Developments in Mental Health Law

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Hendricks and the Future of Sex Offender Commitment Laws

by Eric S. Janus

In its 1997 *Hendricks* decision, the United States Supreme Court upheld the constitutionality of the Kansas Sexually Violent Predator commitment law. In important ways, the decision gives states the green light to use civil commitment as a tool to address sexual violence. More broadly, the decision answers a number of questions about the constitutional limits on the use of civil commitment. Despite the answers, questions remain, particularly about the practical application of these constitutional limits. During the two years since *Hendricks* was decided, several important lower court decisions have begun to shed light on these questions. However, the most significant limits on the use of civil commitment will come from legislative and administrative policy decisions.

I. Sex Offender commitments

Sex offender commitments deploy civil-commitment-style confinement to address sexual violence. Beginning in the late 1930's, states began to enact civil commitment laws aimed at mentally disordered sex offenders. Eventually, such laws were enacted in over half the states.

Also in this issue:

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These laws were conceived of as providing alternatives to imprisonment for sex offenders whose mental conditions rendered them "too sick to deserve punishment." By the mid-1970's, however, a number of influential studies declared these laws to be a failed experiment. The laws were based on the mistaken assumption that sex offenders displayed some medically valid diagnosis. Treatment for detainees was either not provided or had not been shown to be effective. Most states repealed or abandoned these first generation laws.

Since 1989, states have shown a renewed interest in using civil commitment to address sexual violence. The second generation laws differ from the first in a critical respect: instead of providing an alternative to prison, the new laws are specifically intended to extend the incapacitation of convicted sex offenders who are deemed too dangerous to release when their prison terms expire. About 12 states have adopted such laws and an equal number are considering them.

Sex offender commitment laws follow a uniform pattern, though there is some state-by-state variation. All of the laws are denominated "civil," rather than criminal. Civil laws are not subject to the strict constitutional constraints of the criminal law. This is an important feature of the laws, since the laws are designed to extend the incarceration of convicted sex offenders who have completed their penal sentences. Normal rules of criminal procedure prohibit lengthening a sentence beyond its expiration date and imprisoning an individual based on a prediction of future criminal activity.

Typically, the commitment laws require proof of four elements: (1) A past course of sexually harmful conduct. All contemporary commitment schemes aim at individuals who have been convicted of, and have served prison time for, past crimes of sexual violence. (2) A current mental disorder or "abnormality." The Kansas law, for example, requires proof of a "mental abnormality or personality disorder," and defines "mental abnormality" as a "congenital or acquired condition affecting the emotional or volitional capacity." Minnesota law requires proof of a "sexual, personality, or other mental disorder or dysfunction." (3) A finding of risk of future sexually harmful conduct. The Kansas law requires a finding that the person is "predisposed" to "commit sexually violent offenses . . . in a degree constituting such person a menace to the health and safety of others." The Minnesota law requires a finding that the individual "is likely to engage in acts of harmful sexual conduct." (4) Finally, the laws require some form of connection between the mental abnormality and the danger. The Kansas law requires a showing that the mental abnormality "predisposes" the individual to commit sexually violent crimes. The Minnesota law states that the past history and the current mental disorder must "result in" the likelihood of future harmful behavior. California law holds that the diagnosed mental disorder "makes" it likely that future sexually violent criminal behavior will occur.

A key feature of contemporary sex offender commitment laws is their reliance on systematized risk assessment. For example, in Minnesota, the Department of Corrections is required to make risk determinations for all sex offenders about to be released from prison. Those assessed as "high risk" must be further assessed for appropriateness for sex offender commitments. A similar screening requirement is used in California. Both states use "structured screening instruments" as part of the screening process.

Currently, Minnesota's commitment program detains about 150 individuals in highly secure treatment facilities. By comparison, the sex offender population in Minnesota prisons is about 1100. About 350 sex offenders are released from prison each year. Of these, about 10% are referred for possible commitment, and half of those (15 to 18 annually) are civilly committed.

