically not. The insanity defense is essential to the moral integrity of the criminal law. It is rarely invoked and is successful in only a small fraction of the cases in which it is raised. And an occasional moral mistake is the price we must pay to achieve humane justice in the administration of penal law.

Lorena Bobbitt's acquittal does not appear to have aroused public sentiment against the insanity defense. But John Hinckley's did. And in 1983 the insanity defense **was** in danger. The Reagan Administration initially supported abolition and the Montana approach was on the table in every state, including Virginia. It was in this context that a task force was appointed by Secretary of Human Resources Joe Fisher. The task force recommended that the defense be retained but narrowed to eliminate the "irresistible impulse" test, a view that happens to be in accord with my own.

Ultimately, the General Assembly concluded that the law should be left unchanged on the perfectly sensible ground that "if it's not broke, don't fix it". Well, it's still not broke and abolition is still a bad idea. The occasionally controversial verdict is to be expected. From time to time there will be moral mistakes. Lorena Bobbitt's trial may have been such a case. But it is an aberrant case.

III.

As I noted earlier, Lorena Bobbitt's acquittal is less about insanity than about retaliation against abuse. In the wake of the Bobbitt verdict and the Menendez verdicts in California, the prevailing media hypothesis was that these verdicts reflected a reservoir of public sympathy for victims of abuse and perhaps a greater public willingness to lessen punishment in cases involving claims of excuse rooted in emotional distress.

I believe this hypothesis is false. For one thing, two aberrations do not amount to a trend. Second, California is not like the rest of America. Third, there is much counter-evidence regarding the punitiveness of public attitudes. But the notion persists that jurors will forgive the alleged victim of abuse for almost anything. This idea turns up everywhere. Consider this: *Time* magazine did a story in its March 28 issue on the plea bargain in Tonya Harding's case. One theme of the story was that Tonya made out pretty well -- no jail time, and the opportunity to collect $300,000 for talking to ABC's "Inside Edition", and another large sum for selling the rights to her story. In response, the prosecutor emphasized Harding's felony conviction, and other punishments imposed on her as well as the fact that the state was saved the cost of a lengthy trial. And then *Time* added this:

> *Perhaps not coincidentally, [the plea bargain] will spare [the prosecutor] the task of mounting a counterattack to Harding's expected battered-wife argument -- a line of defense that finds increasing sympathy among juries.*

This is silly. It implies that battered women have a general excuse for almost anything they do, and that jury sympathy has displaced the norms of the criminal law whenever a battered woman is put on trial. There is no evidence to support this hypothesis. There is a story to tell here, but it is a much more modest one. Let me summarize it for you.

About fifteen years ago, attorneys representing battered children and spouses charged with killing their tormenters sought to introduce evidence of the abuse and its psychological consequences in support of claims of self-defense. After a period of uncertainty, most courts allowed such evidence to be admitted because they properly recognized that the necessity for defensive action should be judged from the perspective of the abused victim, rather then from the perspective of a neutral bystander. The questions often asked of the defendant in such cases were "Why didn't you leave when you had the chance?" "Why didn't you call the police?" "Why did you kill when there was no danger of imminent attack?" The evidence of abuse and its traumatizing consequences was designed to answer these questions, to show why the defendant felt that she was trapped and had no alternative and why she may have believed that pre-emptive action was necessary.

Justice requires the door to be opened to such testimony, just as justice requires that the door be opened to claims of insanity. Trial courts were told to let the defendants introduce such evidence when relevant to claims of self-defense. In admitting evidence of clinical syndromes experienced by abused women and children, the courts recognized that there are risks and dangers in this practice. The main one is that the jury will lose sight of the **legal** relevance of the evidence and will be swayed by sympathy for the defendant. More pointedly, the danger is that claims that the defendant acted in self-defense will be transmuted into claims that the victim had it coming to him, and that he deserved what he got.

In short, the price of opening the door to just claims of self-defense by battered women and children is that the jury will misunderstand the evidence, or that it will nullify the law. Judging from the jurors' comments, this may have been the problem in the Menendez case. But I see no evidence that there has been an epidemic of moral mistakes in the adjudication of self-defense claims by women and children prosecuted for killing or wounding their abusers.

So we come back to the main point of my comments. Occasional instances of nullification and moral mistake represent the price we must pay to achieve humane justice. The price has not been too high for the insanity defense or for subjective standards of self-defense in abuse cases. We should not be misled by exaggerated claims to the contrary in the press.

[Richard J. Bonnie is the John S. Battle Professor of Law and Director of the Institute of Law, Psychiatry and Public Policy. This commentary was originally presented at the 17th Annual Symposium on Mental Health and the Law March 31, 1994 in Richmond, Virginia.]

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The Prevalence of Sexual Offenders Among Mentally Retarded Criminal Defendants

By Gary L. Hawk, Ph.D.,
Barry D. Rosenfeld, Ph.D.,
Janet I. Warren, D.S.W.

The types of criminal offenses for which mentally retarded individuals are charged has seldom been the subject of empirical investigation. The prevalence of mentally retarded sexual offenders, in particular, remains unclear although the issue generates significant public concern as well as treatment challenges for professionals (1,2,3). Published estimates of retardation among sexual offenders vary considerably, with some authors reporting that retarded individuals are not over-represented among sex offenders (1). Others have suggested that sexually deviant behavior may be more common, or at least identified more often, among the mentally retarded population (2). Much of the research on mentally retarded sex offenders, however, has relied on data generated from subjects already incarcerated in prison (1,4,5). These data do not account for the substantial proportion of retarded individuals charged with a criminal offense, for example, who are considered incompetent to stand trial and are subsequently diverted away from the criminal justice system (6). Thus, data regarding the prevalence of retardation based upon incarcerated samples may substantially underestimate the true prevalence of sex offenses among retarded persons.

More accurate estimates of the proportion of sex offenders who are developmentally disabled may be obtained by analyzing pre-trial forensic evaluations. Evaluations of a subject's competence to stand trial and mental state at the time of the offense (criminal responsibility) are typically sought before plea bargaining or other diversionary procedures are initiated. Although impaired intellectual functioning, or the presence of a serious criminal offense, often prompt a forensic evaluation, the proportion of retarded defendants who are referred for evaluation is still likely to be an underestimate of the true prevalence of retardation among crimi-

Also in this issue:

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The true prevalence of mental retardation among criminal defendants is likely to be underestimated.

nal defendants. Retarded defendants who cooperate with their attorneys or actively disguise their disabilities may not be identified as developmentally disabled (7,8). Nevertheless, a recent study of 103 pre-trial evaluations performed at a Michigan forensic facility revealed a disproportionately high rate of sex offenses among mentally retarded subjects, with sex offenses accounting for 35 percent of retarded defendants and only 10 percent of normal IQ defendants sampled (9).

Our study uses data gathered over a six year period through a statewide forensic evaluation system. We examine the relationship between mental retardation and criminal offense patterns, and in particular, the prevalence of mental retardation among individuals charged with a sex offense.

Method

In 1981, the state of Virginia implemented a statewide forensic training program to enable community clinicians to perform outpatient forensic evaluations (6). In 1985, the state began requiring clinicians to submit a forensic information form with their request for reimbursement. Since that time, these forms have been completed on most forensic evaluations performed in the state.

The 4,485 forms submitted between July 1, 1985, and June 30, 1991 included such data as the offense for which the defendant was charged, *DSM-III* (and *DSM-III-R*) diagnosis, and psycho-legal opinions of the clinician. Diagnoses were recorded in 60 percent of the cases (2,701 of 4,485) and an offense was recorded in 96 percent (4,302 of 4,485). The analyses below are based on the 2,536 cases in which both diagnostic and offense data were available.

