Developments in Mental Health Law

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

Volume 15, Number 1 **January-June 1995**

Professional Licensure, Mental Health Inquiries and the Americans with Disabilities Act

by Diane Long, J.D.

The Supreme Court of the United States has made it clear that states may regulate professions through licensing systems.[1] The Court, confirming this power for bar examiners in *Schware v. Board of Bar Examiners*, concluded that a state may "require high standards of qualification, such as good moral character or proficiency in its law."[2] Frequently, the licensing process includes at least one question about an applicant's past and current mental health.[3] Mental health advocates have argued that inquiries into mental health history violate an applicant's right to privacy and due process of law.[4] However, whether they apply strict or intermediate scrutiny, courts have rejected these challenges and held that the interest in admitting only those who are fit to practice outweighs an applicant's constitutional rights.[5]

The enactment of the Americans with Disabilities Act (ADA) in 1990 gave mental health advocates new grounds to argue for the elimination of these inquiries from any professional licensing applications that ascertain an applicant's character as prerequisite for admission into a profession. Since then, bar examiners nationwide have been reevaluating the wording and scope of such questions. This essay will first describe different varieties of mental health questions, their success in the courts, and their viability under the ADA. The analysis in this part is based on the type and scope of the question. The discussion will then examine how bar examiners can comply with the ADA while fulfilling their duty to admit only those applicants who are competent to practice law.

Mental Health Inquiries and Current Case Law

Section 12132 of the ADA states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[6] Title II defines a

Also in this issue:

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qualified individual with a disability as one who can "with reasonable modifications" meet "essential eligibility requirements" necessary to obtain a professional license. Although it is difficult to define "essential functions" for a profession, a licensing board has the burden to prove that inquiries into mental health are job-related and consistent with business necessity. Thus, the issue is whether mental health inquiries on professional licensing applications are discriminatory and if so, whether they are justifiable burdens under the ADA.

Eight states obviously comply with the ADA because they do not require their applicants to submit any information about their mental health.[7] However, the ADA does not eliminate a state's duty to its citizens to admit only fit attorneys. To fulfill this obligation, most states have decided to ask some type of mental health question on their bar applications.

Eighteen states ask questions that are unlimited in scope or time, such as these:[8]

> (a) Have you ever consulted a psychiatrist, psychologist, mental health counselor or medical practitioner for any mental, nervous, emotional condition or drug or alcohol use?
>
> (b) Have you ever been diagnosed as having a nervous, mental, emotional condition or drug or alcohol problem?

An applicant answering affirmatively to either question must submit the name and address of any treating professional. Bar examiners justify these unrestricted, particularly invasive questions on the grounds that they must protect the public from "unfit" attorneys. They argue that more narrowly tailored questions allow applicants to exclude possibly relevant information and provide only answers placing the applicant in the most favorable light. Such arguments have successfully defeated constitutional attacks on mental health questions.[9]

In the context of ADA litigation, proponents of limitless questions argue that Title II's general anti-discrimination language does not apply to bar examiners' regulation of attorneys. Title I, they note, specifically prohibits employers from conducting pre-employment queries regarding disabilities, whereas Title II is silent concerning pre-screening inquiries. They assert that Congress intended the prohibition on screening individuals to apply only in the employment and not in the licensing context.[10]

First, bar examiners contend that Congress did not disfavor pre-decision inquiries altogether; instead, it simply did not want information about disabilities to disqualify job applicants before their performance could be evaluated. This problem allegedly does not exist in the admissions process because "no one is ever barred on the grounds of drug use or mental disability from sitting for the bar examination or from demonstrating his or her qualifications for admission."[11] Secondly, examiners assert that an employer who is restrained from pre-employment inquiries can immediately determine employees' capabilities once they are hired. Bar committees have no comparable opportunity for post-admission evaluation as it is extremely difficult to revoke an attorney's license. Licensing boards finally claim that because there is no history of excluding mentally disabled applicants, no need exists for prophylactic measures mandated by the ADA.[12]

No court has agreed that Title I's prohibition on pre-screening discrimination is limited to the employment context. Rather, courts have found that the ADA does in fact apply to licensing applications and that neither the Act nor regulations indicate that Title I is restricted to employment pre-screening only.[13] The ADA's purpose is to prevent discrimination against disabled individuals, regardless of its source. Furthermore, the licensing evaluation process is similar to hiring decisions because professionals cannot practice without a license.

Taken as a whole, Title II and its regulations demonstrate that pre-screening applicants based on a disability is not permitted in *any* context, including questions on licensing applications. These regulations explicitly forbid a public entity from administering a licensing program "in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability."[14] Another section prohibits a public entity from imposing or applying "eligibility criteria that screen out an individual with a disability . . . unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."[15] This regulation was intended to prohibit unnecessary burdens on applicants with disabilities when those burdens are not placed on other applicants without disabilities.

Two courts have addressed the legality of broad, unlimited mental health questions on professional licensing applications. The first opinion under the ADA was decided by the United States District Court of New Jersey in *Medical Society of New Jersey v. Jacobs*.[16] Based on the statute and corresponding regulations, the court held the questions in violation of the ADA because they were mere screening devices used to decide "on whom the Board will place additional burdens." The court struck down only questions "exceedingly broad [in] nature" and was "confident that the Board [could] formulate a set of effective questions that screen out applicants" whose conduct poses a threat to the profession. In essence, the court found that specific questions on past status violated the ADA while inquiries into conduct are permissible.

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Developments in
Mental Health Law

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

Developments in Mental Health Law is distributed free of charge to Virginia residents twice a year, and to out-of-state subscribers at an annual rate of $20. If you are not currently on our mailing list but would like to receive the newsletter, please send your full name and address with your subscription request to Box 100, Blue Ridge Hospital, Charlottesville, VA 22901. Changes of address should include both old and new addresses.

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ISSN 1063-9977

In the Federal Courts

Virginia Bar Must Reframe Mental Health Inquiry to Comply with Americans With Disabilities Act

Clark v. Virginia Board of Bar Examiners, 880 F.Supp. 430 (E. D. Va. 1995)

Over the past several years, the Americans with Disabilities Act (ADA) has altered the legal climate regarding mental illness and the duties of public licensing agencies to ensure that its licensees are qualified to practice. Until recently, all applicants to the Virginia Bar were required to answer the following question: "Have you within the past five (5) years been treated or counseled for any mental, emotional or nervous disorders?" A U.S. District Court has ruled that this question from The Virginia Board of Bar Examiners' "Character and Fitness Questionnaire" violates the ADA. The Court ruled that the question discriminated against the mentally ill because it was ineffective, stigmatized illness, deterred treatment, and added burdens to mentally disabled applicants not required of nondisabled applicant.

A few years before she applied to the Bar, Julie Clark was diagnosed with recurring major depression. As a result of this condition she "effectively lost much of [her] ability to concentrate, act decisively, sleep properly, orient [her]self and maintain ordinary social relationships" for about thirteen months. Clark refused to answer the mental health question on her application, and was consequently denied permission to take the Bar Examination. She subsequently brought suit against the Board of Bar Examiners.

The ADA prevents public entities from imposing eligibility requirements that might tend to screen out disabled persons. Clark's suit did not challenge the authority of the Board to certify the qualifications of its applicants, but claimed that the mental health question was too broad, ineffective, and added discriminatory burdens to the application process for mentally disabled applicants. For example, any applicant who answered "yes" to the mental health question was directed to provide the dates of treatment, the name and address of the attending physician or counselor, or treating hospital or institution, as well as a complete description of the diagnosis and prognosis. A preamble to the question explained that its purpose was to assess the "fitness" of the applicant to practice law, and noted that "untreated or uncontrolled mental or emotional disorders may result in injury to the public." The preamble recognized that many factors, including the stress of law school, sometimes made mental health counseling necessary, and encouraged the applicant to obtain counseling if it was needed: "Because only severe forms of mental or emotional problems will trigger an investigation or impact on bar admission decisions, your decision to seek counseling should not be colored by your bar application." The application did not ask about physical disabilities.

The ADA defines "disability" as a "physical or mental impairment that substantially limits one or more of the major life activities of the individual," including work. The court found that Clark met the ADA definition of a "qualified individual with a disability"—a person who otherwise meets the requirements for services, programs or activities provided by public entities, such as the Virginia Board of Bar Examiners, but who is nevertheless disabled. The ADA does

permit, however, the denial of benefits to an otherwise-qualified person if he or she currently poses "a direct threat to the health or safety of others." Thus the District Court had to consider if the question imposed requirements that discriminated against the disabled, and if so, whether they were necessary to protect the public's interests.

Clark offered expert testimony claiming that previous mental health counseling was a poor predictor of future behavior and that broad questions were useless in predicting *current* fitness for legal practice. This position is supported by the American Psychiatric Association's (APA) guidelines for mental health inquiry by its licensing boards: "Only information about current impairing disorder affecting the capacity to function as a physician, and which is relevant to present practice, should be disclosed on application forms."

The mental health question itself was shown to be ineffective in identifying applicants with mental illness. Since the question was added to the application, over 2000 completed applications have been submitted yearly, but only forty-seven of those indicated that the applicant had sought mental health treatment. Both Clark and the Board submitted testimony indicating that at any given time, approximately twenty percent of the population suffers from mental illness. No testimony was offered to show that Bar applicants constituted an uncharacteristic sample of the population. Of the forty-seven applicants who admitted to seeking treatment, only two of those were subject to further investigation beyond the application, and neither was determined to be unfit to practice based on medical history.

The court ruled that the application did not necessarily "screen out" the disabled, but that it did impose additional burdens on applicants with disabilities by subjecting them to further inquiry and scrutiny. Furthermore, it found that the question could possibly deter applicants from seeking counseling when it was needed, and suggested that the Board's own preamble to the question was a tacit admission of this potential effect.

Mental health inquiries might deter applicants from seeking needed counseling.

The court noted that several similar cases have already been argued before state and federal courts, and that broad questions regarding mental health treatment have consistently been ruled in conflict with the ADA. Eight states (Connecticut, Florida, Maine, Minnesota, New York, Pennsylvania, Rhode Island and Texas) have amended mental health questions to avoid litigation under the ADA. The American Bar Association House of Delegates recently agreed that bar examiners "should consider the privacy concerns of bar admission applicants [and] tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law." The National Conference of Bar Examiners has also recently edited its mental health questions to focus on current mental conditions, rather than previous treatment.

The district court ruled in Clark's favor and enjoined the Virginia Board from requiring an answer to the question in the future. The court affirmed that some form of mental health inquiry was appropriate and necessary, but offered no guidance in framing new questions.

[For more on the effects of the ADA upon licensing boards, see page 1 of this issue.]

Fourth Circuit Finds Commitment Hearings by Teleconference Constitutional

U.S. v. Baker, 45 F. 3d 837 (4th Cir. [N.C.]) 1995

The U.S. Court of Appeals for the 4th Circuit has ruled that the use of video equipment to visually link physically separated patients, attorneys, and judges in civil commitment hearings satisfies due process for patients. The first case to challenge this procedure was the result of a pilot study, recommended by the United States Judicial Conference, to investigate the feasibility of video linkages during court proceedings.

Leroy Baker, who has a history of schizophrenia, was serving a fifteen-year sentence for bank robbery. He consented to hospitalization at the Federal Correctional Institution at Butner, North Carolina, in order to receive psychiatric treatment. In June of 1993, Baker's condition worsened and he began to refuse medication, which necessitated continuous seclusion to manage his "inappropriate behaviors and florid psychosis." The warden at Butner initiated a commitment hearing in federal court to allow continued treatment on an involuntary basis. Baker was subsequently committed involuntarily during a U.S. District Court hearing that took place as he and his attorney remained at the federal facility, communicating through video and sound transmissions with the government attorney and the district judge in the courtroom in Raleigh.

The court heard testimony from three parties. A forensic psychologist stated that Baker presented symptoms of chronic paranoid-schizophrenia. A court-appointed physician reported that he had provisionally diagnosed Baker similarly. Baker himself offered a rambling, incoherent statement. Following this testimony, Baker's attorney did not challenge the commitment on the grounds that Baker was not mentally ill, but instead asserted that Baker's mental condition had worsened under government care and was "created by factors that are beyond the control of the patient." The court ruled that Baker should be committed.

The courtroom was equipped with one television monitor facing the judge and another facing the government attorneys and spectators. Two video cameras were used, one focused upon the judge and the other upon the U.S. attorney. At the correctional facility, the conference room also contained two cameras, one focused upon Baker and his attorney and one upon the witness chair, as well as one television monitor, visible to the entire room. The judge determined which images would appear on both courtroom monitors, while at Butner, Baker's attorney controlled the monitor. Neither monitor could show more than one image at the same time. Consequently, the judge and U.S. attorney could not simultaneously view the witness and the defendant.