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In the Federal Courts

ADA Unambiguously Applies to State Prisons and Prisoners

Pennsylvania Department of Corrections, et. al. v. Ronald R. Yeskey, 524 U.S. 206 (1998)

Ronald Yeskey was sentenced to eighteen to thirty-six months in a Pennsylvania correctional facility. The sentencing court recommended the Yeskey be placed in a Motivational Boot Camp for first-time offenders. Upon completing the Boot Camp, Yeskey would have been eligible for parole in just six months. However, the Pennsylvania Department of Corrections denied Yeskey admission to the program due to his long medical history of hypertension.

Yeskey filed suit claiming that by excluding him from the program, the Pennsylvania Department of Corrections violated the Title II of the American with Disabilities Act of 1990 which prohibits a "public entity" from discriminating against a "qualified individual with a disability" because of that disability, 42 U.S.C. §12132. A district court dismissed the suit holding the ADA to be inapplicable to state prison inmates. The Third Circuit reversed the district court, and the Supreme Court granted certiorari.

The Department of Corrections argued that control over state prisons was a primary function of state governments, thus the state had a strong interest in the activity and the ADA should not apply. The Court disagreed. Examining the statutory construction of the ADA, the Court held that "the statute's language unmistakably includes State prisons and prisoners within its coverage." State prisons clearly met the statutory definition of a public entity. The question then focused on what constituted "benefits of services, programs, or activities of a public entity."

[T]he Court held that "the statute's language unmistakably includes State prisons and prisoners within its coverage."

According to the Court, modern prisons provide recreational activities, medical services, and educational programs that "at least theoretically 'benefit' the prisoners." The ADA provides no basis for distinguishing between programs, services, and activities provided by public entities. Coverage under the Act extends to anyone with a disability who "with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the

participation in programs or activities provided by a public entity."

The Department further argued that the statute's statement of findings and purpose did not mention prisons and prisoners, and thus is inapplicable in this case. The Court disagreed, holding that even if Congress did not envision the ADA to be applied to state prisoners, the "fact that a statute can be 'applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.'"

Consequently, the Supreme Court upheld the judgment of the Third Circuit by holding that the "plain text of Title II of the ADA unambiguously extends to state prison inmates."

Personality Disorders if Linked to Future Dangerousness can Justify Involuntary Detention

United States v. David Troy Henley, 8 F.Supp.2d 503 (E.D.N.C., 1998)

David Henley first entered the federal correction system to serve a seventy-nine month sentence imposed after he pleaded guilty to a bank robbery in 1990. In 1996, he began serving a three year period of supervised release. One day after his release, Henley overdosed on a combination of drugs. Henley was admitted to a mental health crisis unit where he was diagnosed with psychotic disorder and amphetamine-induced delusional disorder. After being discharged from the mental health crisis unit, Henley was placed in a halfway house.

> ... [The] court stated that it did not appear that "the involuntary commitment of an individual with a personality disorder linked to future dangerousness is unconstitutional."

Six weeks later, he abandoned the halfway house and was later arrested after jumping out of a closed second story hotel window. Subsequently, an evaluation was conducted at the Metropolitan Detention Center in Los Angeles where Henley was diagnosed with several substance abuse disorders, borderline personality disorder, and antisocial personality features.

During early 1997, Henley was ordered into several supervised release programs from which he absconded. In March 1997, the U.S. Marshals arrested Henley, and he was sentenced to a sixteen month sentence for violations of his supervised release program. Henley was admitted to FCI-Butner for psychiatric evaluation and treatment. There he was diagnosed as suffering from severe substance abuse problems, severe antisocial personality disorder, and severe borderline personality disorder.

While at Butner, Henley was secluded for inappropriate behavior, declined participation in Alcoholics Anonymous and Narcotics Anonymous, expressed suicidal ideation, and stated that if released he would return to criminal behavior. Consequently, the Eastern District Court of North Carolina recommended the commitment of Henley to the care and custody of the Attorney General. However, before issuing the recommendation, the court had to address the issue of whether or not a personality disorder could justify civil confinement.

In *Foucha v. Louisiana*, 504 U.S. 71 (1992), the Supreme Court decided that a state could not indefinitely detain an individual found Not Guilty by Reason of Insanity (NGRI) on the basis of antisocial personality alone. The Court required a finding of both dangerousness and mental illness which, in the opinion of the Court, the diagnosis of antisocial personality did not suffice.