For this study, offenses are grouped into six categories: homicide, crimes against people (i.e., robbery and assault), sex offenses, property crimes, public order offenses (i.e., trespassing and obstruction of justice) and all others (i.e., drug offenses and concealed weapons). In further analyses, crimes are grouped into six broader categories in order to compare retarded and non-retarded subjects charged with a sex offense. These categories include felonies versus misdemeanors, violent versus non-violent crimes, and crimes against adults versus crimes against children.

Chi square analysis and *t* tests are used here to compare mentally retarded defendants with defendants who were not diagnosed as having mental retardation.

Results

Analysis of the relationship between mental retardation and criminal offense revealed significant differences in the rates of various offenses ($p < .0001$, $\chi^2=32.1$, $df=5$). As Table 1 shows, 8.2 percent of those persons evaluated were diagnosed with mental retardation, including those subjects dually diagnosed with mental retardation and mental illness. Mentally retarded defendants accounted for only 3 percent of all homicides and 4 percent of all public order offenses, but over 13 percent of all sex offenders were mentally retarded.

The rate of sex offense charges was nearly twice as high among mentally retarded defendants as among non-mentally retarded defendants (26 percent versus 15 percent; $p < .0001$,

Table 1
Prevalence of criminal offenses among mentally retarded and nonretarded defendants referred for forensic evaluations over a six-year period. (Includes only cases in which the offense charged and clinical diagnosis were recorded.)

Offense category	Mentally retarded (N=209)		Not mentally retarded (N=2,327)		Total (N=2,536)	
	N	%	N	%	N	%
Homicide	6	3	163	7	169	7
Crimes against people	43	21	577	25	620	24
Sex offenses	54	26	347	15	401	16
Property crimes	76	36	682	29	758	30
Public order offenses	8	4	189	8	197	8
Other offenses	22	11	369	16	391	15

χ^2=16.5, *df*=1). Mentally retarded defendants were also younger (mean age=27.9 versus 32.3 years; $p < .001$, *df*=1, *t*=5.36) and less likely than non-retarded defendants to have been previously hospitalized for psychiatric reasons ($p < .0001$, χ^2=15.3, *df*=1). Less than half of all mentally retarded defendants (38 of 83) had been previously hospitalized, compared with more than two-thirds of non-mentally retarded defendants (699 of 1043). Data on prior hospitalizations and criminal convictions were not collected until 1989, and are therefore available on only a subset of the total sample.

Mentally retarded sex offenders were less likely to have previous convictions than those mentally retarded offenders charged with other offenses ($p < .05$, χ^2=5.8, *df*=1). Only 38 percent of retarded sex offenders (8 of 21) had been previously convicted of a criminal offense, while 65 percent of retarded offenders charged with other crimes (33 of 51) had previous convictions. However, no significant differences emerged between retarded and non-retarded sex offenders in the nature of their crimes (felony vs. misdemeanor, violent vs. non-violent, against adults vs. children).

Discussion

Several methodological limitations of this study should be discussed. First, the under-identification of mental retardation among criminal defendants has been repeatedly noted by mental health and legal scholars, and the distribution of criminal offenses among retarded defendants who are not identified during adjudication is unknown (8,9). However, under-identification of mental retardation among sex offenders may be less problematic because defendants charged with a sex crime are frequently referred for evaluation due to the perceived deviance of the offense.

The method used to determine clinical diagnosis also qualifies these results. Data from over 400 different clinicians throughout the state of Virginia are included in the study. The accuracy of assigned diagnoses is unknown and no means exist to ascertain their reliability. However, these diagnoses likely were made cautiously and conservatively, because the

-continued on page 42-

In the Virginia Courts

Virginia Supreme Court Upholds Blue Cross's Right to Determine "Medical Necessity" of Treatment

Blue Cross and Blue Shield of Virginia v. Keller
248 Va. 618, 450 S.E. 2d 136

Blue Cross acted within its contractual rights when it refused a psychiatric patient full compensation for her treatment at Saint Albans Psychiatric Hospital, according to the Virginia Supreme Court. The judgement reversed a lower court ruling in which a jury found Blue Cross in breach of contract and awarded Katherine Keller the remainder of the payment in question. In its opinion, the Supreme Court denied that the insurance company's medical necessity review criteria were insufficient or that it abused its discretionary rights because it did not require reviewing physicians to examine the patient.

Dr. Orren Royal treated Keller for clinical depression from 1984 to 1990. He admitted her to Saint Albans on June 8 of that year because her depression had worsened, and he concluded that she was likely to commit suicide. Keller eventually left the hospital on September 28.

Keller participated in the group health insurance plan for Virginia state employees and their family members underwritten and administered by Blue Cross. The Blue Cross plan allowed up to 120 days of inpatient care per year, but also stipulated that it would not cover services "determined not to be Medically Necessary by the Plan, in its sole discretion, for the treatment of an illness." If it denied coverage, the policy allowed the treating physician to request a peer review to evaluate the necessity of treatment.

Blue Cross had initially approved Keller's treatment only through June 13, but through three peer reviews, extended coverage for treatment through July 16, then July 19, July 23, and finally, August 1, covering about half of Keller's stay. Royal later applied for retroactive approval of the treatment beyond that date, but Blue Cross denied the appeal.

Keller sued Blue Cross, alleging a breach of its contract. Royal testified for Keller that her treatment at Saint Albans had indeed been necessary the entire time of her stay. Royal acknowledged Blue Cross's contractual right to conduct medical necessity reviews. However, he questioned the wisdom of such a practice and stated his belief that it is "unprofessional" and "almost unethical" for reviewing physicians to form judgements without personally examining the patient.

Dr. Paul Mannsheim reviewed Keller's entire case after litigation began and testified for Blue Cross. He stated that the usual treatment period for Keller's diagnosis was 10 to 21 days, that she showed signs of improvement and could have been treated as an outpatient after August 1, and that no suicide precautions appeared to have been taken for her after that date, even though Keller reported suicidal feelings two weeks before her discharge. Mannsheim testified that hospitalization is necessary only when patients are an imminent threat to themselves or others, or when they require potentially hazardous treatments such as electroshock. Although he had never met Keller, Mannsheim claimed that his lack of contact actually aided his judgement in the case, and suggested that long term therapeutic relationships can cause treating psychiatrists to lose their objectivity.

At the trial's conclusion, Blue Cross moved to dismiss the case, arguing that Keller had not proven a breach of contract. But the court refused, and a jury awarded $30,843 to Keller. On appeal to the Virginia

Supreme Court, Blue Cross again argued that Keller's evidence was insufficient to prove her allegations. The company acknowledged that its discretionary rights dictated responsible handling of reviews, but denied that it had been irresponsible or had abused those rights. Keller relied primarily upon Dr. Royal's testimony that the Blue Cross review process was "unreasonable."

The Supreme Court reversed the lower court ruling and entered final judgement in Blue Cross's favor. The Court decision noted that the company had elaborated and clearly articulated a set of well-defined criteria for its medical necessity reviews, and that Keller, through Dr. Royal's peer review requests, availed herself of the policy's appeals process and was granted extended coverage. Although none of the reviewing physicians ever met with Keller, the Court pointed out that Royal's own examinations and evaluations of Keller were considered in the review process. As a matter of law, the Court found that Keller's arguments did not raise questions sufficient to warrant jury deliberation, and that Blue Cross had acted within its contractual rights of discretion, leaving Keller responsible for the contested costs.