On appeal to the 4th Circuit, Baker argued that this arrangement made it difficult to choose the appropriate image at any given moment in the hearing, and also made it necessary to constantly shift one's attention between live and video images. Baker and his attorney could not simultaneously view the U.S. attorney and the judge's reaction, while the judge did not always switch back and forth between the lawyer and witness with every question, but sometimes left the image of either the defense table or witness stand on-screen for several minutes. Baker also contended that the sound and video quality was poor. The district court stated that there were no such transmission problems in the courtroom and that the court reporter transcribed the proceedings without trouble.

Baker's appeal went beyond the particulars of sound and video quality in this spe-

cific case to challenge the fitness of video proceedings for civil commitment hearings in general. The U.S. Supreme Court has ruled that commitment hearings are civil matters, that civil confinement is not as onerous as criminal confinement, and that features of due process afforded to criminal defendants under the Sixth Amendment do not fully apply to patients in a commitment hearing. This is true even if the patient is a prison inmate; commitment remains a civil, not a criminal matter. However, the Court has endorsed certain protections for prisoners subject to civil commitment and those protections have been enhanced by a federal statute to include the chance to present evidence and the right to confront and cross-examine witnesses who testify in favor of commitment.

Can video conferencing provide defendants with adequate access to the court?

Baker's attorney argued that the criminal and civil distinction is theoretical, and that in practice commitment may yield effects worse than those of incarceration. Prison inmates who are committed have no specified release date, and must bear the double stigma of imprisonment and of having been declared legally insane. Physical presence, according to Baker's attorney, is key in such hearings, and video conferencing hampers the ability to make a favorable impression upon the court and present an effective defense. Baker's defense argued that he had been reduced to a voice in a box, while the U.S. attorney had unmediated access to the judge. He claimed that the video arrangement deprived him of an opportunity to gauge the effectiveness of his argument and to sense, first-hand, the court's interest.

The appellate court rejected these arguments, affirming both the constitutionality of video proceedings and Baker's commitment. The court reaffirmed the distinction between civil and criminal proceedings and due process. Video proceedings would not affect the judge's decision, according to the ruling, because in such a hearing "the court will determine which expert's opinions it finds more persuasive based not upon the demeanor of the expert while testifying, but upon the qualifications of the expert, and the substance and thoroughness of the opinions offered." Though defense counsel may prefer to argue directly before the judge, this preference is not a constitutional concern, according to the court. Finally, the court pointed out that video proceedings save the trouble of transporting the patient, which is "hazardous to the respondents and a burden to prison and court officials."

In dissent, Circuit Judge Widener suggested that administrative convenience may not be sufficient grounds for using video links in trials. However, he noted, Baker's need for psychiatric care remained uncontested by the parties, thus reducing the value of this case as a test of the soundness of the video protocol. A proper test of the video conference format would implicate the potential for mistaken judgements of the patient's mental condition. Widener concluded that

> [a]ny risk of mistake in such a case is minimal, even if it exists at all, where the government's expert, the prisoner's expert, the government's attorney, and the prisoner's attorney all agree on the result . . . . It will take a contested case, I suggest, before we should ascertain whether a man should be deprived of his liberty by a merely televised witness and whether a man should be so deprived of the opportunity to be present and face and address the court.

States Required to Provide Legal Assistance for Institutionalized Persons only through Pleading Stage of Civil Rights Cases

Cornett v. Donovan, 51 F.3d 894 (9th Circuit [Idaho]) (1995)

In 1992, four patients at Idaho State Hospital South (SHS), filed a civil complaint claiming that the hospital violated their constitutional rights of access to the courts because it provided neither a law library nor a legal assistant on the premises. Soon after receiving the complaint, SHS agreed to contract with the public defender's office to provide legal advice to patients regarding *habeas corpus* and reexamination of commitment proceedings and to represent the patients in court through an initial pleading. Both parties agreed to the settlement, which rectified all of the plaintiff's complaints but one: the scope of constitutional right of access. Did the right of access require that states provide legal representation beyond the initial pleading stage?

The SHS patients argued that the right of access must extend beyond this phase of a civil rights case because institutionalized mental patients would have difficulty prosecuting their claims. In a declaratory judgement, a U.S. District Court disagreed, stating that a competent attorney can present a plaintiff's case thoroughly at the initial pleading. The Circuit Court of Appeals affirmed this decision and noted that the U.S. Supreme Court had never suggested that the right of access for inmates or patients required states to provide legal assistance beyond the initial hearing.

However, the court explained that the "pleading stage" could be extended by courts to ensure a fair hearing:

> Because the right of access to the court requires assistance through the pleading stage, the right requires that the state provide assistance if a defendant raises a counterclaim or cross-claim, or [if] the court orders a reply. Requiring assistance throughout the pleading stage enables the inmate to rebut the State's arguments *when a court determines that a rebuttal would be of assistance.* The inmate thus receives the full assistance necessary to file a "legally sufficient" claim. [emphasis added]

The appellate court emphasized that the right of access for mental patients and prisoners in civil matters should not be confused with the right to counsel in criminal trials. Such a right levels the playing field, and "once a claim reaches a court, an indigent institutionalized person is in the same position as an indigent noninstitutionalized person filing, for example, a civil rights claim."

In the Virginia Courts

Diminished Mental Capacity Alone Does Not Void Consent to Sex

Adkins vs. Virginia 20 Va. App. 332, 457 S.E. 2d 382 (1995)

In a recent decision overturning a conviction for rape, the Virginia Court of Appeals ruled on two important issues regarding mental incapacity and expert testimony. The court decided that intelligence tests not administered by a psychologist, but given under his or her supervision, could be used to form an opinion admissible in court. The court also clarified the definition of "mental incapacity" as it relates to consensual sexual activity under Virginia law.

Robert Adkins was convicted of rape for having sexual intercourse with a woman who exhibited diminished mental capacity. The victim, whom the court called "Teresa," was sixteen years old, enrolled in the eighth grade and living with her parents at the time of the sexual encounter. Doctors had diagnosed Teresa as mentally retarded when she was three.

Theresa met Adkins at a local mall and they exchanged telephone numbers. The day before the alleged rape, Teresa's mother overheard a telephone conversation between Adkins and Teresa. She ended it by taking the phone, telling Adkins of Teresa's mental retardation, and warning him to leave her daughter alone.

The next day, while her mother was shopping, Teresa phoned Adkins and asked him to meet her at a nearby convenience store. They went to Adkins's home, had sexual intercourse twice, ate dinner, watched television, and fell asleep. The couple was discovered after Teresa's mother notified police that her daughter was missing.

Adkins signed a statement admitting that he had sex with Teresa. He was subsequently prosecuted and convicted of rape under a Virginia statute that protects people with mental impairments from being sexually exploited due to their mental incapacity. Adkins was twenty-seven years old and living with his father at the time of his encounter with Teresa. Although his own mental capacities were not an issue at trial or on appeal, the appellate opinion notes that Adkins' sister receives his social security checks because "he is not capable of handling his own money."

At the trial, a licensed clinical psychologist testified that Teresa's IQ was fifty-nine, her mental age was 10.4 years, and her IQ range was between fifty-eight and seventy. The psychologist, who had treated Teresa and periodically tested her since she was seven years old, based his opinion on personal interviews with Teresa and on IQ tests administered by his assistants.

On appeal, Adkins argued that the psychologist's statements were not acceptable because the tests were not "based upon his own knowledge of the facts" as required by Virginia law. The appellate court disagreed, pointing out that the tests were administered under the psychologist's direct supervision and control and that he had personal knowledge of and access to the testing procedures involved.

However, the court did agree with Adkins that Teresa's mental retardation did not necessarily meet the criteria of "mental incapacity" as it is defined in Virginia law. Virginia Code §18.2-61(A)(ii) provides that "[if] any person has sexual intercourse with a complaining witness who is not his or her spouse . . . and such act is accomplished . . . through the use of the complaining witness's

spouse . . . and such act is accomplished . . . through the use of the complaining witness's mental incapacity . . . he or she shall be guilty of rape." Virginia Code §18.2-67.10 defines "mental incapacity" as "that condition of the complaining witness existing at the time of an offense under this article which prevents the complaining witness from understanding the nature or consequences of the sexual act involved in such offense and about which the accused should have known."

At trial, Teresa stated that she first met Adkins on her own initiative and willingly gave him her phone number. Teresa testified that it was "mostly" her idea to "make love." She admitted to calling Adkins with that possibility in mind, but told him that she was eighteen. When asked about the consequences of sex, she replied that "you could catch AIDS" and "you could get pregnant." She used anatomically accurate terms when describing the act of intercourse and stated that she had had sex education classes in school. Adkins argued on appeal that evidence of Teresa's diminished mental capacity was not adequate to prove she did not understand the nature or the consequences of sexual intercourse.

Statutes protecting the mentally disabled must not create an unintended rule that would prohibit all mentally impaired persons from engaging in consensual sexual activity.

The court concluded that though the mentally disabled must be protected from exploitation, the statutes protecting them "must not be interpreted or applied in a manner that creates an unintended rule that would prohibit all mentally impaired or retarded persons from engaging in consensual sexual intercourse without having their partners commit a felony." Understanding the nature and consequences of sex, according to the ruling, might range from knowing the physical mechanics of sex and that it can provide pleasure to a sophisticated comprehension of the social and moral issues surrounding sexuality.

The court continued:

> the legislature did not intend to include as part of the protected class of people those whose mental impairment or handicap may prevent them from comprehending the more complex aspects of the nature or consequences of sexual intercourse, but who, nevertheless, have the mental capacity to have a basic understanding of the elementary and rudimentary nature and consequences of sexual intercourse . . . . The fact finder cannot infer from proof of general mental incapacity or retardation or an IQ range or mental age that a victim is prevented or unable to understand the nature and consequences of a sexual act, unless evidence proves that the victim lacks the ability to comprehend or appreciate either the distinguishing characteristics or physical qualities of the sexual act or the future natural, behavioral, or societal results or effects which may flow from the sexual act.

In other words, diminished mental capacity alone does not diminish the prosecution's burden of proof regarding a supposed victim's capacity to understand sex. Teresa's willingness and apparent instigation of sexual activity weighed heavily in the court's decision. The court reversed the trial verdict and dismissed the conviction, although it did note that Adkins and Teresa's sexual activity might be classified as "fornication," a Class 4 misdemeanor under Virginia law.

Cases from Other States

West Virginia Circuit Court Must Reconsider Advocacy Agency's Request for Legally Incompetent Client's Records

West Virginia Advocates, Inc. v. Appalachian Community Health Center, Inc. 447 S.E. 2d 606 (1995)

J.K., a developmentally and mentally disabled adult male, participated in vocational and counseling services offered by the Appalachian Community Health Center, Inc. (ACHC). Because of his disabilities, his mother had been appointed as his guardian following a declaration of incompetency under West Virginia law. However, according to West Virginia Advocates, Inc. (WVA), an independent advocacy organization, J.K. contacted them to request assistance in resolving conflicts with his mother and in having a new case manager assigned to him at ACHC. He signed a written authorization to allow WVA to represent him and have access to his records.

When Eileen Good of WVA contacted ACHC, she was permitted to attend a meeting held to address his request for a new case worker, but was denied access to his records. Good learned that J.K.'s mother opposed attempts to obtain a new case manager, and ACHC said that they could not release his records without his mother's consent, which she refused to give. WVA then went to court to obtain the records, claiming that the *Federal Developmental and Disabilities Assistance and Bill of Rights Act* (DDA) authorized their access to J.K.'s records, and that this law overrides any West Virginia laws to the contrary.

The DDA authorizes federal funding to states to help pay for services to mentally disabled persons, but conditions that aid upon the maintenance of advocacy organizations such as WVA. The state of West Virginia had received such funding, and WVA claimed that the law specifically mandates the release of records to an advocacy organization if the client authorizes it to do so. ACHC argued, however, that the County Commission report that declared J.K. incompetent nullified his consent, and that only his guardian could agree to the release of the records. A state appeals court agreed with ACHC, and WVA appealed to the state Supreme Court.

In its opinion, the West Virginia court pointed out that the DDA specifically states that its purpose is "to offer persons with developmental disabilities the opportunity, to the maximum extent feasible, to make decisions for themselves." The court continued:

> Further, the wording of the statute appears to place each individual authorized to give the system permission to access records on equal footing; hence, a disabled person has just as much authority to permit the system to have access to his records as the legal guardian. Moreover, there is no statutory requirement that if a disabled individual has a legal guardian or conservator, that the system must first obtain the consent of said guardian.

However, the DDA leaves unaddressed a situation such as J.K.'s: how should the courts gauge his ability to understand the meaning of his authorization to grant WVA access to his records? WVA itself acknowledges that his consent is meaningless unless he understands its implications. The trial court had ruled the authorization invalid.

However, it did not consider the issue of J.K.'s capacity to consent to record release because it assumed that the County Commissioner's ruling on J.K.'s legal incompetency to be final. But the Supreme Court ruled that this decision conflicted with the DDA's "strong intent" to offer J.K. the possibility of making his own decisions. Therefore, it returned the case to the trial court for a new hearing and ordered the court to base its decision "on such factors as the developmentally disabled individual's capability to understand the implication of granting such authority to the system, the individual's ability to express preferences and personal needs, as well as the individual's competency." However, the Court noted that their remand of the case did *not* overturn the mother's status as guardian, and specifically ordered that she continue to be consulted in J.K.'s treatment and in other matters concerning him.