However, in *Kansas v. Hendricks*, 521 U.S. 346 (1997), the Court found constitutional a "sexually violent predator" commitment statute that required the finding of future dangerousness linked to a mental abnormality to justify confinement. Consequently, the North Carolina court stated that it did not appear that "the involuntary commitment of an individual with a personality disorder linked to future dangerousness is unconstitutional." The court went on to note that very few cases categorically drew a line between personality disorders and mental diseases and defects.

Henley's history of violent episodes and violations of supervised release programs suggested to the court that his disorders combined to impair substantially his ability to function in society.

The court turned to the American Psychiatric Association's Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) to find the definition of a personality disorder. The court concluded that personality disorders may be properly considered a mental disease or defect. Furthermore, the legislative history of the Insanity Defense Reform Act suggested to the court that mental disease or defect may sometimes include antisocial personality disorders.

Henley's history of violent episodes and violations of supervised release programs suggested to the court that his antisocial personality disorder and his borderline personality disorder combined synergistically to impair substantially his ability to function in society. The court held that the impairment was significant enough to be considered a mental disease or defect. Consequently, Henley was

committed to the care and custody of the Attorney General. However, the court was careful to limit the decision to the facts so as not to suggest that merely an antisocial personality disorder, without more, would justify detention.

Prior Term of Confinement in Community Treatment Center does not Constitute a Sentence of Imprisonment for Determining Criminal History under Sentencing Guidelines

United States v. Adrian Pielago, Maria Varona, 135 F.3d 703 (11th Cir.(Fla.) 1998)

In the course of sentencing Adrian Pielago for a conviction of conspiring to possess cocaine with the intent to distribute, the United States District Court for the Southern District of Florida treated Pielago's prior term of confinement in a community treatment center as a "sentence of imprisonment" for purposes of determining his criminal history category under the Sentencing Guidelines. The criminal history category is used as part of a point system for Federal sentencing guidelines which determine the sentence to be imposed upon those convicted of crimes. Pielago argued that a six month sentence that he had served in a community treatment center for a weapons charge should not have been classified as a sentence of imprisonment.

Under the Sentencing Guidelines, a sentence of imprisonment means a sentence of incarceration. The legislative history and commentary surrounding the Sentencing Guidelines clearly states that temporary residence in a halfway house does not qualify as a sentence of imprisonment. The instant question before the court was whether or not confinement in a community treatment center equates to residency in a halfway house, or to imprisonment.

Pielago argued that a six month sentence that he had served in a community treatment center for a weapons charge should not have been classified as a sentence of imprisonment.

The court examined how other circuits had answered similar questions. The Sixth Circuit, in *United States v. Rasco*, 93 F.2d 132 (6th Cir. 1992), held that confinement in a community treatment center as a result of a parole revocation was imprisonment under the Sentencing Guidelines. In *Rasco*, the court reasoned that because the question at hand dealt with confinement for a parole revocation, the Sentencing Commission had concern for *why* the defendant had been confined -- his failure to stay out of trouble while on parole. The question of *where* the defendant spent his sentence was irrelevant; it was the parole

revocation that was the critical issue for *Rasco*.

Pielago's stay in a treatment center was not for a parole violation but rather for a direct sentence to that treatment center.

The Eleventh Circuit distinguished Pielago's case from the case in *Rasco*. Pielago's stay in a treatment center was not for a parole violation but rather for a direct sentence to that treatment center. Instead, the Eleventh Circuit chose to follow the line of reasoning developed by the Ninth Circuit's decision in *United States v. Latimer*, 991 F.2d 1509 (9th Cir. 1993). The *Latimer* court found that a halfway house had been specifically distinguished from a sentence of imprisonment. The Ninth Circuit found that a community treatment center was closer to a halfway house than to a sentence of confinement and thus was not a sentence of imprisonment.