Court of Appeals Overturns Rape Conviction Based on Confession in Court-Ordered Therapy

Husske v. Commonwealth of Virginia, 448 S.E. 2d 331 (Va. App.)

The Virginia Court of Appeals reversed the conviction of Paul Josef Husske for forcible sodomy, rape, robbery, and breaking and entering with intent to rape, ruling that Husske's incriminating statements to a mental health counselor were barred by the constitutional privilege against self-incrimination.

In June 1990, an unidentified man broke a window and entered a woman's apartment. After striking the victim in the head and face, the intruder raped and robbed the woman. Although the victim heard the intruder's voice and saw enough of him to conclude that he was a Caucasian male, she could not identify him by sight. After the attack, the police retrieved fluids suitable for genetic testing from a cervical swab of the victim and from a stain on her skirt.

Four months after the assault but before an arrest was made, Husske was observed near the apartment complex where the assault occurred. Police arrested Husske, who on the advice of his attorney, contacted the County of Henrico Area Mental Health and Retardation services for treatment of depression, suicidal inclinations and the conduct related to his "peeping Tom" arrest. At that time, Husske was admitted to a hospital psychiatric unit and given antidepressant medication.

Two weeks after his arrest, Husske pleaded guilty to two charges of furtively peeping into dwellings. The judge sentenced Husske to twelve months in jail for each charge but suspended the sentence on the condition of Husske's future good behavior and five years of monitoring by the Community Diversion Incentive Program (CDI). A CDI worker was appointed to monitor Husske's progress and to file an evaluation with the court.

A week after sentencing, Husske signed a release form authorizing the exchange of information between CDI and the County of Henrico Area Mental Health and Retardation Services. Dr. Michael Elwood, his therapist there, agreed to notify CDI if Husske refused to comply with his treatment plan.

After more than a month of therapy, Elwood asked to include Husske's wife in therapy sessions. During one session, both Elwood and Husske's wife pressed Husske to explain more about "what's going on and what's troubling you." Husske responded

that he had committed one rape and attempted others. At a later session, Husske provided more detail concerning the rape he had completed, including when, where, and how he accomplished it.

When Dr. Elwood recommended that Husske be screened by the sex offender's group conducted by Mental Health Services, Husske expressed fear of legal consequences but nevertheless provided details of the attempted rapes and the completed rape. During one of the screening sessions he related details that matched the rape incident a victim had reported to the police five months earlier.

Husske was rejected for admission to the sex offender's program. The program's report stated that he should "be required to account for his crimes even if it causes him to risk himself." Dr. Elwood told Husske that in order for his therapy to be successful, he would have to tell his CDI monitor the extent of his sexual offenses. Husske reported to his CDI monitor but fearing legal consequences, omitted the details of his crimes. Dr. Elwood, however, told Husske's CDI monitor of Husske's admissions in therapy, and CDI informed the police of Husske's statements.

Husske was arrested for the rape. At a pre-trial hearing, Husske argued that his statements to therapists should be excluded from evidence. The trial judge ruled that the statements were admissible.

The Fifth Amendment to the U.S. Constitution provides that "no person ... shall be compelled in any criminal case to be a witness against himself." The principle embodied by the amendment is that the state bears the burden to produce evidence against a defendant that will prove his crime; the state may not coerce an accused person to testify against himself.

Husske argued that he revealed his participation in the crimes as a part of his participation in a mental health treatment program. He further asserted that the revelations were made because he was obliged to relate his criminal activity to therapists in order to comply with the court order. Had he failed to comply, he would have been at risk of having his suspended sentence revoked, and serving the suspended jail term. Thus, the revelations in therapy were "coerced" in violation of the Fifth Amendment. The prosecution responded that Husske's mental health program was not "court-ordered."

The defendant's revelations in therapy were "coerced" in violation of the Fifth Amendment.

The appellate court stated that although Husske voluntarily made the initial contact with Mental Health Services, it is clear from his record that after the sentencing order was entered, Husske's participation in the treatment program was mandated by the court order. The sentencing order clearly stated that a condition of Husske's suspended sentence was participation in CDI. In addition, the sentencing order explicitly mandated "mental health reference with report." Further evidence that the two were linked was contained in notations accompanying the judge's signature on the CDI deferral form requiring CDI "to monitor [Husske's] mental health program." Furthermore, when he was terminated from the mental health program, the Commonwealth determined that Husske had violated the terms of the sentencing order and sought to have the sentencing judge revoke Husske's suspended sentence. Finally, Dr. Elwood told Husske that his treatment program required that he tell the CDI of his crimes.

The appellate court stated that the requirement for Husske to choose between confessing his crimes (and thereby comply-

ing with the requirement of candor in the mental health treatment) or not cooperating in the treatment program (and thereby suffering revocation of his sentence and serving time in jail) made his statements involuntary and violated his Fifth Amendment privilege.

The court reversed the convictions and ruled that the incriminating statements he made as part of his court-ordered treatment plan must be excluded from evidence.

Psychological Disability Unrelated to an Industrial Accident

Warren v. Bengston, Debell, Elkin and Titus, Ltd., 1994 WL 557954 (Va. App.)

The Virginia Court of Appeals recently affirmed a decision of the Workers' Compensation Commission against a surveyor who claimed that he should continue to receive wage loss compensation and medical benefits for an accidental injury and psychological disability which he argued was causally related to a physical injury.

The surveyor was injured on June 17, 1991 and the treating neurologist released him for work on February 24, 1992. Soon afterwards, the surveyor sought treatment from a psychiatrist for a psychological disability. The psychiatrist later testified that this mental condition was a direct result of the industrial accident.

The surveyor was also evaluated by an independent psychiatrist at the employer's request. This evaluator believed that the surveyor's mental condition was actually the product of past substance abuse and ongoing methadone treatment, and was unrelated to the accident.

The commission evaluated the competing testimony of the psychiatrists and found that the psychological disorder was not a result of the physical injury. Although the employer had been paying for the psychiatric treatment, the commission found that the employer was not forced to admit liability that might be inferred from paying for earlier treatment. The surveyor appealed these findings.

The Workers' Compensation Commission is entitled to resolve medical evidentiary conflicts as it sees fit.

The Virginia Court of Appeals sustained the decision of the commission. The surveyor argued that the commission had abused its discretion in favoring the testimony of the independent evaluator over that of the treating psychiatrist. The Court agreed that "the commission should give great weight to the diagnosis of the treating physician...[but this] opinion is not binding on the commission where additional direct medical evidence appears in the record." The commission is entitled to resolve such evidentiary conflicts as it sees fit.

The surveyor also argued that since the evaluator was unfamiliar with his employment requirements he was not qualified to render an opinion on the surveyor's ability to return to work. The Court decided, however, that since the commission relied on the evaluator's opinion only as evidence of the connection between the physical injury and the subsequent mental condition, a familiarity with employment requirements was unnecessary.

Finally, the surveyor challenged the commission's finding that the employer was not barred from denying liability. He argued that the employer's voluntary benefit payments for psychiatric treatment constituted an admission of liability. The appellate court disagreed, holding that since the employer was challenging the causality of the psychological disability at the same time that

it made conditional payments, it would not be prevented from asserting the invalidity of the underlying claim.

Appeals Court Refuses to Subpoena Murder Victim's Psychiatric Records

Wilkinson v. Virginia 1993 WL 479771 (Va. App.); 1994 WL 41086 (Va. App.)