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Mental Health Inquiries. . . .

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The Southern District Court of Florida, the second court to hold that a broad mental health question on a bar application violated the ADA, specifically rejected the argument that Title I is restricted to the employment context.[17] It also determined that the anti-discrimination language of Article II must be read in conjunction with the regulations prohibiting a public entity from administering a licensing program in a discriminatory manner and from using the eligibility requirements as a means to screen out otherwise qualified individuals. The court denied the Bar Examiners' argument that there was no discrimination because the plaintiffs were not denied a license. Instead, the question and subsequent investigation were declared to be discriminatory because they subjected applicants to additional burdens based on disability. The court suggested that bar examiners could comply with the ADA by developing narrowly tailored questions that will elicit information relevant to an applicant's competency to practice law.

Case law suggests that simply narrowing the time frame of the question, as sixteen states have done, may not be enough to comply with the ADA.[18] For example, Maine once asked: "Within the past ten (10) year period prior to the date of this application, have you ever received treatment of emotional, nervous or mental disorder?" (Colorado also includes a question similar to this.) An applicant to the Maine bar brought suit against the state's Bar Examiners, alleging that questions such as these violated the ADA.[19] Despite the more limited scope of the inquiry, the Supreme Judicial Court of Maine held that

> [a]lthough it is certainly permissible for the Board of Bar Examiners to fashion other questions more directly related to behavior that can affect the practice of law without violating the ADA, the questions and medical authorization objected to here are contrary to the ADA. Accordingly, the applicants cannot be required to answer the questions or sign the medical authorization.

In response to this decision, the Maine Board has removed the offending questions.

In *Clark v. Virginia Board of Bar Examiners*, the most recent case in this area, the contested question asked applicants if they had been treated or counseled within the past five years for a mental, emotional or nervous disorder. **[For more on the *Clark* decision, see page 4 of this issue.]** An affirmative response required the applicant to disclose additional treatment information to aid the investigation.[20] The court ruled that the question violated the ADA. At the outset, the court recognized that applicants may not be qualified under the ADA if they "pose[] a direct threat to the health or safety of others." Applicants who had received counseling were considered "otherwise qualified" as required under the ADA, because the Virginia Bar Examiners did not present any evidence connecting a positive response to clear risks to the safety of others. The court then focused on two issues: "(1) whether the Board ha[d] established requirements or imposed eligibility criteria that subject qualified individuals to discrimination on the bases of their disability, and (2) whether such requirements or criteria [were] necessary to the Board's licensing function." The court concluded that the question did indeed impose additional eligibility criteria on applicants with disabilities. In the second part of the analysis, the court found that the question was not necessary under the ADA because it offered "little marginal utility in identifying unfit applicants."

The plaintiff in *Clark* further contended that potential applicants will be deterred from getting

counseling if they know that they will have to report their mental health history on bar applications. The Virginia Bar Examiners did not present any evidence of a correlation between mental illness and competency, but the plaintiff presented considerable evidence describing the stigmatic and dangerous deterrent effect these questions have on applicants. Thus, the court held that the question, in its form presented to the court, violated the ADA. Similar to other courts deciding this issue, the court in *Clark* advised that a question could be drafted that would not violate the ADA, but it gave no guidance as to what form would be lawful.

Clark and other cases indicate that bar examiners may not inquire into applicants' past mental health records without evidence demonstrating a correlation between past mental health and competence. However, boards have not definitively linked previous mental health problems and an inability to practice competently.[21] No empirical evidence shows a connection between the ability to practice law and any history of mental health treatment:[22]

> Research and clinical experience demonstrate that receipt of mental health treatment is not predictive of a person's ability to carry out responsibilities with competence and integrity. Nor does the evidence in the field indicate that bar examiners or mental health professionals can predict inappropriate behavior on the basis of a person's mental health history.[23]

Disorder-specific questions defer to the authority of mental health professionals, but may still place illegal burdens on the applicant.

Unless and until they can show such a nexus, bar examiners should abandon broad mental health inquiries, or general inquiries limited to a specific time frame.

Questions regarding specific mental illnesses have been slightly more successful in the courts. Disorder-specific questions are appealing because they defer to mental health professionals and require applicants to disclose only severe mental illnesses that may be pertinent to an applicant's mental fitness. Texas, Delaware and Florida currently use this type of question:

> (a) Within the last ten years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?
>
> (b) Have you, since attaining the age of eighteen or within the last ten years, whichever is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

These two questions were disputed before the Texas District Court in *Applicants v. Texas State Bd. of Law Examiners*.[24] The Texas State Board of Bar Examiners asserted that the format of these questions satisfied the requirements of the ADA because "they narrowly addressed only those disorders relevant to the practice of law." The court agreed and upheld the limited right of the Texas Board Examiners to inquire into the mental condition of applicants diagnosed with specified illnesses in order to protect the public from unfit attorneys. The case has not been appealed.

Even though this is a more narrowly tailored inquiry, the examiners still must show a nexus between these disabilities and competency to practice law. The "serious" nature of a disorder does not necessarily link it to incompetency. Advocates of such questions argue that a large

percentage of people who have these serious disorders cannot practice law, at least on certain occasions or times.[25] But this rationale may not be sufficient, considering prior case law. First, diseases affect different people differently so that a particular disease, even a serious one, may not always render one incompetent to practice law. Thus, the question is still over-inclusive. Second, the specified diseases may be controllable with medication or proper supervision. Hence, the disease does not equal incompetence and, moreover, the ADA requires examiners to provide reasonable accommodations to qualified persons with disabilities. Medication and supervision would likely be considered reasonable.[26] Third, the relevant information—whether an applicant is capable of competent practice—could be ascertained by asking questions about specific conduct. If this information can be ascertained by different methods, bar examiners are prohibited from asking these questions because they are no longer "necessary." Given these considerations, disorder-specific inquiries may not be justifiable burdens on the applicant. To pass muster under prior case law, examiners will have to show (1) a nexus between the enumerated disabilities and competency and (2) that less burdensome means are not available.

Reframing Mental Health Inquiries

Given the relative success of applicant's attempts to strike down mental health questions, bar examiners and other professional licensing boards need to reexamine their questions. It should be noted that although some narrowly tailored mental health questions may be permissible under the ADA, an affirmative answer alone would not be sufficient to disqualify an applicant. The examining agency would have to investigate further to determine that the person is not competent to practice. Bar examiners must first clearly establish the criteria needed to be a competent attorney, because they can ask questions only about whether an applicant meets essential eligibility requirements necessary to maintain a license. The American Bar Association, in its most recent resolution pertaining to the issue, recommends limiting inquiries to the following issues:

> (1) whether the applicant has exhibited specific behaviors related to character and fitness, such as the individual's conduct, exercise of responsibility, trustworthiness, integrity and reliability; or
>
> (2) whether an applicant has a condition that significantly impairs that applicant's ability to exercise the responsibilities of an attorney such as handling funds, exercising independent judgement, meeting deadlines or otherwise affecting the representation of clients.[27]

The qualities described in the resolution can be used as criteria around which to tailor questions. If a state determines that exercising independent judgment is necessary to be a competent attorney, the questions asked should elicit information about an applicant's independent judgment. Each state should establish its own criteria and then formulate questions which elicit only information directly related to that criteria. Bar examiners must also obtain information demonstrating a direct relationship between disability and their competency criteria. They should, therefore, employ mental

Bar examiners must clearly establish the criteria needed to be a competent attorney, and ask only questions specifically related to those criteria.

health professionals to conduct studies to determine what disabilities, if any, will likely interfere with the practice of law. This research should also indicate the extent of such interference and whether it can be accommodated.

For example, the West Virginia Bar Examiners ask, "Have you ever had a mental disorder," which they define as

> a substantial disorder of thought or mood which significantly impaired your judgment, behavior, capacity to recognize reality or the ability to cope with ordinary demands of life to such extent that you required care and treatment for your own welfare or the welfare of others in the community.

The definition of "mental disorder," which mirrors language in the state commitment statute, is likely to be valid because it sets forth characteristics that tend to show that an applicant is not capable of practicing law. These questions should be distinguished from general questions about whether an applicant has ever been hospitalized for treatment of mental illness. Questions of that nature are impermissible for the same reason that broad, unlimited questions are unlawful; they are over-inclusive and not necessarily applicable to the competency of an attorney. No court has specifically addressed this type of question.

Inquiring into current mental fitness directly relates to the ability to practice law at the time of the application.

However, the above cited question, in its present form, probably does not comply with the ADA because it is not limited to current disorders. Questions regarding past mental health are unlawful because they may screen out an applicant with a disability or a record of a disability without a direct correlation to the practice of law. In contrast, inquiring into current mental fitness directly relates to the ability to practice law at the time of application. Under the ADA, examiners may ask whether applicants have any current mental impairment that will affect their ability to practice. Eight states ask this type of question, taken from the Florida Bar Application:

> Do you currently have a mental condition which in any way impairs or limits, or if untreated could impair or limit, your ability to practice law in a competent and professional manner?[28]

There is no definition of "current" in the ADA. Florida and Delaware bar examiners define current to mean "recently enough so that the condition may have an ongoing impact on one's functioning as a licensed attorney." Although no court has determined what "current" means, some commentary indicates that a time limitation of twelve months or less would be acceptable.

Other commentators suggest that the ADA would not prevent asking if a person has been adjudicated incompetent, remains incompetent or if a person is presently subject to an involuntary civil commitment order because these conditions have a direct correlation to an applicant's ability to practice law.[29] Eight states include questions of this nature. Again, however, these inquiries cannot be unlimited in scope, because they then would risk being unduly invasive. The questions should be limited in some manner to elicit only information related to competency.

The ADA also allows licensing boards to reject applicants who pose a "direct threat" to the health and safety of others. If examiners can show a particular question would elicit information demonstrating an applicant's direct threat, then the question would be permitted. Formulating a

mental health question to identify a potentially dangerous applicant may not be possible. Given the potential for bias and stigma in such cases, empirical evidence demonstrating the nexus between disease and threat would be especially crucial, and the likelihood that the question would be over-inclusive is high. Furthermore, there are less invasive and perhaps more effective means to ascertain whether a person is a direct threat, such as asking about previous violent or anti-social behavior. Examiners should be cautious in devising questions intended to ascertain an applicant's level of threat and be open to alternative forms of inquiry.

The ADA requires that the disabled be accommodated where feasible. Therefore, licensing boards should gather information in the least burdensome fashion. To comply with this requirement, some states ask about mental fitness by asking about applicants' behavioral histories rather than mental health histories. For example, the Bar Examiners of Pennsylvania deleted all mental health inquiries, but asked instead whether an applicant had ever been confronted by an employer, teacher, or other person regarding "such conduct as excessive absences, inability to work with others, diligence in preparation, moral standards and similar attitudes." Minnesota deleted its mental health question and developed detailed questions concerning conduct that is often found in persons suffering from incapacitating mental illnesses. In Maryland, the Bar Examiners ask about "any circumstances or unfavorable incident in [an applicant's] life . . . which may have a bearing upon [his or her] character or . . . fitness to practice law [and which was] not . . . disclosed in [the applicant's] answers."

Questions about a person's past behavior indicating a lack of competence may conform with ADA requirements if they do not necessarily single out those with disabilities or make gross generalizations about a particular disability, but still elicit relevant information. For example, bar examiners will want employment and academic records because they are likely to reveal any history of erratic, unreliable behavior that might indicate an applicant's unfit status. They can supplement this request by asking whether and under what circumstances an applicant has ever been suspended, expelled or had disciplinary action taken against him or her by a school or an employer. Licensing boards may also want to ask if an applicant has a history of failing to meet obligations, failing to be present or prompt at work, or failing to maintain consistent averages in school. Each of these inquiries, pertinent to the practice of law, may indicate that a person suffers from a disabling condition that may worsen with added responsibilities.

Questions about behavior, rather than mental condition, may be more useful in screening unfit applicants.

These inquiries may be even more useful than a mental health question because some mental illnesses go undetected or untreated. Therefore, examiners should ask these questions in addition to any mental health questions that are lawful under the ADA. However, sole reliance on these questions may not elicit information critical to an informed decision regarding certification. An applicant could screen out pertinent information and provide only self-promoting responses. Bar examiners can mitigate the problem by expanding their verification and investigation procedures and by rigorously monitoring licensed attorneys through disciplinary action, attorney assistance programs and post-admission review.

Lastly, examiners should keep in mind the sensitivity surrounding mental health and medical records. Bar examiners typically ask for more information if an applicant answers affirmatively to a mental health inquiry. Courts have ruled that this requirement places additional burdens on

persons with disabilities. The request for information is further suspect because disclosure of medical records is highly sensitive. However, this problem may be tempered if the investigation is kept highly confidential and is completed within the usual time for certification.[30] In other words, if the investigation can be completed in the same time period as an investigation into a non-mental health inquiry, then the requirement may not be viewed as unduly burdensome and may be permitted under the ADA. And though legal, such inquiries can still carry the potential for deterring applicants from seeking counseling. The court in *Clark* was especially concerned that mental health inquiries would deter law students from getting counseling for fear of exposure or rejection on the bar application. However, if examiners follow the guidelines set forth above so that their questions are narrowly tailored, it is likely that the deterrent effect will be minimized, if not eliminated.