The Eleventh Circuit held that Pielago's six month sentence in a community treatment center was not a sentence of imprisonment. The Sentencing Guidelines themselves place community treatment centers alongside halfway houses in five of the six sections in which the term "halfway house" appears. Consequently, the court concluded that Pielago should not have received a criminal history point for that period of confinement, and his sentence should have been reduced to a sentencing range of 121 to 151 months. Pielago's sentence was vacated and the case was remanded for resentencing.

ADA Prohibits Employers from Offering Benefit Plans that Discriminate on the Basis of Mental Disability

Harold Lewis v. Aetna Life Insurance Company and Kmart Corporation, 7 F.Supp.2d 743 (E.D.Va. 1998)

Harold Lewis had suffered from severe depression since 1979, but through treatment was functioning without significant impairment. Through his job with Kmart, where he had been employed since 1984, Lewis was offered and accepted an employee disability benefit plan issued by Aetna Life Insurance Company in 1987.

Under the plan, physical disabilities were to be covered through age sixty-five, but benefits for mental disabilities were to be terminated after twenty-four months of coverage. In 1993, Lewis accepted a successor plan that offered similar benefits and contained a similar distinction in the benefit coverage for physical and mental disabilities.

In March 1995, Lewis's depression became worse, and he became unable to work. Initially, Lewis went on medical leave under

Kmart's leave program. By September 1995, he began receiving monthly long-term disability benefit payments under the Aetna plan. In the Spring of 1996, Lewis learned that Aetna had classified his disability as mental and thus subject to the two-year cap. Under the plan, Lewis's benefits were to be terminated in September of 1997.

In July of 1996, Lewis filed a charge with the Equal Employment Opportunity Commission alleging that he had been subjected to discrimination on the basis of his disability. In August of 1997, Lewis brought suit claiming that Kmart and Aetna had discriminated against him on the basis of his disability in violation of the Americans with Disabilities Act (ADA).

In pretrial rulings, the court dismissed Lewis's claim against Aetna and held that at issue were: (1) the date the plaintiff became aware that his condition was classified as mental under the benefit plan and (2) if Kmart had sufficient actual justification for offering an employee benefit plan that distinguished between physical and mental disabilities.

Since Lewis was employed, maintained his residence, and received insurance benefits in Virginia, Virginia law guides the federal courts in their analysis and interpretation of applicable federal law, here the ADA. The court cites the Code of Virginia, which states that "[n]o person shall [r]efuse to insure or limit the amount, extent or kind of insurance coverage available to an individual . . . solely because of . . . mental or physical impairments, unless the refusal, limitation or rate differential is based on sound actuarial principles." If Kmart could provide sufficient reasons for the discrepancy, the plan could be protected under §501 of the ADA which was designed to avoid unnecessary disruption of state insurance regulation.

Kmart chose to offer its employees an insurance plan that "provided inferior coverage for mental as opposed to physical disabilities . . . [and] demonstrated no actuarial justification for the dichotomy."

Kmart failed to offer any actuarial justification for choosing the Aetna plan. Kmart instead presented evidence that, in spite of the fact that two of Aetna's largest clients used uncapped plans for mental disabilities, they were unaware that plans without a cap existed. Kmart's decision to offer a plan that specifically limits benefits for disabilities that are mental rather than physical was not based in actuarial considerations, was inconsistent with Virginia law, and therefore, Kmart's plan was not entitled to the protections of §501 of the ADA.

Kmart chose to offer its employees an insurance plan that

"provided inferior coverage for mental as opposed to physical disabilities . . . [and] demonstrated no actuarial justification for the dichotomy." Consequently, the court held that Kmart violated the ADA by offering Lewis a plan that discriminated against him on the basis of his mental disability. The court then awarded Lewis damages, ordering continued payment of monthly disability benefits as long as he remains disabled within the meaning of the plan.

Maryland Law Requiring Reasonable Belief of Mental Disorder and Clear and Imminent Danger to Justify a Petition for an Emergency Evaluation Upheld

S.P., a Citizen of Takoma Park, Maryland v. The City of Takoma Park, Maryland, 134 F.3d 260 (4th Cir.(Md.)1998)

In May 1992, Susan Peller and her husband had an argument in their Takoma Park home. As a result of the argument, the husband called telephone information seeking a mental health hot-line. The operator told him that no such listing existed. He then called the police department's business line and asked for a referral to a marriage counselor. The non-emergency police dispatcher to whom he was talking transferred his call to an emergency dispatcher. After an extended conversation with the husband, the emergency dispatcher sent police officers to the Peller's home to investigate a "possible suicidal person: Susan Peller."