The Virginia Court of Appeals has refused to overturn the conviction of a murder defendant, Richard Ashley Wilkinson, who during trial sought and was denied access to the victim's psychiatric records. Wilkinson claimed self-defense in his first degree murder case, and stated that the victim had threatened him with a knife during an argument. The claim was not contradicted, but Wilkinson was convicted nonetheless. Wilkinson requested a subpoena of the victim's files on the grounds that "certain facts have disclosed that the [victim]...possessed aggressive behavior towards others; that there have been several charges of assault placed against" him. The trial judge responded that the affidavit for subpoena did not conclusively prove that the records were material in the case and denied the request.

Wilkinson appealed his conviction on numerous grounds, including a claim that the trial judge's refusal to subpoena prejudiced the case against him. In an opinion released November 23, 1993, a panel of three judges of the Court of Appeals denied all grounds for appeal, except this one. Recognizing that Virginia law required that a party requesting a subpoena must "demonstrate at least a substantial basis for claiming that the objects sought are material," Judge Barrow disagreed with the trial judge that the defendant had not done so, and writing for the majority stated that these records "may have supported a claim that the victim was the aggressor. Without seeing the records, the defendant could not have alleged a more substantial basis for claiming materiality." (At trial, Wilkinson had also claimed that a suicide attempt by the victim suggested an aggressive nature. The trial judge excluded the evidence, and the Court of Appeals upheld the ruling.)

Judge Barrow's opinion vacated the conviction and returned the case to the lower court. The records were to be subpoenaed for a review in chambers, and, if they were found to be material to the case, the trial court would order a new trial. If not, the conviction would stand. Judge Coleman bitterly dissented, and argued that Wilkinson's request had cited no specific evidence to suggest that the records contained information related to the victim's alleged aggressive nature. "The majority" he wrote, "speculates or surmises that the deceased victim's psychiatric records may have been material." Such speculation, he argued, was not sufficient to warrant the subpoena.

However, before the case could be returned, the entire Court of Appeals issued a stay against the order and granted a rehearing. In this opinion, dated August 2, 1994, and written by Judge Coleman, the court upheld the trial court in all respects and substantially repeated the original dissent. Thus the conviction was ultimately upheld and the subpoena denied, with only Judge Barrow dissenting.

Repealed Virginia Statute Denied Due Process to Insanity Acquittees

Williams v. Virginia, 444 S.E. 2d 16 (Va. App. 1994)

The Virginia Court of Appeals has declared unconstitutional a law requiring insanity acquittees to prove that they are not dangerous in order to avoid involuntary commitment. The plaintiff, Jeanette Williams, was indicted in 1986 on an arson charge;

although an initial evaluation found her not mentally ill and competent to stand trial, under a plea agreement she pled "not guilty by reason of insanity." As dictated by Virginia State law, the court committed her for evaluation. After six years, Williams remained in custody of the Department of Mental Heath, though she had twice petitioned for release.

Under the Virginia law in effect at the time of William's initial confinement, an insanity acquittee was temporarily committed for evaluation by a panel of physicians and psychologists to determine if the acquittee was still mentally ill or if release would be dangerous to him or herself or to others. If the panel determined that the acquittee was still dangerous, the court would commit the defendant for an additional term of confinement. An acquittee could petition yearly for release, at which time proof was required that he or she was neither mentally ill nor dangerous.

In Jeanette Williams' case, a pre-trial evaluation stated that she was susceptible to impulsive and self-destructive behavior, especially when under the influence of alcohol or when frustrated and angry. Following her plea agreement, the examining physicians agreed with the earlier evaluation and added that she presented "no florid symptoms of mental illness." Although no record of a further commitment order exists, Williams remained in the custody of the Department of Mental Health, whose physicians thereafter filed annual reports testifying to her need for continued detention and treatment. Her 1988 petition for release was denied.

When she petitioned again in 1992, doctors from the Department announced a new diagnosis in letters to circuit court Judge Sarver; Dr. Nichols concluded that Williams was neither "safe nor sane" and Dr. Nieves reported symptoms of "organic personality disorder." The court heard no testimonial evidence, and denied the petition solely on the basis of these letters.

Williams appealed, arguing that the letters were hearsay evidence, and that they did not clearly prove her alleged insanity and continued dangerousness. Most importantly, she argued that the statute under which she was committed was unconstitutional. In *Foucha v. Louisiana,* U.S., 112 S.Ct. 1780, 118 L.Ed. 2d 437 (1992) the U.S. Supreme court ruled that an insanity acquittee "may be held as long as [she] is both mentally ill and dangerous, but not longer." (**See 14 *Developments in Mental Health Law* 4, 1994**). Like Williams, Foucha had been deemed dangerous, but not mentally ill, and had been involuntarily held. The Supreme Court determined that the Louisiana statute covering the commitment unfairly required the defendant to prove that he or she was not dangerous when not mentally ill. As such, it violated rights of due process and was therefore unconstitutional.

Virginia repealed and replaced the contested statute.

In an opinion by Judge Benton, the Virginia Court of Appeals agreed with Williams that the Foucha case was relevant, and found that Virginia law placed the same unconstitutional burden of proof on an insanity acquittee. The lower court's denial of her petition was overturned and the case was returned to that court for a new hearing.

The statute under which Williams had been detained (Virginia Code section 19.2-181) was recently repealed and replaced (see Virginia Code sections 19.2-182.2 to 19.2-181.16).

Cases from Other States

Pennsylvania Court Permits Sterilization of Disabled Woman

Estate of C.W., 640 A.2d 427 (Pa. Super., 1994)

In a case litigated for more than seven years, a Pennsylvania appellate court has appointed the mother of a woman with multiple disabilities as her guardian, with authority to consent to a tubal ligation for the purpose of sterilization. The case raises significant questions about the reproductive rights and the right to treatment of those who may be legally incapable of consenting to surgical procedures. Additionally, it highlights the procedural burdens that must be overcome by parents who wish to consent to sterilization on behalf of their disabled children. The lawsuit serves as a reminder that elaborate legal procedures were put in place in many states to remedy the historical abuse of sterilization among mentally ill and developmentally disabled populations.

C.W., the real party at interest in this case, is a 24-year-old woman with the mental age of a three to five year old. She suffers from moderately severe mental retardation, grand mal epilepsy, cerebral palsy, and scoliosis. She has been diagnosed with organic brain damage and is unable to speak. Her seizure disorder is extremely severe; every day she receives three drugs, Phenobarbital, Dilantin, and Tegritol, some in toxic doses, to control her epilepsy. Even this array of medication is sometimes insufficient to prevent seizures.

C.W.'s mother filed a petition to be appointed C.W.'s guardian and to be given specific authority to consent to a tubal ligation that would render C.W. unable to become pregnant. The court appointed a guardian *ad litem* to look after C.W.'s interests during the legal proceeding. The guardian *ad litem* took the position that the sterilization operation was not in C.W.'s best interest.

Testimony was taken from medical and mental health experts over seven different days, probing C.W.'s abilities and disabilities. The court determined that she had no understanding of sexual or reproductive functions, and is not now nor will she ever be capable of giving informed consent to any medical procedures. She has apparently experienced normal reproductive development and has the potential for becoming pregnant. Testimony also revealed that the experience of pregnancy might lead to severe and possibly life-threatening trauma to C.W. and that while discontinuing her medications could be fatal, some of those medications could cause congenital defects to a developing fetus.