Conclusion

Bar examiners and other professional licensing boards need to reevaluate the types of questions on their applications. Examiners should avoid asking questions that are unlimited in time or scope. They should gather evidence proving that their questions elicit information that is relevant to the practice of law and that their questions are the least burdensome means of ascertaining that information. However, before beginning such an endeavor, the examiners should weigh whether the benefits of asking mental health questions outweigh the costs of possible lawsuits, employment of evaluation commissions, and employment of mental health professionals to prove the correlation between illness and competency—a task that may be impossible. Given that questions about past conduct and behavioral characteristics can be good substitutes for eliciting information about an applicant's mental fitness, eliminating mental health questions altogether may be the best alternative.

Notes

1. *See generally Dent v. West Virginia,* 129 U.S. 114 (1889) (upholding statute establishing criteria for a license to practice medicine).
2. 353 U.S. 232 (1957) at 239.
3. Phyllis Coleman & Ronald A. Shellow, *Ask About Conduct, not Mental Illness: A Proposal for Bar Examiners and Medical Boards to Comply with the ADA and Constitution,* 20 J. Legis. 147, n. 43 (1994).
4. *Fla. Bd. of Examiners Re: Applicant,* 443 So.2d 71, 72 (Fla. 1983).
5. *See e.g., Id.* at 75-6; *In re Martin-Trigona,* 302 N.E.2d 68, 70-71, 74 (1973).
6. The ADA defines "disability" as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 42 U.S.C.§ 12102(2). Since mental health questions ask about physical or mental impairment or a record of an impairment, these questions deal with "disability" as defined in the ADA. Because a "public entity" under the ADA includes any "instrumentality of a State or States or local government," state professional licensing boards fall within the purview of the ADA. 42 U. S.C. §12131.
7. *Clark v. Va. Bd. of Bar Examiners, 880* F. Supp. 430 (E.D. Va. 1995). Arizona and Massachusetts have never inquired into applicants' mental health. Hawaii, Illinois, New Mexico, Pennsylvania, and Utah have recently stricken their broad mental health questions on the grounds that they violate the ADA. Maine suspended its question on mental health in light of a court decision. Stephen W. Townsend, *Admission to Bar: Review by Committee on Character,* 1995 N.J.L.J. 71.
8. Wade Lambert, *Bar Debates Screening Out Mentally III,* Wall St. J. March I 0, 1995 B I.
9. *See, e.g., Fla. Bd of Examiners,* 443 So.2d at 75.

9. *See, e.g., Fla. Bd of Examiners,* 443 So.2d at 75.
10. Stephen Fedo & Kenneth H. Brown, *Character and Fitness Review: Is it Legal to Ask About Addiction and Mental Disabilities?* 61 B. Examiner 40, 41 (1992).
11. *Id.* This assertion can not be validated because bar examiners can claim no one is rejected on these grounds and without blatant discrimination, it is very difficult to prove otherwise.
12. Charles L. Reischel, *The Constitution, the Disability Act, and Questions About Alcoholism, Addiction and Mental Health,* 61 B. Examiner 10, 19 (1992).
13. *See e.g., Ellen S.,* 859 F. Supp. at 1493; *But see In re Frickey,* 515 N.W.2d 741 (Minn. 1994). (Questioning the application of the ADA to bar applications, court enjoined Minnesota Bar Examiners from asking broad mental health questions on other grounds.)
14. 28 C.F.R. §35.130(b)(6).
15. 28 C.F.R. §35.130(b)(8).
16. 62 USLW 2238, 2 A.D. Cases 1318 (D.N.J. 1993). In controversy were the following questions asked by the New Jersey State Board of Medical Examiners:

    7. Have you ever been dependent on alcohol or Controlled Dangerous Substances?
    8. Have you ever been treated for alcohol or drug abuse?
    10. Have you ever suffered or been treated for any mental illness or psychiatric problems?

    If the applicant answered affirmatively to any of the questions, the applicant was required to have any treating physicians submit to the Board a summary of diagnosis, treatment and prognosis.
17. *Ellen S.,* 859 F. Supp. at 1493.
18. *Clark,* note 8 above, n. 16, 18, 19. Colorado, Delaware, Florida and Tennessee limit the time frame to ten years. Oregon asks applicants to report illnesses manifested in the last seven years. Alabama, District of Columbia, Georgia, Rhode island, Virginia, Washington, and Wisconsin restrict their questions to a five year period. Missouri requests information about illnesses which occurred since the applicant was eighteen years of age. California and Minnesota only ask about mental illnesses occurring in the last two years. Similarly, Connecticut only asks for information about illnesses applicants may have had since entering law school.
19. *In re Underwood,,* 3 A.D. Cases 573, 4 A.D.D. 773, 1993 WL 649283 (Me.).
20. *Clark,* n. 16. Applicants who answered affirmatively had to submit dates of treatment or counseling, name, address and telephone number of attending physician or counselor or other health care provider- name, address, telephone number of hospital or institution. Applicants also had to describe completely the diagnosis, treatment, the prognosis and any other relevant facts.
21. Coleman & Shellow, 20 J. Legis 147.
22. Rhode, 94 Yale L. J. at 581-583.
23. Mary E. Cisneros, *A Proposal to Eliminate Broad Mental Health Inquiries on Bar Examination Applications: Assessing an Applicant's Fitness to Practice by Independent Means.* 8 Geo. J. Legal Ethics 401 quoting *Report on Proposed ABA Resolution Concerning Inquiries Into Mental Health Treatment of Bar Applicants,* Section on Human Rights and Responsibilities and the Commission on Disability Law.
24. Townsend, 1995 N.J.L.J. 71 This case is not reported.
25. *See Piltch, Mental Disabilities and the Americans with Disabilities Act: A Practitioner's Guide.* Ed. John Parry. Washington, D.C. American Bar Association, 1994.
26. *See Jonson v. Shalala,* 991 F.2d 126, 128 (1993) (no reasonable accommodations necessary when employee could not take medication to prevent narcolepsy).
27. Coleman & Shellow, 20 J. Legis 147, n. 90. *citing ABA Report on Resolution Concerning Inquiries Into Mental Health Treatment of Bar Applicants.*
28. The other states are Connecticut, Delaware, Idaho, Minnesota, Nevada, Rhode Island, and Washington. *See Clark,* n. 16, 18, 19.
29. Piltch, *Mental Disabilities and the Americans with Disabilities Act.*
30. Ken Myers, *Privacy of Mental Health Records Poses Concern for Bar Applicants,* Nat'l.L.J. July 11, 1994 at A16.

Books

Representing the History of Reform

by Michael Furlough

America's Care of the Mentally Ill: A Photographic History by William Baxter and David Hathcox. Washington, D.C.: American Psychiatric Press, 1994. xx + 156 pages. $75.

The Turning Point: How Men of Conscience Brought about Major Change in the Care of America's Mentally Ill by Alex Sareyan. Washington, D.C.: American Psychiatric Press, 1994. xii + 309 pages. $16.95 paper, $43.50 cloth.

Historical narratives ultimately turn upon the starting point of the story, the author's investment in the subject, and the sources used to construct it, as these two accounts of mental health institutionalization in the United States make clear. Alex Sareyan's *The Turning Point* details the work of conscientious objectors employed in mental hospitals during the second World War, and their continued influence upon mental health care after the war. William Baxter and David Hathcox have put together *America's Care of the Mentally Ill: A Photographic History* to present a visual account of mental health treatment in the United States from colonial times to the present. Both books draw upon fascinating materials, but the preconceptions of the authors and publisher may hamper the presentation of material.

America's Care of the Mentally Ill is a kind of family photo album published by and presented to the American Psychiatric Association on its 150th birthday. Using photographs, drawings, engravings and old books found mainly in the APA archives, Baxter and Hathcox have created a visually compelling account that scans the changing face of mental health treatment. Although photographs appear to represent reality clearly with an undeniable documentary effect, photographers always select details and frame a photo according to the impression they want to make. The viewer must then supply the background and do the selective work of interpretation, noticing certain details and ignoring others. Photographs take items out of history by detaching them from their contexts. Simply looking at photographs cannot enable a viewer to comprehend the social and political contexts of mental health history, but can still offer insights into the way treatment has been conceptualized and represented in the past. Baxter and Hathcox readily admit that their album is not meant to be an academic history, but an attempt "to paint a picture of these people, how they were treated and cared for, and how psychiatry and society have continued to try to improve the care given."

Thus the images show not so much what treatment environments really looked like, but instead what ideals practitioners and care providers endorsed. The editors include drawings and pages from Renaissance books on demonic possession, indicative of the still largely religious-based view of human health dominant even in a period of advancing humanism. The Enlightenment's fascination with classification is represented by charts and drawings that purport to depict a typology of the mentally ill based on physical appearance. That rage for orderliness extends into the nineteenth century's methods of treatment and the opening of state hospitals for the mentally ill. The peace, rest and calm prescribed for patients can be found in the engravings that nestle those early hospitals in idealized pastoral scenes.

Some photographs can be quite disturbing, especially when these underlying principles are

coupled with apparently disconnected subject matter. Take, for example, a presumably pre-civil war photograph that depicts the variety of restraining devices available to "treat" mentally ill persons. The objects are symmetrically arranged. In the center sits what could easily be taken for an electric chair. The wooden seat is replete with leather straps and iron shackles for the legs, arms and head. Leaning against either side of the chair are long rods culminating in u-shaped braces used to restrain patient's by pinning them to the wall or floor. Directly above this trio hang three circular leather collars, arranged in a triangle, of which the bottom two feature long belt straps. Their function is not entirely clear. Yet there is no mystery about the purpose of the iron braces and chains that hang on either side of the top collar, above each of the two lower ones. Similar hand and leg braces are also hanging on the wall, interspersed regularly throughout an array of trusses, face masks, and leather mittens. Chains, draped and hung like banners, crown the entire layout, providing the bunting for this celebration of physical restraint. It takes only a moment to notice the ghastly orderliness of this photograph's composition: these objects are arranged in a pyramid, with the most restrictive—the chair—at the base and the least restrictive at top. The order that would be brought to the disordered mind appears here in the arrangement of the physical objects used to keep patients motionless (i.e., static, calm, orderly). In this sense, the photograph is comparable to the symmetrical and orderly architectural layouts of nineteenth century asylums designed by J.S. Kirkbride. Care providers countered disorder inside the mind with symmetry and regimen outside in the physical world.

Photographic histories of mental health treatment can offer insights into the way that illness and care have been conceptualized in the past.

Although this is a book of pictures, the choice of photos and their arrangement tell a story. Here, it is a tale of loss that is simultaneously a return. When Baxter and Hathcox come to present-day care, the narrative thrust of this photographic series becomes clear. Both the commemoration of the APA, and the subject matter of most pictures—state mental hospitals—suggest a clear bias toward professionalization and institutionalization. This is no great shock, but it takes a curious turn. Baxter and Hathcox have chosen to depict postwar deinstitutionalization as a complete absence of mental health care. "This wholesale emptying out of the state mental hospitals created many problems, the most obvious of which is today's large population of the homeless mentally ill," they write. This text accompanies bountiful images of the homeless under bridges, on park benches, staring into space, and in confrontation with police officers. In this context, these persons appear to be the ultimate victims. Yet these scenes are juxtaposed with shots of weed filled lots, broken windows and cobwebbed stairs in what we are meant to assume were once grand old hospitals. The buildings, it seems, are just as forlorn. One wonders which is the greater tragedy in the eyes of Baxter and Hathcox, that of the homeless, or that of the asylum?

If the nineteenth century depictions of mental illness and its treatment focused on order, then disorder apparently characterizes the contemporary scene. The implication is that we have returned to the days of gruesome typologies and unscientific care: "Have we come full circle? Are we back to the time when only those who can afford care get it while the rest are left to their own devices? 'Almshouses, jails and the streets' have become 'halfway houses, jails and the streets' in the twentieth century." Baxter and Hathcox are preaching to the choir. Published in a limited edition at a cost of $75 by the APA's own press, this polemic will not reach those who

Baxter and Hathcox represent contemporary mental health treatment as a complete failure of care. If order prevailed in nineteenth century depictions of mental illness, disorder characterizes the contemporary scene.

need to see it.

As a family album, *America's Care of the Mentally Ill* serves its purpose by reflecting the APA's image and perspective. Without denying the seriousness of these problems, or the need for greater attention from politicians and the public, it is hard not to wish that they had attempted to include photos of community treatment centers or of other kinds of outpatient-based care. But decay, nostalgia and sensation are easier to convey in a visual medium, and in the end, more interesting, than limited and quiet success.