Officer Rich and three other uniformed officers arrived at the Peller's home later that morning. The officers noted that Susan Peller was visibly agitated and crying. She stated that she and her husband had engaged in a "painful argument." The conversation continued, and Officer Rich and Sergeant Bonn decided that the officers should take Mrs. Peller to the hospital for an emergency psychiatric evaluation. Mrs. Peller disagreed and refused to leave her home. Consequently, the officers were required to handcuff her before removing her from her home.

> The relevant Maryland law on seizure for psychological evaluation only required that a police officer has a reasonable belief that an individual suffers from a mental disorder and presents a clear and imminent danger to herself or others.

Officer Rich prepared a petition seeking an emergency psychiatric evaluation. In his petition, Officer Rich stated that Mr. Peller had called the police to report that his wife might commit suicide. Officer Rich also reported that Mrs. Peller was very upset and had stated to him that if not for her children she would take her life. Officer Rich believed

Mrs. Peller to be very upset, irrational, and in danger of hurting herself.

Following the submission of Officer Rich's petition, two emergency room psychiatrists examined Mrs. Peller and concluded that she had a mental disorder, needed inpatient care, presented a danger to herself, and was unwilling to be voluntarily committed. These findings met the Maryland requirement for involuntary admission. After her confinement, Mrs. Peller called her husband who then sought her release, claiming that his wife's detention was the result of a grave error and miscommunication with the police.

The hospital staff refused to release Mrs. Peller to her husband's custody. Mrs. Peller had met the qualifications for involuntary detention and had been given a diagnosis of "depression/suicidal." The following day, an attending psychiatrist gave Mrs. Peller a complete psychiatric examination and determined that she was neither suicidal nor suffering from a mental disorder. Mrs. Peller was then released from the custody of the hospital.

Mrs. Peller then filed suit claiming a violation of her civil rights by being involuntarily detained by the officers and the staff of Washington Adventist Hospital. The district court dismissed Mrs. Peller's claim on the grounds that a causal link between the city's involuntary commitment policy and Mrs. Peller's injuries simply did not exist. The Fourth Circuit granted a review of the appeal from the district court and affirmed the decision.

Under Maryland law, the police officers are not entitled to qualified immunity if: 1) they violate a clearly established right of an individual and 2) if a reasonable officer would have understood that the police conduct at issue was unlawful and clearly violated the rights of the individual.

The relevant Maryland law on seizure for psychological evaluation only requires that a police officer have a reasonable belief that an individual suffers from a mental disorder and presents a clear and imminent danger to herself or others.

The court concluded that the officers who detained Mrs. Peller were acting well within the bounds of their authority. Mrs. Peller appeared quite distraught during her conversations with the police. The officers on the scene had been advised that they were likely to find a potentially suicidal person at the scene. Mrs. Peller made statements that suggested that she may in fact take her own life. By examining the totality of the circumstances, the court concluded that officers had sufficient probable cause to believe that Mrs. Peller posed a clear and imminent danger to herself if left alone. Thus the court dismissed Mrs. Peller's claim against Takoma Park and the officers at the scene.

The ADA Imposes a Duty on Regional Hospital to Provide Treatment in the Most Integrated Setting Appropriate to Each Patient's Needs

L.C., by Jonathan Zimring as guardian ad litem and next friend; E.W. v. Tommy Olmstead, Commissioner of the Department of Human Resources; Richard Fields, Superintendent of Georgia Regional Hospital at Atlanta; Earnestine Pittman, Executive Director of Fulton County Regional Board, all in their official capacities, 138 F.3d 893 (11th Cir.(Ga.) 1998)

L.C. and E.W. filed an action against the Georgia Regional Hospital at which they were treated challenging their continued confinement in a segregated environment, when a community treatment setting may have provided the most beneficial treatment option. The doctors treating both L.C. and E.W. recommended that a community treatment setting would provide the best treatment options for both of these patients. Nonetheless, the hospital continued to treat them in a segregated environment. L.C. and E.W. claimed that the state's failure to provide them with care in the most integrated setting appropriate to their needs violated Title II of the American Disabilities Act.