Other evidence was submitted describing C.W.'s regular schedule. She lives in a closely supervised community living arrangement with other disabled adults and several staff members. During the day she is checked once or twice every half-hour in order to monitor her seizure disorder; at night the supervision is much less frequent. While there was no evidence that she has engaged in sexual intercourse, the evidence suggested that without more restrictive supervision, that possibility could not be ruled out. C.W.'s behavioral problems and difficulties with other medications apparently make most temporary and/or self-administered birth control options inappropriate.

The trial court weighed this evidence in concluding to appoint C.W.'s mother as guardian with authority to consent to tubal ligation for C.W. The guardian *ad litem* appealed the court ruling.

The Superior Court of Pennsylvania

began its inquiry by outlining the controlling precedent. The standards governing whether sterilization of an incompetent is to be permitted in Pennsylvania were established in *The Matter of Mildred J. Terwilliger*, 304 Pa. Super. 553, 450 A.2d 1376 (1982). *Terwilliger* set five procedural ground rules: the party seeking the sterilization has the burden of proof; the standard of proof is clear and convincing evidence; a guardian *ad litem* must be appointed; comprehensive medical, psychological, and social evaluations must be performed on the incompetent person; and the court must meet with the incompetent person. Two threshold issues must be resolved: 1) the individual must lack the capacity to make a decision concerning sterilization and the incapacity must be unlikely to change in the foreseeable future, and 2) the individual must be capable of reproduction. The most important part of the *Terwilliger* court's decision was the "best interests" test. An incompetent person will only be sterilized if it is in his or her best interests. In practical terms this means that an incompetent will only be sterilized if sterilization is the only practicable means of contraception and detailed medical testimony shows that the sterilization procedure requested is the "least significant intrusion necessary to protect the interests of the individual."

The appellate court found that all of the procedural requirements were followed and C.W. met the threshold tests. It was undisputed that a pregnancy and/or birth could be detrimental to her fragile health. Only two issues were disputed: First, is there sufficient likelihood that C.W., with or without assent, will be involved in sexual activity? Second, is the proposed procedure the only practicable means of contraception? The guardian *ad litem* argued that C.W. is constantly monitored and not at risk of pregnancy; she also contended that even if she were at risk of pregnancy, other methods of contraception are available.

The appellate court concurred with the lower court that there is a sufficient likelihood that C.W. may become involved in sexual activity. The testimony from the trial court suggested that she is excessively affectionate and desires physical closeness; she often engages in inappropriate touching, especially with strangers. In a mid-1989 visit to her primary physician, her caretaker noted "increased kissing involvement" between C.W. and her "boyfriend."

Testimony was also presented concerning a staff person's report of hearing noises from C.W.'s room and upon investigation, seeing a male running out of it. The staff person described C.W. as "visibly upset" and noted that her nightgown was pulled up. She related via sign language that the man touched her breasts and pubic area. This evidence led the court to conclude that C.W. may, with or without her assent, become pregnant.

The Superior Court considered and rejected all alternatives to sterilization.

In deciding if there might be any alternative to sterilization, the court considered and rejected all options. Education and training has failed in the past; C.W. has forgotten almost everything about contraception that she has been taught. Increased supervision would restrict C.W.'s freedom and be detrimental to normalization and a life in the community.

In light of these findings, and in agreement with the trial court that all the requirements of *Terwilliger* had been met, the appellate court endorsed C.W.'s mother's wishes to consent, as guardian, to tubal ligation by laparoscopy. A majority of the court

emphasized that the operation was very effective as a contraceptive measure; that it is safe, with a mortality rate of approximately one in three hundred thousand; and that eighty percent of tubal ligations are reversible. The court concluded:

> Anything short of tubal ligation requires experimenting with various contraceptive medications that may cause her to experience more seizures, more pain and discomfort. When the alternative medical procedures are weighed against tubal ligation, a relatively simple and extremely effective procedure, the latter emerges as the best option.

"Courts have held that sterilization implicates a fundamental right and requires that we impose the least restrictive" contraceptive measures for the mentally incompetent.

Three judges joined two separate dissents. One dissent argued that C.W.'s constitutional right to bodily integrity and reproductive autonomy were not adequately considered and that in light of U.S. Supreme Court precedent, incompetence does not negate those rights:

> Based on these sound principles and the long history of eugenic sterilization of the mentally retarded in the United States, courts...have held that sterilization... implicates a fundamental right and requires that we impose the least restrictive alternative in seeking contraceptive measures for those individuals.

The second dissent stated that sterilization should not be considered in the absence of evidence of voluntary sexual activity:

> The protection of this woman's physical person from harm is the real issue in this case. Sterilization will not and cannot protect [C.W.] from untoward sexual advances and abuse. It can only prevent one of the unwanted results of sexual abuse and activity, pregnancy. What about the trauma of rape? what about the death sentence of AIDS and the horrors of syphilis?

The guardian *ad litem* filed an application for an emergency stay to prevent the sterilization pending U.S. Supreme Court review of the case. The emergency stay was denied first by Justice Souter, then the full Court. At her mother's insistence, C.W. was sterilized in early 1995, thereby rendering further Supreme Court review moot.

Alaska Supreme Court Recognizes Quasi-Judicial Immunity for Court Appointees

Lythgoe v. Guinn, 884 P.2d 1085 (Alaska, 1994)

Superior court Judge Andrews appointed Dr. Janet Guinn in 1992 as an independent investigator in the divorce and child custody proceeding of Jacqueline Lythgoe and Paul Wellman. When Dr. Guinn recommended in her final report that the court award Wellman full custody of their six-year-old son Cooper, Lythgoe requested a separate evaluation, which the court allowed. Judge Andrews followed this motion with a private review of Dr. Guinn's files at the State Division of Occupational Licensing; the court then struck all of Dr. Guinn's reports and testimony in the case from its record and ordered that they should

not be provided to the new custody investigator.

Lythgoe next filed suit against Dr. Guinn, claiming that "she performed the custody investigation negligently, willfully, and wantonly." Dr. Guinn moved to dismiss the suit on the grounds that quasi-judicial immunity protected her from civil liability. Judge Shortell of the superior court agreed that her duties as a court-appointee rendered her immune and dismissed the suit. The court drew upon a California decision (*Howard v. Draokin*, 271 Cal. Rptr. 893 [Cal App. 1990]) which held that "a psychologist engaged by the court to evaluate the parties to a custody dispute is entitled to the protection of absolute quasi-judicial immunity."

Upon appeal by Lythgoe, the Alaska Supreme Court affirmed this dismissal and recognized for the first time the existence of quasi-judicial immunity in Alaska. In her appeal, Lythgoe claimed that such immunity left her with no remedies or safeguards from the alleged negligent actions of Dr. Guinn. Lythgoe also contended that Dr. Guinn had acted as an advocate for Wellman, and that she should be denied absolute immunity on these grounds. She further argued that because Dr. Guinn's recommendations had not been incorporated into the final custody judgement, the extension of immunity was "improper."

Immunity does not protect malicious or negligent behavior, said the Court. Adequate safeguards against negligence, other than civil liability, do indeed exist. For example, the complainant has the opportunity to cross-examine the expert witness and call attention to any inadequacy in the testimony. Complainants may appeal the court's judgement if it incorporates the expert's testimony. Finally, courts can hold their independent appointees accountable by dismissing negligent agents from cases, preventing their future appointments, or reporting them to the medical boards. (Lythgoe had in fact successfully used the first of these remedies, the Court noted.) The Court also maintained that appointed experts are not analogous to attorneys, and cannot be said to advocate for a client when serving as an impartial investigator.

Civil immunity for court appointees does not protect malicious or negligent behavior, said the Alaska Court.