Alex Sareyan offers a more upbeat view of institutional reform in *The Turning Point*. This must be one of the first histories of mental health told not from the bottom up, or top down, but from the middle. Rather than focusing on patients or on the professionals who directed the field, Sareyan presents the story of those who usually had to work in the institutions with both groups. At the start of World War II, the Selective Service System created the Civilian Public Service (CPS) in response to lobbying from Quakers, Mennonites, Brethren and other traditionally peace-oriented religious groups. These pacifist denominations hoped to prevent the persecution that their conscripted but objecting members had experienced during the previous world war. Finding them productive service work at a time of national crisis, it was hoped, would enable them to prove their loyalty both to the nation and to their convictions. CPS draftees worked in many areas, but eventually about 3,000 "COs" were assigned to hospitals for the mentally ill and training schools for the retarded. CPS members labored according to their skills when possible. They might work as attendants or secretaries, but also as nurses, administrative assistants, or physicians. Hospital administrators, doctors, governors, and even Eleanor Roosevelt publicly supported and praised COs in the face of public scapegoating and charges of cowardice.

Sareyan, who was himself a member of the CPS, explains that their hospital work contributed directly to the reform of psychiatric care in the United States. CPS members were shocked at the conditions of state hospitals during the war. Wartime mobilization had decimated staffs, while funding had never recovered from the Depression, leaving many hospitals ill able to care for the massive numbers of committed patients. In the place of proper care, COs could find corruption, abuse of patients, and unsafe buildings. Compared with other staff members, they often brought new and profoundly different attitudes to their jobs, and the benefits for patients could be immediate. Sareyan uses one entire chapter to reprint letters from Warren Sawyer, a CO who worked in Philadelphia State Hospital for most of the war. Describing his daily routine to his family, Sawyer explained exactly how his religious and political beliefs affected the way he did his job:

> This is a perfect setting in which to demonstrate the superiority of pacifism over brute force in handling tense situations. If you can convey to patients that you're not afraid of them and respect them as individuals—even though you're shaking in your boots—they return your respect. A few attendants have had their jaws smashed, but they're usually the ones who approach troublesome patients with broom handles and other similar weapons . . . . I've already broken up several fights using this technique, and it works. (page 44)

As the war continued, many of these COs improved conditions in the hospitals through administrative channels whenever possible. When they were rebuffed, as they were frequently, they developed relationships with the local press and blew the whistle on fraud and poor conditions. (Sareyan briefly discusses a probe into Eastern State Hospital at Williamsburg, Virginia sparked by the reports of COs, including two physicians, who worked there. Among the results was the resignation of the hospital superintendent.) Because the source of these problems lay in wider social misunderstanding of and indifference to mental illness, many CPS members directed their efforts toward education and public relations. When the war ended, several such CPS members formed the National Mental Health Foundation, which, though seriously under-funded and often in conflict with organizations such as the APA, continued its educational efforts to build support for reform.

The inclusion of primary documents like Sawyer's letters, press releases and interviews with former CPS members makes *The Turning Point* a valuable and interesting record of mental health treatment during the War. Yet, when Sareyan reaches the War's end, the tone and pace of the book changes. The story of the NMHF and its successor organizations frequently becomes little more than the story of PR campaigns, planning sessions and editorial correspondence told in tedious and repetitive detail. Sareyan includes many excerpts from NMHF publications to document the organization's work in detail. However, he imparts little sense of how these post-war publicity campaigns intersected with similar campaigns undertaken by the APA, the massive amount of research money pouring into the field after the war, or even the growing popularity of psychotherapy, all of which surely had as much, or more, to do with changing public attitudes and reform. In the post-war period, Sareyan's scope is too narrow.

Part of the reason for this could be the author's own participation in the organizations he discusses. The "About the Author" note says that he worked in the CPS unit at Connecticut State Hospital in Middletown, that he was appointed assistant director of the unit, that he established the first full time public relations unit at a U.S. public mental hospital while there, and that after the war he joined the staff of the NMHF as public relations director. Clearly, he knows his subject, but his in-depth knowledge sends him into the minutiae when expanding his gaze outward would be more useful. His enthusiasm for the work that he and his colleagues did comes through on every page of the book, but this can eventually only raise questions about the importance he places on some events he discusses. As if aware of this potential conflict of interest, Sareyan has some difficulty representing himself and his own actions in the narrative. The biographical sketch is written in third person, as such notes usually are, but in the body of the book he calls himself alternately "Sareyan" and "I." In a section on the Connecticut State Hospital and the establishment of their internal newsletter, *The Attendant*, he refers to the founder and editor only as "the assistant director of the CPS unit of the hospital." That would be, of course, Sareyan himself.

Ironically, the overabundance of information that mars Sareyan's account could have helped Baxter and Hathcox's photographic history. Limitations of the APA repositories prevent full documentation of many of the photographs in their collection. While they present an archive with too little information, Sareyan presents too much irrelevant or repetitive material that might have been replaced with more archival material. Based upon the few excerpts he provides, it appears that the work done by the NMHF was innovative, interesting, and even entertaining. In fact, the development and modernization of public relations within the field of psychiatry, and medicine in general, is a subject that cultural historians need to address. Anyone interested in taking up the subject would do well to look at these two books.

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

Volume 15, Number 2 **June–December 1995**

Health Care Confidentiality: Current Virginia Law and a Proposal for Legislation

By Paul Lombardo

> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.[1]

This is Hippocrates' ancient prescription for medical confidentiality. Once presumed only for physicians, the rule of confidentiality is now a universal ethical requirement for those who work in health care settings, including psychologists, social workers and others who provide mental health services. The ethical norm for practitioners is matched by an expectation on the part of patients who yield the secrets not only of their bodies, but of their minds, in an effort to achieve health.

Some have argued that developing practice trends give too many people access to a patient's records. As a result, the foundation of trust characteristic of the doctor/patient relationship has eroded, they say, and the ethic of shared secrets is threatened.[2] Additionally, the new technologies that require computerized medical records and convenient electronic data transmission have made the protection of clinical information difficult. Legal practice has also evolved, and demands for medical evidence in all types of litigation—from personal injury, to employment actions to child custody—have become commonplace.

Certain kinds of medical innovations have led to proposals for new laws. For example, the availability of previously unknowable genetic information set the stage for the devel-

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opment of a model genetic privacy act,[3] and general concerns over the possibilities for abuse of electronic medical records have yielded calls for a comprehensive national law to regulate medical confidentiality. A bill that would accomplish that goal has recently been introduced in Congress.[4] In the judicial arena, the importance of mental health confidentiality is coming into focus as the United States Supreme Court reviews the application of the psychotherapeutic privilege to actions in federal courts.[5]

Meanwhile, though some federal statutes provide extraordinary protection for certain kinds of records,[6] and occasional exceptions that supersede state prohibitions on disclosure,[7] medical confidentiality is generally a creature of state law.

Virginia Confidentiality Law

Virginia's law relating to confidential medical or mental health information is contained in a patchwork of statutes that are difficult to find and more difficult to understand and apply. Taken together, those laws neither instruct the subject of sensitive information when his or her expectation of confidentiality will be respected, nor clearly alert the professional when a disclosure of confidential information is appropriate. Ironically, while there are as many as fifteen different statutes that allow or require doctors and psychotherapists to breach patient confidentiality, there is no statute in Virginia that specifically requires confidentiality to be maintained in both public and private therapeutic contexts. (See Table 1.)

There are, however, several statutes that protect some features of medical and mental health confidentiality. A statute on the "Rights of Patients and Residents" of facilities operated, funded or licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services promises "legal rights and care consistent with basic human dignity." A specific provision of

Table 1: Virginia Law Allowing or Requiring the Disclosure of Patient Information

§ 32.1-36	*physician must report HIV+ patients, children with STDs*
§ 32.1-37	*medical care facility directors and others must report certain diseases*
§ 37.1-226	*patient "deemed" to consent to disclosure for purpose of insurance reimbursement*
§ 46.2-401	*medical directors of state facilities must report discharged mental patients unable to operate motor vehicles to Department of Motor Vehicles*
§ 54.1-2400.1	*health professional immunity for making reports to police and others concerning patient threats*
§ 54.1-2906	*hospital's duty to report disciplined or impaired health professionals*
§ 54.1-2907	*practitioner's duty to report impaired heath practitioners*
§ 54.1-2908	*health professional organization's duty to report disciplined members*
§ 54.1-2909	*organizational duty to report malpractice, discipline in other states, professional incompetence, etc.*
§ 54.1-2966	*physician to report the disability or infirmity of a person licensed to operate aircraft*
§ 54.1-2966.1	*physician to report the disability of a person licensed to operate a motor vehicle*
§ 54.1-2967	*physician to report wound inflicted by certain weapons*
§ 54.1-2968	*physician immunized for identifying any person under the age of 22 who has physical or mental handicapping condition*
§ 63.1-55.3	*physician and others must report evidence of adult abuse*
§ 63.1-0248.11	*physician and others must report evidence of child abuse*
§ 65.2-607	*workers' compensation exam by physician designated by employer not privileged*

the statute allows a facility resident to "[h]ave access to his medical and mental records and be assured of their confidentiality . . . ."[8]

Another statute settles the ownership of medical records in health care providers while simultaneously mandating that "providers shall keep medical records confidential and only authorized personnel shall have access to such records."[9]

The only other broad legal protection of confidential information is provided by a privilege against compelled disclosure in the litigation context.

The Privilege Statutes: Virginia Code §§ 8.01-399; 8.01-400.2

Two statutes protect against compelled court disclosure of confidential information communicated during a health encounter. Section 8.01-399 covers communications made to physicians and other "duly licensed practitioners of the healing arts," specifically including clinical psychologists. The privilege insulates "any information. . . acquired in attending, examining or treating the patient in a professional capacity." It is operative in civil (but not criminal) litigation except when the patient's physical or mental condition has been put at issue, or in the court's judgment when "necessary to the proper administration of justice." Though courts have broad discretion under this statute to compel disclosures concerning otherwise confidential communications, the practices of trial judges are quite variable. At times confidentiality is honored even in criminal trials—though the statute does not protect it.[10] At other times, though confidential medical information has seemed particularly relevant to fair adjudication, the judge's discretion in excluding it from a civil trial has been upheld.[11]

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Developments in Mental Health Law

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

Developments in Mental Health Law is distributed free of charge to Virginia residents twice a year, and to out-of-state subscribers at an annual rate of $20. If you are not currently on our mailing list but would like to receive this publication, please send your full name and address with your subscription request to Box 100, Blue Ridge Hospital, Charlottesville, VA 22901. Changes of address should include both old and new addresses. This publication is also available electronically over the World Wide Web at the following address: http://www.ilppp.virginia.edu/ilppp.

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ISSN 1063–9977

In the Federal Courts

Supreme Court Remands Tuggle Case a Second Time

Tuggle v. Netherland, 116 S. Ct. 283, 64 USLW 3315 (1995)

Lem Tuggle was convicted of murder by a Virginia state court in 1984. At his sentencing hearing, the Commonwealth presented psychiatric testimony that there was a high probability that Tuggle would represent a danger to the community in the future. Tuggle's request for an independent psychiatrist to review his case was denied, and so the testimony of the Commonwealth's expert went unrefuted. A jury found Tuggle guilty, and because it recognized the aggravating circumstances of future dangerousness and vileness of his crime, it sentenced him to death.

The next year the Supreme Court decided *Ake v. Oklahoma*, 470 U.S. 68 (1985), [See Ake v. Oklahoma*: New Directions for Forensic Evaluation*, 5 **Developments in Mental Health Law** 1(1985)] and held that "when the prosecutor presents psychiatric evidence of an indigent defendant's future dangerousness in a capital sentencing proceeding, due process requires that the state provide the defendant with the assistance of an independent psychiatrist." Relying on *Ake*, Tuggle appealed the decision of the Virginia Supreme Court. The United States Supreme Court overturned both the Virginia decision and the subsequent decision of the 4th Circuit Court of Appeals rejecting habeas corpus relief, and returned the case to state court.

On remand, the Virginia Supreme Court invalidated the portion of the jury's decision that resulted from the finding of future dangerousness, but reaffirmed the death sentence based upon the jury's finding of vileness. On petition for habeas corpus by Tuggle, a Federal District Court faulted that conclusion, (See "*Federal District Court Grants Habeas Corpus Petition Claiming Denial of Right to Independent Experts*," 14 **Developments in Mental Health Law** 5 [1994]) but was overturned by the Fourth Circuit Court of Appeals.

The judgement of the Fourth Circuit was rejected a second time by the U.S. Supreme Court. Because of the *Ake* error, it reasoned, Tuggle was unable to develop his own psychiatric evidence, and the Commonwealth's assertions went unchallenged. The lack of any contradictory testimony may have increased the persuasiveness of the expert's opinion. With other evidence, the Supreme Court said, the jury may not have imposed the death penalty. While the existence of another aggravating factor, such as vileness, may permit the death penalty to stand, it does not necessarily do so. The Supreme Court encouraged the Court of Appeals to conduct "harmless error" analysis in order to determine whether, without the finding of future dangerousness, the jury would have decided the Tuggle case in the same way.