The Supreme Court's opinion stated that both judicial and quasi-judicial immunity serve public needs by protecting litigants. Exposing court psychologists to civil liability, the Court explained, could discourage qualified professionals from accepting appointments, or could affect their impartiality. The opinion further noted that the recommendation of a court-appointed psychologist need not be incorporated into final judgements in order to fall within the scope of quasi-judicial immunity. Agreeing that Dr. Guinn acted as an "arm of the court," the Justices held that considerations of public policy justified extending absolute immunity to her.

Criminal Act by Mentally Ill Policyholder not an Exception to Insurance Policy Exclusions

Municipal Mutual Insurance Company v. Mangus, 443 S.E. 2d 45 (W.Va., 1994)

The West Virginia Supreme Court considered whether an insurance policy covering accidental events would exclude damages caused by a policyholder who shot his neighbor, even though the policyholder was being treated for mental illness at the time of

the shooting. Because the results of the assault were both "expected and intended" by the insured, the court ruled for the insurance company, and no coverage was extended.

Denver L. Mangus and Ricky Lee Fields were neighbors. Fields' fence divided their two lots, with Fields' property line extending several inches on Mangus' side of the fence. In the winter of 1987, Mangus attached a fencepost without Fields' permission. Despite several requests by Fields to remove the post, Mangus refused. On July of 1987, Fields began shaking the fencepost in an attempt to dislodge it. Mangus yelled a warning, "you get out of here or I'm going to shoot you." Fields ignored him. Mangus armed himself with a 12-gauge shotgun, and fired on his neighbor. Fields suffered permanent and extensive damage to his eyes, teeth, chest, shoulder, and hand. Mangus later pleaded nolo contendere to criminal charges and served a prison term.

At the time of the shooting, Mangus was diagnosed as clinically depressed and exhibiting psychotic features. He was taking medication to lower his anxiety and affect his mood. Mangus reported delusional beliefs that his phone was tapped and that his neighbors were involved in drug-dealing and were conspiring to drive him from his land.

Mangus was covered by a homeowner's policy with Municipal Mutual Insurance Company of West Virginia. However, the policy excluded personal liability and medical payments to others if bodily injury or property damage was "expected or intended by the insured."

Fields filed a personal injury claim against Mangus in the Circuit Court of Kanawha County. Municipal Mutual immediately brought a declaratory judgment action seeking absolution of any responsibility for coverage. The insurance policy, argued the insurer, did not cover intentional acts such as Mangus' assault on Fields. The trial court entered judgment for the insurance company; both the defendant Mangus and his victim Fields filed an appeal to the Supreme Court of Appeals of West Virginia.

The Supreme Court noted precedent from other states which supported both parties. One line of cases, advanced by Mangus, found that injuries resulting from insane acts render an intentional injury exclusion clause inoperative and the insurer liable. Another line of cases, embraced by the insurer, stated that an injury inflicted by a mentally ill person is 'intentional' where the actor understands the physical nature of the consequences of the act and intends to cause the injury, even though he is incapable of distinguishing right from wrong.

The court criticized the assertion that mental illness precludes one from intending the results of one's actions.

The court criticized the assertion that mental illness precludes one from intending the results of one's actions. It ignores the continuum on which various degrees of mental illness exist. Even though a psychiatrist testified at trial that Mangus was mentally ill, he also stated that Mangus fully understood what he was doing when he shot Fields. Thus the shooting was not accidental and covered as a risk that could be insured against; it was intentional.

Mangus argued that the court should use the same test in his case as the test for criminal insanity in West Virginia. Under the criminal test, if an insured lacks substantial capacity to appreciate the wrongfulness of his act and does not have the ability to conform his behavior to the requirements of the law, the act may not be truly intentional and should be covered by insurance.

Mangus claimed that it was inconsis-

tent for the law to excuse him from full criminal sanctions, yet claim that he cannot be indemnified by insurance because he intentionally shot someone. The court responded to Mangus' inconsistency claim with several analogies. Killing in self-defense, killing in war, and killing by an executioner of the state are all killings which are excused but intentional. Furthermore, the court added, allowing a blanket legal excuse for a mentally ill person's actions would seriously interfere with an insurance company's ability to rate risks and achieve an equitable insurance premium. Consequently, the court will deny coverage under a homeowner's policy when a mentally ill insured policyholder causes injury with a "minimal degree of understanding of the nature of his act."

South Carolina Court Endorses Post-Hypnotic Testimony

State v. Evans, 450 S.E. 2d 47 (S.C., 1994)

In a decision endorsed 4-1 by the Supreme Court's members, South Carolina affirmed a conviction based in part on a declarant's post-hypnotic testimony. The Court ruled: 1) that evidence law does not prohibit a declarant from testifying according to his own recollection induced by hypnosis; and 2) that admission of post-hypnotic testimony did not violate the defendant's Sixth Amendment right to confront and cross-examine witnesses against him.

Lauren and Larrae Bernardo received fatal injuries when they were struck by a truck as they walked alongside a road with their grandparents in the summer of 1991. Two other grandchildren were also injured. The truck did not stop after striking the victims. In initial stages of investigation, police subjected the grandfather to hypnosis in an effort to obtain a better description of the truck. After an intense investigation, police charged Jerry Evans with two counts of murder, two counts of felony driving under the influence, two counts of leaving the scene of an accident involving death, and two counts of leaving the scene of an accident involving personal injury. Police also charged Evans' brother-in-law, Victor Altman, who allegedly was a passenger in the truck, with two counts of concealing of a felony.

Based in part on the post-hypnotic testimony of the grandfather, a jury convicted Evans of two counts each of manslaughter and leaving the scene of an accident involving death and personal injury.

Evans contended on appeal that the trial judge erred in allowing the grandfather to testify at trial because post-hypnotic testimony is inadmissible per se under *State v. Pierce*, 263 S.C. 23, 207 S.E.2d 414 (1974). *Pierce* addressed the question whether persons present during hypnosis could testify as to the results of the examination. The court in *Pierce* adhered to the general rule that "testimony as to the results of hypnotic examination is not admissible if offered for the truth of the matter asserted," and held that the trial judge did not abuse his discretion in excluding the testimony. The *Evans* court stated that *Pierce* is limited to the testimony of persons other than the declarant when that testimony is to be admitted for the truth of the matter asserted. In rejecting Evans' claim, the court stated that *Pierce* did not prohibit a declarant from testifying as to his own recollection.

Evans also claimed that admission of the grandfather's post-hypnotic testimony violated the Confrontation Clause of the Sixth Amendment. Because of the danger of using hypnosis as an investigative tool, Evans urged the court to adopt the view that post-hypnotic testimony is inadmissible unless stringent safeguards are followed to ensure reliability of the hypnotic procedure. Such safeguards were adopted in the New Jersey case of *State v. Hurd*, 86 N.J. 525, 432 A.2d 86 (1981). *Hurd* requires that: 1)

hypnosis be conducted by a psychiatrist or psychologist experienced in hypnosis; 2) the hypnotist be independent of and not regularly employed by the prosecutor, investigation, or defense; 3) any information given to the hypnotist be recorded for purposes of determining what the hypnotist could have communicated to the witness directly or through suggestion; 4) the witness's recollection of the facts be recorded prior to hypnosis; 5) all contacts between the hypnotist and the witness be recorded; and 6) only the hypnotist and the subject be present during any phase of the hypnotic session.

The Supreme Court stated that although adherence to the procedures enunciated in *Hurd* is preferable, it did not find that evaluating the procedure used in the hypnosis session answered the question of whether admission of post-hypnotic testimony violates the Confrontation Clause. To determine whether the admission of post-hypnotic testimony violates the Confrontation Clause, a court must examine whether hypnosis affected the witness's ability to testify and respond freely to cross-examination. If post-hypnotic testimony is shown to be independent of the dangers associated with hypnosis, the admission of the testimony does not violate the Confrontation Clause.

To determine whether a witness's testimony is independent of the dangers associated with hypnosis, the court laid out three facets that courts must examine: 1) the witness's trial testimony was "generally consistent" with pre-hypnotic statements, 2) considerable circumstantial evidence corroborates the witness's post-hypnotic testimony, and 3) the witness's responses to examination by counsel "generally were not the automatic responses of a preconditioned mental process." If the trial judge determines that such evidence is admissible, the parties may fully explore questions of credibility before the jury.

In this case, the grandfather's post-hypnotic recollection of the accident differed from his pre-hypnotic recollection only in that he was able to recall the color of the driver's hair and more accurately recall the color of the truck after hypnosis. Importantly, his post-hypnotic testimony is corroborated by physical evidence found at the scene and the testimony of other witnesses. Lastly, the grandfather's uncertain responses to both direct and cross examination indicate that his testimony was not the automatic response "of a preconditioned mental process." Therefore, the supreme court found that the grandfather's testimony was independent of the dangers associated with hypnosis and concluded that the trial judge did not abuse his discretion in admitting it.

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Prevalence of Sexual Offenders....

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evaluations were performed for legal purposes and with the possibility of courtroom scrutiny.

Despite these qualifications, the data reported here indicate that sex offenses comprise a substantial proportion of the crimes for which mentally retarded defendants are charged. Over one-fourth of the mentally retarded defendants evaluated in the state of Virginia during the six year period of the study were charged with a sex offense, and this group comprised 13 percent of all the sex offenders in the larger evaluation sample. Mentally retarded defendants were also younger and less likely to have been previously hospitalized than non-mentally retarded defendants. No differences emerge, however, regarding the type of offense alleged. Mentally retarded offenders were no more likely to victimize children or adults, or commit violent or non-violent sex offenses than were non-mentally retarded sex offenders.

Even though many mentally retarded sex offenders come into contact with the criminal justice system, specialized treatment programs for this population are scarce in both the community as well as in correctional facilities (10). Until recently, few treatment programs designed for treating sexually deviant mentally retarded individuals existed in any setting, and virtually no research has addressed their efficacy (2,3).

The high prevalence of sex offenses among retarded criminal defendants indicates a considerable demand for treatment programs designed specifically for developmentally disabled sex offenders. Future research on the treatment of sex offenders should specifically address the efficacy of such treatment with mentally retarded persons.

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Book Review

Committed to Treatment?

By Bruce Cohen, M.D.

Back to the Asylum: The Future of Mental Health Law and Policy in the United States
By John Q. La Fond and Mary L. Durham. Oxford University Press, 1992.

The authors, a mental health lawyer and a social scientist, have written a dense, articulate, and at times infuriating book. Their goal is not only is to summarize developments in American mental health law, both civil and criminal, but to delineate broad swings of the societal pendulum in the treatment of the mentally ill. Rather than focussing on the traditional tension between *parens patriae* and police-powers justifications for involuntary treatment, they focus on civil libertarian issues. Does society prefer to safeguard the rights of those of its citizens who happen to be mentally ill, or to safeguard society from the sight of the mentally ill homeless and from the crimes of mentally ill offenders? Such a question has prompted different answers over the past twenty years:

> From about 1960 to about 1980—a period we will call the Liberal Era—law and mental health policy strongly emphasized fairness to mentally ill offenders in assessing their criminal responsibility and permitted most other mentally ill individuals to live in the community, largely free of government interference. From about 1980 on—a period we will call the Neoconservative Era—there has been a noticeable reversal in these policies. Over this decade, the public clamored for the reestablishment of "law and order" by holding mentally ill offenders criminally responsible for their deviant behavior and by hospitalizing other disturbed citizens against their will. In short, there was growing pressure to return the mentally ill to the "asylum" of prisons and mental hospitals, a trend that continues to this day.

The authors believe that developments in mental health treatment have played a far smaller role in mental health policy than have changes in the general culture. The Liberal Era was characterized by a faith that individuals could succeed if their rights were protected, discriminatory barriers were removed, and opportunities were provided. When legislators and regulatory agencies did not rise to the task, the civil rights movement turned to activist courts, using litigation as a weapon against entrenched bureaucracies. The mentally ill became recognized as another unrepresented minority, and states were pressured to release them from

> the scandalously overcrowded "warehouses" euphemistically called state hospitals....As a result, another important group of social misfits arrived on the scene in growing numbers. Many people who led unusual or eccentric lifestyles were left alone by these formal systems of social control because of a more tolerant attitude toward individual differences and the promotion of individual rights. During the Liberal Era, communities turned a blind eye to their presence as long as they remained mostly invisible within the community. For the most part, these people lived out-of-sight in urban skid rows, in rural areas, or otherwise off the beaten path.

In the 1970s, however, economic prosperity faded and the welfare state came under increasing criticism for having created a dependent "underclass" of citizens. The pendulum

reversed direction, accelerating as it swung through the neoconservative 1980s, which gave us Ronald Reagan, the religious right, "family values," and the Rehnquist court. Along with societal concerns for increased community security came the movement to abolish the insanity defense and detain insanity acquittees in institutions longer. In the civil arena, lawmakers have expanded efforts to return the nondangerous mentally ill from the community "back to the asylum." According to the authors, civil commitment is "once again being characterized as a medical question and not a moral, social, and legal one." Concepts of free will and responsibility are now taking a back seat to scientific models of human behavior, which provide "intellectual support for coercively intervening in the lives of the mentally ill to reassert social control over irrational people." Psychiatrists therefore are treated quite differently in the criminal and civil settings. While society pressures the criminal courts to reject psychiatric opinion on insanity, it embraces psychiatric opinion on civil commitment. In other words, psychiatric opinion is considered relevant only to the extent that it furthers an agenda of social control.

The authors appear ambivalent about what these changes imply for the future. For example, in a chapter titled "Does Legal Reform Make a Difference?" they cite studies indicating that insanity and commitment reform efforts over the years, while reflecting society's values, likely have had little overall effect. Despite this, they build their suggestions for future mental health reform on the premise that "America is perilously close to losing touch with its core values and doing irreversible damage to the mentally ill." Their primary concerns include: restriction of the insanity defense, either through outright abolition or introduction of the Guilty But Mentally Ill alternative; inappropriate expansion of social control over insanity acquittees through extended, indeterminate inpatient stays; the misuse of psychiatric diagnosis through sexual predator laws; and expansion of civil commitment laws to include the "nondangerous" mentally ill. Their proposed solutions include making state insanity standards more restrictive by eliminating the "irresistible impulse" prong (as the federal government has done) while expanding outpatient control over insanity acquittees (as Oregon and now Virginia have done). In this way, critics of the insanity defense might be appeased, while the civil liberties of insane offenders would still have some protection. In the civil arena, they recommend restricting civil commitment to those who are truly "dangerous" to themselves or others, while increasing funding for social supports for the mentally ill in the community, such as affordable housing, supervision, and voluntary psychiatric care. For those patients who require more aggressive supervision, they consider outpatient commitment as a limited option. Coerced inpatient treatment for those who are not imminently violent, however, is "unacceptable."

La Fond and Durham give little consideration to the notion that the mentally ill are in fact mentally ill. Their view of treatment is often incomplete.