California May not Take Social Security Benefits of Hospitalized Mental Patients

Crawford v. Gould, 56 F. 3d 1162 (9th Cir. 1995)

The Ninth Circuit Court of Appeals recently ruled that California's practice of withdrawing money from the accounts of involuntarily committed patients without adequate notice and consent violates federal

law. Under California law, patients who are committed to state psychiatric hospitals are held liable for the cost of their own care, support, and maintenance. California deducted the money, which included Social Security benefits, in order to reimburse hospitals for such costs. The Court, however, found California's procedure unacceptable.

California protocol required that upon commitment all patients received a "Statement of Financial Liability" informing them that they were responsible for the cost of their care. The State then conducted a financial investigation of each patient to determine an appropriate contribution and to calculate a monthly bill. Patients were asked to sign an "Authorization for Deposit and Withdrawal," in which they agreed to deposit their money, including their Social Security benefits, into a trust account maintained by the hospital. The form also gave the hospital trust officer the authority to withdraw funds from the account, which was entitled "patients' personal deposit fund." When an individual patient's total deposits exceeded $500, the hospital could apply the excess to the cost of that patient's care.

The State's practice was challenged in a class action suit brought by several patients on behalf of "all current and future patients involuntarily committed to California state psychiatric hospitals." Five of the six plaintiffs either refused to sign the authorization or subsequently revoked their authorization for withdrawal. Even if a patient declined, California removed the money from the patients' fund and presented the protesting patient with a "Notice of Intended Withdrawal," informing him or her of the monthly deduction. While both the authorization and the intended withdrawal forms included a statement about a patient's right to appeal withdrawals, neither described a process of appeal; rather, they simply instructed patients to contact the trust officer who administered the deposit fund.

The district court enjoined both California's practice of withdrawing Social Security benefits without consent and the State's deduction of any funds from patient accounts without adequate notice. The lower court required that patients be informed about the proposed share of costs and how that determination is made, their right to appeal the determination, and the appeals process and procedure. Adequate notice must also include a warning that certain benefits are exempt from legal process and cannot be used to pay for the cost of care without "the patient's knowing, affirmative, and unequivocal consent."

Patients must be informed that certain benefit payments cannot be used to pay for treatment without their knowing, affirmative and unequivocal consent.

The Court of Appeals affirmed the district court's opinion; Social Security benefits cannot be deducted absent meaningful patient consent, and adequate notice must be provided. The Court further found that California's practice was preempted by federal statute. The nonassignment provision of the Social Security Act, 42 U.S.C. Section 407(a), provides that "the right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law." The Court considered California's procedure to be in conflict with the federal statute, and the Supremacy Clause of the United States Constitution therefore requires the State's procedure to be set aside.

The Court relied on the 1988 case of

Bennett v. Arkansas (485 U.S. 395) in which the Supreme Court held that an Arkansas statute allowing the attachment of a prisoner's Social Security benefits to pay for the costs of incarceration violated the Supremacy Clause. The Bennett Court ruled that section 407 (a) of the Social Security Act "does not contain an implied exception for attachment of payments when a state has provided the recipient with care and maintenance." The Ninth Circuit was constrained to follow the Supreme Court's interpretation of Congressional intent, and it had already applied the reasoning of *Bennett* in a previous case with facts quite similar to *Crawford.* Because the differences between the two cases were insignificant, the Court of Appeals concluded that California's procedures were inconsistent with the federal statute and therefore preempted by it.

The court decided that California's procedures of withdrawal from patient accounts constituted "other legal process" even though technically there is no threat of court involvement or formal legal proceedings. This interpretation is consistent with the purpose of the federal statute, which is designed to protect Social Security beneficiaries from the claims of their creditors. To interpret the statute more narrowly would allow the state to obtain benefits through procedures that afford less protection than those of the judicial process.

Because a contract requires consent, involuntarily committed patients cannot be said to have an implied contract with hospitals.

Contrary to the State's argument, the Court also noted that patients do not have an implied contract with hospitals, in which they agree to apply their benefits to the cost of their care. A contract requires consent, and involuntary commitment, by definition, is devoid of consent.

Federal Habeas Relief Granted in Washington Sexual Predator Case

Young v. Weston, 898 F. Supp. 744 (W.D. Wash., 1995)

A Federal District Court has granted a writ of habeas corpus in a case challenging the constitutionality of Washington State's Sexually Violent Predator statute. That law, previously upheld as constitutional by the Supreme Court of Washington, authorized indefinite commitment of defendants determined to be "sexually violent predators." (See "*Supreme Court of Washington State Finds Sexual Predator Commitment Law Constitutional,*" 13 **Developments in Mental Health Law** 35 [1993]).

The controversial statute defined a sexually violent predator as one "who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence." It permitted the state to initiate an involuntary commitment process when certain detainees were on the verge of release. Individuals convicted of a sex offense, found incompetent to stand trial for such an offense, or found not guilty of a sex offense by reason of insanity could be the target of further institutionalization just as their sentences were about to expire or when their release was imminent. The statute required that they be confined in correctional institutions but established no mandates for treatment. Detainees had no right to a hearing other than an annual review unless they convinced a court that their conditions had changed.

Andre Brigham Young had been convicted of three separate rapes spanning a twenty-two year period, the last in 1985. Pursuant to the sexual predator statute, Washington state filed a petition for the involuntary commitment of Young one day before his scheduled release from prison. A

jury found him to be a sexually violent predator, and he was committed indefinitely. Young appealed the commitment on constitutional grounds, and the Washington Supreme Court held that the statute was not unconstitutional.

The United States District Court for the Western District of Washington disagreed. First, the court held that the statute violated substantive due process, a doctrine that prevents the government from undertaking arbitrary and wrongful actions even if the procedures involved are fair. A long line of cases has established that state infringements on liberty require a compelling interest, and the method of restriction must be tailored narrowly to achieve only that interest.

Courts have been reticent to permit detention or incarceration for any reason other than punishment. For example, while detention of mentally ill individuals is permissible, in *Foucha v. Louisiana*, 504 U.S. 71, 112 S.Ct.1780 (1992), the Supreme Court reiterated its long-standing rule that patients be both mentally ill and dangerous to warrant continued confinement. (See 12 **Developments in Mental Health Law** 4 [1992]). The most significant problem with Washington's statute was that it lacked a mental illness requirement. In fact, the legislature explicitly targeted individuals who did not meet accepted definitions of mental illness. It stated that a "small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for the existing involuntary treatment act." The legislature asserted that sex offenders exhibit antisocial personality features that are not amenable to treatment, that the prognosis for cure is poor, and that traditional involuntary commitment was inadequate to address the risk sex offenders pose, since they are unlikely to engage in overt acts of violence while confined. Thus, the statute endorsed indefinite incarceration based only on a showing of potential future dangerousness. Furthermore, the language of the statute was circular: it defined a sexually violent predator as a person who suffers from a mental condition that predisposes him or her to commit acts of sexual violence. The federal court decided that disorders falling short of mental illness could not justify indefinite confinement.

The court also determined that Washington's statute violated the *ex post facto* clause of the Constitution. That doctrine guarantees individuals fair warning of the effect of the law and permits reliance on established law until it is explicitly changed. For a statute to violate the *ex post facto* clause, it must be retrospective, that is, it must apply to events that occurred before the enactment of the new law. In addition, the law must be disadvantageous to the person who challenges it. Young's case satisfied both of these criteria. The *ex post facto* clause applies only to criminal laws, and although the Washington legislature has considered its Violent Predator statute a civil matter, the District court found it to be punitive in nature. The statute authorized affirmative restraint for an indefinite period of time, it applied to criminal behavior, and it promoted retribution and deterrence, the traditional aims of punishment.

Washington's Sexual Predator law targeted individuals who did not meet accepted definitions of mental illness.

Finally, the District Court remarked that the statute punished offenders twice for the same crime. The Constitution's double jeopardy clause protects citizens against this abuse, and the court found that the Predator statute subjected sex offenders to a second incarceration for one offense, in violation of double jeopardy.

Young's case is currently pending on appeal before the 9th Circuit Court of Appeals.

In the Virginia Courts

Town May Allow Mental Health Facility not Explicitly Permitted by Virginia State Law

Trible v. Bland, 250 Va. 20, 458 S.E.2d 297 (Va. 1995)

The Supreme Court of Virginia recently decided that a town may define the type of group home which is allowed in its district in more permissive terms than those that appear in the state statute. Virginia Code section 15.1-486.3 provides that "a residential facility in which no more than eight mentally ill, mentally retarded, or developmentally disabled persons reside," which is licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services, "shall be considered residential occupancy by a single family." The Court has now clarified that, with a permit from the Department of Social Services, a town has the authority to operate a group home containing more that eight people in a residential district.

In December of 1992 the Town of West Point issued a Certificate of Use and Occupancy to the owner of a single-family detached dwelling. The certificate permitted the use of the dwelling as a group home and restricted occupancy to no more than 21 residents.

In August of 1993 Charlotte W. Trible filed a complaint against West Point, naming Mayor R. Tyler Bland as one of the defendants. Trible lived in a single-family residence adjoining the newly-established group home, and she disputed the granting of the certificate, which was issued without notice to adjacent property owners. Upon learning of the group home, Trible had first taken her complaint to the board of zoning appeals in July 1993. She was denied a hearing there because her request for review of the zoning administrator's decision was time-barred.

In her complaint Trible asserted that the issuance of the permit, which allowed 21 residents in the group home, violated various provisions of the state statutes and town ordinances, particularly Virginia Code Section 15.1-486.3. She claimed that the ordinance was not in compliance with the authority granted to localities by the General Assembly. Trible sought a judgment declaring the ordinance invalid, an injunction preventing the enforcement of the ordinance and operation of the home, and a rescission of the certificate of occupancy.

The trial court ruled that West Point's more expansive definition of a group home was not in violation of the Dillon rule, a principle of state law that prohibits municipalities from exercising powers not expressly granted by the Commonwealth, and that the zoning administrator's decision was therefore appropriate. The trial court also found that it was proper for the board of zoning appeals to decline to hear Trible's complaint because she was time-barred under Virginia Code Section 15.1-496.1, which provides a 30-day window of appeal. Though permitted to amend her pleadings to the Supreme Court of Virginia, Trible declined to do so.

The question before the Court concerned the interpretation of Virginia Code Section 15.1-486.3. Trible contended that the language of that section limited the zoning power of local authorities to *allow* group homes in residential districts. Conversely, West Point argued that the statute limited the zoning power of localities to *exclude* group homes from residential districts.

The Court decided that the statute at issue was not a maximum occupancy restriction but rather a "use restriction and complementing family composition rule." The statutory provisions do not mandate a cap on the number of people who may live in a

group home; instead, the statute simply says that residential facilities meeting certain specifications should be treated the same as residences occupied by a typical family composed of people related by blood, marriage, or adoption. Although a locality clearly cannot be more restrictive than the statute, it is free to be more permissive in its treatment of group homes than the statutory language requires.

Virginia Court Lacks Jurisdiction to Try Minor as Adult Absent Meaningful Hearing

Douglas v. Commonwealth, 19 Va. App. 324, 451 S.E.2d 49 (1995)

When a juvenile court transfers a minor to circuit court for trial as an adult, the minor appealing such decision is entitled to a proper hearing or a meaningful review in the circuit court. The Court of Appeals of Virginia has held that without conducting a meaningful review of the decision to transfer, the circuit court is not empowered to try the juvenile.

In two separate bench trials, Lamont O. Douglas was convicted of malicious wounding, robbery, two counts of use of a sawed-off shotgun, and use of a firearm in the commission of a felony. Though only sixteen years old at the time of the offenses, Douglas was tried as an adult in the Circuit Court of Fairfax County. Douglas appealed the convictions, asserting that the trial court failed to conduct the type of review of the transfer proceedings to which he was entitled by law and that therefore it did not have jurisdiction to try him. Douglas further contended that he was denied due process of law when the trial court refused to allow an additional mental health examination that he requested.

On January 31, 1992, Douglas was taken into custody for the commission of several crimes, some against Augustin Garcia and the others against Kenneth Mandeville three days later. He was charged with robbing the first victim with the use of a sawed-off shotgun and shooting the other, also with a sawed-off shotgun, with the intent to maim, disfigure, disable, or kill him.

On separate occasions with respect to each event, the Commonwealth's attorney provided notice of its intent to seek transfer to the circuit court for trial as an adult. Likewise on separate occasions, the Juvenile and Domestic Relations Court found probable cause to believe that Douglas had committed each of the crimes, and the court ordered a consolidated transfer investigation and report to be made. The juvenile court conducted a hearing on May 11, 1992 and ordered the case to be transferred to circuit court for trial as an adult on all charges. Douglas noted his appeal of the decision, and counsel set May 28 as the date for argument of the appeal in the trial court.