Ironically, this formulation gives little consideration to the notion that the mentally ill are in fact mentally ill. The most frustrating aspect the authors' discussion is that they are clearly aware of psychiatrists' concerns that mental illness itself robs patients of personal freedom and that it is usually treatable. Relevant references to the psychiatric literature appear in the endnotes. However, their view of the nature of this treatment is often incomplete, jaundiced, and nihilistic. One senses that their recipe for mental health reform has been heavily seasoned by Thomas Szaz and the antipsychiatry movement.

For example, the introduction of antipsychotic drugs in the 1950s, while given some of the credit for the push toward deinstitutionalization, is believed by the authors to have played only a

minor role compared to the efforts of the activist bar. In addition, the mentally ill are repeatedly described not as people who have diseases which can be reliably diagnosed and (in the majority of cases) effectively treated, but as "symptomatic deviants," "persons whose behavior deviates from prevailing norms," or "social misfits" who lead "unusual or eccentric lifestyles." Even modern advances in neurobiology and pharmacology have done little to influence this view. Clozapine, the first in a new generation of antipsychotic agents with broader effects and lower neurologic toxicity, is mentioned only once, and serves for La Fond and Durham only as an example of how the current expense of this medication

> exceeds the capacity of public coffers to pay for it. Thus, those who can pay for the drug will reap its benefits while legions of poor mentally ill will continue to live with the demons of their disease. Hence, while biomedical discoveries for the mentally ill are promising, they have yet to offer much assistance to patients in public mental hospitals, where health service rather than biochemistry is still the preeminent need.

Here we have reached the heart of the matter. Do the authors recommend that mentally ill citizens, regardless of their finances, should be guaranteed access to a medication that could potentially treat their condition, potentially making the concern over involuntary hospitalization a moot point? Do they recommend that the price of the medication be lowered, or that alternative medications which don't require such expensive blood-monitoring be developed (as has already happened with resperidone and several new drugs about to be brought to market)? They do not. In fact, the authors believe that, given the current limitations of psychotropic medications in "curing" mental illness, that psychiatrists are deluding themselves with "promises that cannot be kept." Given this, they recommend that psychiatric treatment be further curtailed. For example, involuntary hospitalization for treatment with these medications should be constrained, and efforts should be directed away from more difficult-to-treat conditions, such as schizophrenia, toward more treatment-responsive conditions, such as mood disorder.

Given the current limitations of psychotropic drugs in "curing" mental illness, the authors believe that psychiatrists are deluding themselves with "promises that can't be kept."

They base this recommendation on several fundamental assumptions. The first, alluded to above, is that current inpatient psychiatric treatment is generally ineffective. Therefore, the goal for involuntary hospitalization should be to physically prevent some threatened harm from occurring, rather than to treat a condition that might have led to the threatened harm in the first place. The second assumption is that coercive hospitalization is generally unnecessary, that in many cases patients will be harmed by it, that it provides little in the way of treatment, and that it stifles initiative and encourages dependency. Echoing Szaz, they voice concern that only the poor are committed to state hospitals, suggesting that "whether a mentally ill citizen is forcibly hospitalized depends primarily on wealth and status, and not on the illness."

Absent from the authors' discussion is the data convincingly documenting that mental illness itself creates a "downward drift" into poverty, accounting for the increased incidence of mental illness among the poor, or the fact that those mentally ill with "wealth and status" can simply be committed to private hospitals. Again, rather than recommend parity of treatment for the poor and wealthy mentally ill, their answer is to close the doors of the state hospital to all but

the violent, and set a different standard of care for those with and without health insurance.

The authors further assume that the mentally ill generally have insight into the nature of their illness and the treatment options available to them. With the exception of a single paragraph about the Joyce Brown case, the book contains no discussion about those patients who are not imminently dangerous, but who lack the competence to make decisions about psychiatric treatment. Presumably, as these patients do not pose an immediate threat to themselves or others, treating them would serve no purpose. *Parens patriae* considerations play no role here. This is underscored most dramatically when the authors cite Ed Koch's 1986 mandate to involuntarily transport the homeless mentally ill to shelters when the temperature dropped below the freezing point as an example of how "community security has reemerged as a dominant social theme." Koch's plan is lumped together with attempts to quarantine AIDS patients.

The closest the authors come to recognizing that some patients are in need of treatment for benevolent reasons is when they recommend that outpatient civil commitment be utilized more in the future. Even here, however, the authors are vague as to whether nonviolent, incompetent treatment-refusers would qualify for such treatment, or only formerly committed patients at high risk for relapse and violence. Even in the latter case, given their aversion to coerced treatment, the authors can only weakly conclude that "significant resource constraints and limited sanctions for violating the terms of outpatient commitment require that this strategy be used sparingly." Therefore, while the authors recommend that funding for voluntary outpatient treatment and community support be increased, they leave clinicians in the community with few options when their patients clinically deteriorate beyond termination of therapy. They also leave few options for those providing the mentally ill with housing beyond eviction.

Market forces are likely, in the long run, to be of far greater consequence than changes in the statutory language of civil commitment laws.

The authors contend that, unless such changes are instituted, we are on the verge of a fiasco of reinstitutionalization, as the pendulum continues to swing toward the neo-conservative pole. Surprisingly absent from the discussion, however, are the current economic forces shaping virtually all aspects of medical practice. Practitioners in the private sector are constrained by extensive managed care guidelines restricting their ability to hospitalize, treat, or be reimbursed unless certain conditions are met. In some private treatment settings, financial incentives and disincentives further influence clinical decision-making. While the authors believe there is a need for increased review by the courts of psychiatric care to prevent abuse of patients, they do not mention the significant percentage of their time psychiatrists already currently spend justifying their treatment decisions to reviewers from insurance companies, sometimes on a daily basis. Similarly, in the public sector, continuing budget cuts already pressure psychiatrists to slash lengths of stay, decrease the patient census, and transfer patients to outpatient settings.

These changes in market forces are likely, in the long run, to be of far greater consequence than changes in the statutory language of civil commitment laws. We also shouldn't forget that three-quarters of psychiatric hospital admissions are voluntary, and that of the remaining patients, the same ones tend to be committed for inpatient care regardless of changes in statutory language. It is true that many of these patients are being released "quicker and sicker" back into the

community, only to enter the "revolving door" of repeated admissions and releases. However, this state of affairs is quite different from the scenario depicted by the authors of patients being "coercively dumped" into hospitals only "for the public's convenience," where society's show of compassion is a disguise for self-interest and social control.

In the daily practice of psychiatry, patients' competence to refuse treatment and the treatability of their illness are both routinely assessed. In the La Fond and Durham world, however, doctors only assess patients' competence to refuse treatment to "declare" them incompetent and deprive them of their civil liberties. Similarly, in this world, "treatment" cannot be extricated from the phrase, "in the name of treatment." Since hospitalization is harmful and treatment is ineffective, these issues do not relate to the subject of clinical care and merely allow for further social control. The only concern which justifies such a potentially harmful intervention is when a person is truly "dangerous" to himself or others as a result of his condition.

At times, such a view forces the authors into awkward positions. What are we to make of their opinion that they do not "think hospitals are the appropriate place for most seriously mentally ill people, although we certainly believe that voluntary hospitalization should be available to those who need and seek it." Apparently, what determines whether a patient will be harmed or helped by being in the hospital is not his clinical condition or the available treatment options, but his legal status. In addition, the competent mentally ill patient, who has retained the ability to ask for treatment, should be hospitalized, while the incompetent patient, who lacks the capacity to ask for such treatment, should not be. This does not strike me as an especially sound basis for social policy.

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