A few days after the hearing in juvenile court, Douglas's attorney received a telephone call from the clerk of the circuit court. Based upon the trial court's review of Douglas's file only, the appeal had been denied and the Commonwealth's attorney had been notified to seek an indictment in the trial court. This decision was made prior to the receipt of the transcript of the transfer proceedings that had been conducted in juvenile court; that transcript was not filed in the trial court until May 29,1992.

In a series of pretrial motions Douglas's counsel argued that the trial court should have done more than merely read the defendant's file before swiftly denying his appeal. In response, the Judge stated, "I am of the opinion that the Code does not require a hearing."

The Court of Appeals of Virginia has left less room for differences of opinion. Virginia Code Section 16.1-269 (E) requires the circuit court to examine all "papers, reports, and orders" when determining whether a

juvenile case should be transferred to the circuit court. The Court held that the transcript of the transfer proceedings is a document that falls within the meaning of "papers, reports, or orders." The trial court either should have considered the transcript or should have provided Douglas a hearing on the matter. The appellate court recognized that it is critical for the circuit court to make an independent determination about transfer. It pointed out the paradoxical result of the trial court's procedure: Douglas was afforded a right to appeal to the circuit court in regard to the transfer proceedings that occurred in juvenile court, but once in the circuit court he was afforded neither a hearing nor any meaningful review. The right to appeal, without more, afforded him nothing.

The appellate court ruled that transcripts of transfer hearings must be reviewed by the circuit court before adult trial of a juvenile proceeds.

Douglas also argued that his due process rights had been violated because he was denied an additional mental health examination. In advance of his trial, Douglas was examined by a clinical psychiatrist who found him to be competent to stand trial and sane at the time of the offenses. These findings were not contradicted at the sentencing hearing by the clinical psychiatrist employed by Douglas, although that doctor did recommend further review by an expert in Maryland. As part of the transfer hearing, the juvenile court had ordered a study and psychological report, the results of which indicated no psychiatric disorder. Douglas requested an additional mental health examination to be conducted before sentencing, and he wanted to be transported to Maryland to get it.

Considering the record before it, the Court of Appeals was not convinced that another mental health examination "would have been a significant factor in the sentence [Douglas] would have received." The court was satisfied with the previous examinations, particularly since they included a review by a psychologist chosen by Douglas. The Court indicated that Douglas's sanity at the time of the offense had not been shown to be a significant factor in his defense.

Furthermore, no authority was presented that would support a decision to transport Douglas to another state for such examination.

The case was remanded to trial court, which must conduct either a hearing or a meaningful review of all papers, reports, and orders.

Hunter Who Mistakes Man for Turkey Entitled to Psychological Expert

Farley v. Commonwealth, 20 Va. App. 495, 458 S.E.2d 310 (1995)

The Court of Appeals of Virginia has ruled that the trial court erred in refusing to hear expert psychological testimony proffered to explain how one hunter might have mistaken another for a turkey. Although the trial court had ruled the evidence inadmissible as a matter of law, the Court of Appeals remanded the case, requiring the trial court to exercise its discretion in determining the admissibility of the expert testimony.

While turkey hunting in the early morning hours of May 20, 1992, Newton Wesley Farley, Jr. shot and killed another hunter. At trial he was convicted of involuntary manslaughter and reckless handling of a firearm.

According to Farley, he went hunting with his father and brother, and the three men took their own paths in the woods. Farley proceeded to use a turkey call, and he

heard a turkey gobble. As he moved towards the noise he heard a turkey coming toward him and believed he saw a turkey. He also thought he saw the turkey ruffling its feathers as if it were going to fight. Farley testified that he looked at his target through his scope for approximately one minute before he shot. Though he believed in his mind that he was shooting a turkey, he discovered after firing that in fact he had shot a man dressed in camouflage. The camouflage included a hood with a mask, and the other hunter, while hiding in the bush, had also been using a turkey call.

At trial Farley wanted to introduce expert testimony about perception. He proffered the testimony of John L. Kibler, Chairman of the Psychology Department at Mary Baldwin College, to explain the phenomenon known as "closure." According to Dr. Kibler, when the brain is confronted with ambiguous stimuli, it will draw a conclusion to complete an unclear image, even though the conclusion may be wrong. Internal factors such as previous experiences, expectations, fears, and anticipations influence the brain's interpretation of ambiguous stimuli, so two people who witness the same ambiguities might arrive at different conclusions about them. In other words, when the environment is difficult to interpret, internal factors tend to lead humans to their own conclusions about their surroundings. Given that the purpose of camouflage is to create ambiguous stimuli, Dr. Kibler planned to testify that, with certain internal expectations, a person could perceive the existence of a turkey that wasn't really there.

To prove that Farley committed involuntary manslaughter, the Commonwealth had to convince the jury that he was grossly, wantonly, and culpably negligent "such as to indicate a reckless or indifferent disregard of human life and of the probable consequences of the act." In order to convict Farley of reckless handling of a firearm, the Commonwealth also had to prove that Farley handled his rifle "in a reckless manner such as to endanger the life, limb, or property of another person." Therefore, a crucial issue in determining both criminal negligence and recklessness was the extent to which Farley tried to identify his target.

The Court of Appeals said that Farley had a right to introduce evidence that he didn't act in a gross, wanton, culpable, and reckless manner. The court noted that probative evidence is normally admissible; it should be excluded only when its probative value is outweighed by policy considerations such as unfair prejudice, needless consumption of time, or unnecessary confusion of the jury.

The perceptual phenomenon known as "closure" may have caused the hunter to believe he was shooting a turkey, when in fact he was shooting another hunter.

Relevant scientific evidence is likewise admissible provided that the expert is qualified to give testimony and the science offered is considered reliable. A judge may exclude scientific testimony if he thinks the evidence is a matter of common knowledge and will not be helpful, or if the testimony will force the jury to make a certain conclusion on an ultimate issue in the case.

At trial neither Dr. Kibler's expertise nor the reliability of the science upon which he based his testimony were at issue. The Commonwealth did contend, however, that the proffered testimony about "closure" was a matter of common knowledge, making it unnecessary, and that to admit it would force the jury to make a particular decision about Farley's state of mind. Since Farley's mental state at the time of the offense was an ultimate issue in the case, it was a topic about which the jury should deliberate, and an expert should not draw such an influential

conclusion about it.

The Court of Appeals disagreed. That misperception can be the result of a psychological phenomenon over which the mind has no control is not necessarily common knowledge. The Court believed that the expert testimony might have assisted the jury in understanding and resolving the case. In particular, the psychologist would have explained how the camouflage could have contribute to Farley's misperception. This may have dispelled the jury's impression that Farley was grossly, wantonly, and willfully negligent, an essential issue of the case. In addition, the expert testimony may have bolstered Farley's claim that he carefully identified his target before shooting, refuting the Commonwealth's theory of recklessness.

The Court of Appeals did not concur with the Commonwealth's claim that Dr. Kibler's testimony would have required the jury to find that Farley believed he shot a turkey. Dr. Kibler would have testified only to the possibility that one can misperceive what one sees; he would not have addressed the central question of whether Farley actually mistook the hunter for a turkey. Even with Dr. Kibler's testimony, the jury could have disbelieved Farley's story.

For all of these reasons, the Court of Appeals found that the doctor's testimony could be admitted, and remanded the matter to the trial court, where the judge may use his discretion in deciding whether or not to admit the evidence.

Ultimate Issue and Hearsay Testimony of Expert Reverses Conviction for Sexual Battery

Jenkins v. Commonwealth, 21 Va. App. 222, 463 S.E. 2d 330 (1995)

Following a grand jury indictment, James Lloyd Jenkins was charged with the aggravated sexual battery of his nephew, a child born in 1990. At trial, evidence was submitted that the boy was cared for by his grandparents on weekdays, and that Jenkins visited the home frequently. The trial judge then permitted the testimony of a licensed clinical psychologist who offered the opinion that the boy had been sexually abused. Over defense objections, the expert was permitted to repeat certain statements made to him by the child and upon which his opinion had been founded.

Experts may tesitify only about matters outside of common knowledge, and may not express opinions about the case's "ultimate issue."

Specifically, the psychologist testified that in private sessions the boy reported having been "sexed." He pointed to his groin when asked for more details. Further, the child gyrated his pelvic area in a forward-thrusting motion to demonstrate and used anatomically-correct male dolls to further illustrate the incident. The psychologist concluded that the child had developed an adjustment disorder as a reaction to the stress of sexual abuse. The jury subsequently found Jenkins guilty.

Jenkins' appeal of the conviction was based on two arguments. First, he claimed that the trial judge erred in allowing the expert to testify about an ultimate fact at issue in the case. The Court of Appeals of Virginia agreed, relying on the Virginia Supreme Court decision in *Cartera v. Commonwealth*, 219 Va. 516, 248 S.E.2d. 784 (1978). In that case, the rule was established that while an expert may be permitted to express an opinion about matters that fall outside of common knowledge and experience, an opinion about "the precise or ultimate fact in issue" is not admissible. Thus, since the fact at issue in the *Jenkins* case was whether the child had been sexually abused, the psy-

chologist should not have been permitted to assert his opinion that sexual abuse had been committed. The determination of that question was better suited for the jury.

Jenkins also argued that the psychologist's testimony contained inadmissible hearsay statements made by the child. Again citing *Cartera*, the Court of Appeals agreed. To justify an expert opinion, the court noted, an expert may testify about statements made to him or her concerning a patient's pain, suffering, or subjective symptoms, but *Cartera* did not extend this rule to include statements concerning the circumstances of an offense. The boy's claim that he had been "sexed" fell into the latter category according to the appellate court, and the trial judge erred in admitting it. The conviction was reversed and the case remanded to the circuit court for a new trial.

Videotaped Psychiatric Examination under Hypnosis not Admissible in Virginia

Radcliff v. Commonwealth, 1995 WL 332217 (Va. App. 1995) [not reported]

When Robin Kallen Radcliff appealed her conviction of capital murder and conspiracy to commit capital murder, she complained of three errors at the trial level. Radcliff first argued that a videotape of her psychiatric examination, during which she underwent hypnosis, should have been admitted into evidence. The Court of Appeals rebuffed this argument stating, "It is well established that hypnotic testimony is considered unreliable and inadmissible evidence in this Commonwealth."

The Court justified the Commonwealth's position by noting several problems with hypnosis, all of which are enumerated in the Court's earlier decision, *Hopkins v. Commonwealth*, 230 Va. 280, 337 S.E.2d 264 (1985), *cert. denied*, 475 U.S. 1098 (1986). The law questions the reliability of hypnotic testimony because under hypnosis a person is vulnerable to suggestion. Furthermore, in order to benefit herself or please her psychiatrist, a person under hypnosis may attempt to fill in gaps in memory by imagining details or by intentionally fabricating facts. Both during hypnosis and following it, a hypnotized person may not be able to distinguish fact from fiction. Finally, hypnosis may foster strong confidence in the recollection of the events that were uncovered only through hypnosis. The trial court found that the videotape of Radcliff's hypnosis "would be of little probative value and carries with it great risk of fabrication." The Court of Appeals considered this decision to be within the discretion of the trial court and refused to disturb the ruling.

Radcliff was also dissatisfied with the amount of time she was held in custody before going to trial. Under Virginia Code section 19.2-243, defendants are entitled to be released if trial has not commenced within five months of the finding of probable cause in the district court. Some circumstances, however, serve to excuse an otherwise unacceptable delay. In Radcliff's case, the delay was attributable to the defendant's successive motions to the lower court. Thus, since the delay was the result of Radcliff's own actions, and since her motions indicated no concern about being afforded a speedy trial, the court found that she was not in need of the statutory protections generally given to others.

It is well established that hypnotic testimony is considered unreliable and inadmissible evidence in Virginia.

Radcliff further challenged the lower court's decision to admit the hearsay statements of her alleged coconspirators. Contrary to Radcliff's claim, Virginia law clearly provides that once the court has made a

threshold decision that a case involves a conspiracy, the actions and statements of any conspirator in furtherance of the conspiracy are admissible evidence against any other. Radcliff's own statements convinced the court that she conspired with at least two other cohorts to carry out a murder. With the conspiracy proven, the coconspirators hearsay statements—made after the commission of the murder but before payment for the crime—were deemed admissible against Radcliff.

Spring 1996 Forensic and Civil Training Schedule

at the

Institute of Law, Psychiatry and Public Policy

Charlottesville, Virginia

CIVIL TRAINING PROGRAMS

Civil Commitment Training Program
Institute of Law, Psychiatry and Public Policy
February 15-16

Alternatives to Patient Consent
Institute of Law, Psychiatry and Public Policy
April 19

Mental Health and Law Orientation
April 22,
Central State Hospital

Mental Health and the Law Annual Symposium
June 6-7
The Jefferson - Richmond, Virginia

Substance Abuse and Law Orientation
Institute of Law, Psychiatry and Public Policy
March 4

FORENSIC TRAINING PROGRAMS

Basic Forensic Evaluation Training
Institute of Law, Psychiatry and Public Policy
March 19, 20, 21, 22 & 25

Sex Offender Evaluation Training
Institute of Law, Psychiatry and Public Policy
March 8

Capital Sentencing Evaluation Training
Institute of Law, Psychiatry and Public Policy
June 14

Introduction to Forensic Mental Health Law
May 3
Western State Hospital

Forensic Symposia
May 10
Charlottesville

The **Advanced Forensic Evaluation Training Program** originally scheduled for January 11 & 12 will be rescheduled. Please contact the Institute for more information.

All training programs are subsidized by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. Continuing Legal and Medical Education Credit is available for some programs with two months advance notice.

A fee schedule is available upon request. Contact the Institute of Law, Psychiatry and Public Policy at (804) 924-5126, FAX (804) 924-5788, or e-mail ilppp@virginia.edu. For descriptions of training programs visit the Institute's world wide web site: www.ilppp.virginia.edu/ilppp.

In Other State Courts

Warrant Required before Police Entry of Home to Carry out Involuntary Commitment Orders

McCabe v. The City of Lynn 875 F. Supp. 53 (D.Mass. 1995)

Rose Zinger, a sixty-four-year-old woman suffering from extreme obesity and high blood pressure, died of a heart attack when Lynn, Massachusetts police officers kicked in her door and physically restrained her to carry out an involuntary commitment order. A U.S. District Court ruled that the police policy permitting warrantless entry violated the Fourth Amendment protection against unreasonable searches and seizures.

Zinger lived alone in Lynn, and spoke little English. In addition to the physical ailments described above, she also suffered from "psychological problems" that were said to be related to her past experiences as a survivor of the Holocaust. In September 1989, her physician applied to the Tri-City Mental Health and Retardation Center to initiate the involuntary commitment process under Massachusetts law. However, the Lynn police did not attempt to take her into custody until the following afternoon, choosing to coordinate the commitment with a State Constable who planned to serve an eviction order that day.

The Constable, in light of his prior attempts to serve eviction notices on Zinger, informed the officer in charge of the commitment that she was unlikely to cooperate or open her door. When the police arrived at Zinger's home, they rang the door bell but received no answer. After one minute, they kicked in the door. Once inside, the officers proceeded upstairs where they found another door locked, identified themselves, but again received no response. They started to kick this door in but stopped when Zinger opened it slightly.

An officer showed Zinger the commitment papers and tried to explain that she needed to see a doctor. But her understanding of English was limited and she began to close the door, shouting: "Why, why, no doctors!" When the police entered the room Zinger reached for a small knife on a nearby table. One officer knocked Zinger to the floor, and while she lay face down, screaming, her hands were cuffed behind her back. When the Emergency Medical Technicians (EMT) arrived, they explained that Zinger's size and uncontrollable behavior made it impossible to carry her downstairs on a stretcher. According to the subsequent trial court record: "Upon hearing this, the officers forced Ms. Zinger down the stairs on her buttocks one step at a time."

The city policy allowed police serving involuntary commitment orders to "escalate the degree of force," but it did not require a warrant to forcibly enter a home.

The EMTs placed Zinger on a stretcher, face down, still handcuffed behind her back. One of the police officers then noticed blood running from her mouth and removed the cuffs. An EMT found no pulse, and began cardiopulmonary resuscitation, but Zinger was pronounced dead at two p.m., an hour after the officers arrived at her home.

In depositions filed with the court, the City of Lynn explained that it normally followed the policy of serving involuntary commitment papers peacefully. However, officers were authorized to "escalate the degree of force" if they met with resistance.

The policy did not require that a magistrate be consulted, or that a warrant should be sought prior to forcible entry of a home in such cases. The city cited the beneficent motives of involuntary commitment and argued that the application for a commitment order, when completed by a physician, made a warrant unnecessary. In such situations, the police's role as agents of the doctor outweighs their role as agents of the city. Furthermore, the doctor's application noted that Zinger was dangerous to herself and others and needed to be evaluated immediately.

But if that was so, the court noted, "the Lynn Police acted with leisure in arranging a convenient time" to serve the order. Clearly moved by the circumstances of the case, the court was unequivocal in its application of Fourth Amendment guarantees to personal liberty and domestic privacy in civil commitment cases. "This case" the court began, "involves Rose Zinger who survived the Holocaust only to die at the hands of the Lynn Police." Of the city's attempt to characterize police behavior as part of a therapeutic plan, the court noted that "[c]oerced hospitalization is uniquely susceptible to abuse."

> Although a certified physician or psychologist might be uniquely qualified to evaluate the emotional condition of a patient, he or she is not qualified to determine whether probable cause exists to support an unconsented entry of an individual's home or seizure of an individual. The Constitution specifically imparts that responsibility to the judiciary . . . Moreover, the agents of the doctors in this case are police officers with guns and batons, not hospital orderlies and nurses. There is no therapeutic relationship which a warrant mechanism might disrupt.

Since the officers already expected that Zinger would be uncooperative, they could easily have applied to a magistrate to secure a warrant, said the court. This case presented none of the extenuating circumstances elaborated by other courts to allow warrantless search and seizure.

Health Care Confidentiality...

—continued from page 27—

A similar statute (§ 8.01-400.2) applies to communications between licensed professional counselors, licensed clinical social workers and licensed psychologists, and their clients. The privilege it establishes is also limited to civil actions and contains most of the same exceptions of the companion statute (§ 8.01-399), as well as a specific cross reference to the statutory requirement of reporting child abuse.

Though these laws can provide a harbor against compelled revelations of confidential matter in court, they provide inadequate barriers to other improper disclosures of personal information. This inadequacy was highlighted in a recent Virginia Supreme Court opinion involving a medical malpractice claim for breach of confidentiality.

Pierce v. Caday

A woman consulted her physician for advice and a prescription sedative, asking that the "highly confidential" nature of their discussion be respected. She later found that details of her conversation with the doctor had been repeated by his employee to her coworkers. A suit followed, alleging that the doctor's failure to control his employees amounted to breach of an explicit contract of confidentiality.[12] The trial court dismissed the suit, questioning both the form (a contract action) and the substance (an allegation of wrongful disclosure of information) of the woman's legal claim.

On appeal, the Supreme Court upheld the trial court's decision because the plaintiff had not complied with provisions of the malpractice act. It agreed that the claim was properly characterized as an action in tort, not a contract. The analysis of doctor/patient confidentiality that followed was instructive:

> While the General Assembly implicitly has recognized the existence of a qualified physician-patient privilege in Virginia, the only explicit statutory pronouncement of the privilege is an evidentiary rule restricted to testimony in a civil action. . . . In the present case, the plaintiff seeks to fashion a cause of action for recovery in damages out of what has thus far been recognized in Virginia as merely a rule of evidence.

Some states, the Court noted, had recognized wrongful disclosure of medical information as a valid tort claim; others had not. Because the plaintiff and defendant presumed that the claim was valid, the issue was not put to the Court, thus a decision on whether to judicially recognize such a cause of action was unnecessary. The Court could "assume without deciding" that such an action would be available.

The Virginia Supreme Court has characterized the legal privilege for confidentiality as "merely a rule of evidence."

The Pierce case dramatized the absence of clear statutory protection in the Code of Virginia for medical and mental health confidentiality in contexts other than the courtroom.

Proposed Confidentiality Law

For the past two years, the Committee on the Needs of the Mentally Disabled of the Virginia Bar Association has studied the problem of medical and mental health confidentiality. Following a review of laws in other states and consultation with lawyers and representatives of health professional associations, the Committee drafted a comprehensive bill that has been introduced to the Virginia General Assembly.

The bill is an attempt to formulate a comprehensive legislative statement on the subject of medical and mental health confidentiality.

House Bill 750 is an attempt to formulate a comprehensive legislative statement and to set a general standard on the subject of medical and mental health confidentiality in Virginia law. It addresses current deficiencies in the law, while providing clear legislative guidance to both patients and practitioners concerning appropriate legal duties, responsibilities and expectations.

The draft legislation is divided into six sections. Section I provides definitions of common terms used throughout, and clarifies the scope and coverage in the act. For example, the definition of "provider" affected by the proposed law mirrors the use of that term in Section 8.01-581.1 (listing all health care practitioners affected by the Medical Malpractice Act) but unlike that section of the Code, also includes state facilities, as well as anyone licensed by the boards within the Department of Health Professions. "Records" protected by the law include all material maintained in any form, along with the substance of any communication made by a patient to a provider in the course of receiving health services.

Section II recognizes a right of privacy in a patient's medical records. It establishes the general principle that disclosure of records is prohibited without patient consent or unless it is otherwise permitted under conditions set forth in the law.

Section III describes the scope of coverage of the law, noting that release of information under provisions of the workers compensation statute is not affected, nor are the records of minor patients, in most cases. It also authorizes limited disclosures to caretakers of mental health patients.

Section IV lists twenty-five specific situations in which disclosure of patient information is permitted. This section cross-references most current law that mandates or authorizes disclosure, such as child and adult abuse reports or reports on impaired practitioners. It also incorporates existing provisions of Section 8.01-413 regarding medical records.

Section V enumerates the requirements for responding to requests for records from patients or anyone else, and it includes a suggested form for providing consent to release of confidential health care information. It also incorporates procedures contained in current Section 32.1-127.1:02 for the copying of medical records.

Section VI outlines in detail the procedure to be followed for issuing subpoenas to health care providers. It includes strict requirements of notice to the patient and the patient's attorney, and the time line that must be met before records may be released by a provider. A new provision of this section would require lawyers seeking records to notify patients of their right to object to a subpoena. The section supplies the legal standard the court should apply when challenges to subpoenas are filed.

Taken as a whole, the proposed legislation would have several beneficial effects. By cross-referencing existing statutes concerning confidentiality, it establishes a single reference point on

that topic in the Code for patients, providers and lawyers. It gives those who create and maintain patient records clear guidance concerning prohibited and permitted disclosures. It requires lawyers to notify patients before disclosures of private information contained in their records are made in response to a subpoena, and it alerts patients of their right to object to the disclosures. It clarifies how providers can comply with subpoenas without violating the law and gives patients an explicit right to their records. Finally, it announces a strong legislative policy in favor of confidentiality, long an expectation of patients and an ethical mandate for practitioners, though never before so clearly protected by Virginia law.

Direction for both the legal and health care communities on the extent and limit to patient confidentiality is long overdue. Whether the law will finally reflect both patient expectations and the ethical norms of the health care professions is a matter to be addressed in the current session of the General Assembly.

[The full text of the Virginia Health Care Confidentiality Act may be viewed on the Internet at http://www.ilppp.virginia.edu/ilppp/medconf.html].

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Notes

1. Ludwig Edelstein, "The Hippocratic Oath: Text, Translation and Interpretation." *Bulletin of the History of Medicine.* (Supplement 1, 1943).
2. Mark Seigler, "Confidentiality in Medicine—A Decrepit Concept." *New England Journal of Medicine* (December 9, 1982, p. 1582).
3. Annas et al., *The Genetic Privacy Act, 1995.*
4. U.S. Senate Bill 1360, *Medical Records Confidentiality Act of 1995.*
5. *Jaffee v. Redmond* 51 F. 3d 1346 (CA 7, 1994) cert granted, 64 USLW 3281 (existence of psychotherapist/patient privilege under Federal Rules of Evidence).
6. *Federal Confidentiality of Drug and Alcohol Abuse Patient Records*, 42 USC § 290dd-3; 42 CFR Part 2.
7. *Developmental Disabilities Act* (access to Program Records by Advocacy Program authorized to investigate abuse) 42 USC § 6042 (a) (1); similar provisions under the *Protection and Advocacy for Mentally Ill Individuals Act* (PAMI) 42 USC § 10801-501.
8. Va. Code § 37.1-84.1; accompanying *Rules and Regulations to Assure the Rights of Residents of Facilities* contain lengthy provisions concerning permitted and prohibited disclosures of patient information and records, VR 470-03-01 (July, 1983) .
9. Va. Code § 32.1-127.1:02 Medical records; ownership; provision of copies; § 54.1-2403.3 contains substantially the same language concerning provider ownership of records.
10. For example, *Wilson v. Commonwealth* 1995 WL 293050 (Va. App.) (unreported decision), (appeal followed exclusion of records of a mentally retarded complaining witness in a sexual battery prosecution).
11. See, for example, *Peoples Security Life v. Arrington* 243 Va. 89, 412 S.E.2d 705 (1992), holding that the exclusion of medical records of a woman whose husband died of stabbing and gunshot wounds incurred while sitting next to her in their auto and who later claimed the proceeds of his life insurance policy was nonetheless within the discretion of the court.
12. *Pierce v. Caday* 244 Va.285, 422 S.E. 2d 371 (1992); see 13 *Developments in Mental Health Law* 5 (1993) for details of the case.

Index of Cases

The following index lists in alphabetical order all cases that have been cited in volumes 10-15 of *Developments in Mental Health Law*. Volume and page numbers in boldface indicate a full discussion of the cited case. Other citations refer to the named case in light of another case or subject. Legal citations are complete as of December, 1995. A case index for earlier volumes can be found in issue 9.2. (July-December 1989).

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