Title II of the ADA prohibits discrimination against individuals with disabilities in the provision of public services by states and local governments. Under §12132 of the ADA, "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." Furthermore, under the Attorney General's implementing guidelines, "public entities are required to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. §35.130(d).

"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."

The plain language of the ADA clearly prohibits a state from providing services to individuals in an unnecessarily segregated setting. In the case at hand, the State did not seriously contend that the Attorney General's guidelines were clearly erroneous.

The court looked to Congress's interpretation of the ADA, which expressed a desire to eliminate the segregation of individuals based on their disability. The segregated

treatment offered by the regional hospital to L.C. and E.W. was of the exact type of discrimination that the ADA was designed to eliminate. Although the denial of community based treatment programs to L.C. and E.W. did not stem from a malevolent intent on the part of the state, that indifference to the needs of these patients is precisely the kind of benign neglect the ADA aims to prevent.

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Furthermore, the court rejected the State's suggestion that the hospital was unable to place L.C. and E.W. in a community-based treatment facility because of a lack of funds. The failure of the hospital to place them in a community treatment setting for financial purposes did not lessen the discriminatory character of their segregation. Congress only wanted to permit a lack of funding defense in the most limited of circumstances. Consequently, unless a state can prove that the requiring of additional expenditures would be so unreasonable given the demands on a state's mental health budget that the services offered by the state would be fundamentally altered, the ADA requires the state to make the additional necessary expenditures to eradicate the discrimination.

The Eleventh Circuit held that the ADA imposes a duty on care givers to provide treatment in the most integrated setting appropriate to each patient's needs, and thus concluded that the state had discriminated against L.C. and E.W.

[*Editor's Note*: The United States Supreme Court granted certiorari in this case, which will likely result in a ruling in the summer of 1999. The Federal Appeals case is reported here in the 1998 volume so that readers may be aware of the substance of the decision, which was the state of the law at the end of 1998. *Developments* will report on the Supreme Court decision, when it becomes available, in the 1999 volume.]

The 23rd Annual Symposium on Mental Health and the Law

September 22nd, 1999
Omni Hotel - Charlottesville

This conference will center on the recent Supreme Court Case,

Olmstead v. L.C.,

in which the justices addressed the states' responsibility for providing treatment in the community

In the Virginia Courts

An Explicit Finding of Competency to Stand Trial is not Required in Juvenile Cases

Santos Panameno v. Commonwealth of Virginia, 255 Va. 473, 498 S.E.2d 920, (1998)

In May 1995, Santos Panameno was charged with two counts of rape and three counts of extortion. The juvenile and domestic relation district court entered a transfer order to the circuit court to try Panameno as an adult. The transfer order did not contain an explicit finding that Panameno was competent.

Panameno appealed the order, but the district court held that the transfer complied with the statute. Panameno entered a conditional plea of guilty on the two counts of rape and one count of extortion.

> The court held that the specific language of §16.1-269.1 did not require an explicit finding of competency.

The Supreme Court of Virginia awarded appeal to address the single issue of whether §16.1-269.1 requires an explicit finding that the juvenile is competent before entering an order of transfer to the circuit court. Prior to 1994, §16.1-269 required that in order to transfer a juvenile defendant to the circuit court to be tried as an adult, the juvenile and domestic relations court had to make specific findings including a finding that the juvenile was competent to stand trial.

In 1994, §16.1-269 was repealed and the Virginia legislature replaced it with §16.1-269.1, which makes the transfer of a juvenile subject to certain conditions. One of the conditions for transfer holds that "[t]he juvenile is presumed to be competent [to stand trial] and the burden is on the party alleging the juvenile is not competent to rebut the presumption by a preponderance of the evidence."§16.1-269.1(A)(3). The court held that the specific language of §16.1-269.1 did not require an explicit finding of competency, and thus Panameno's guilty plea was upheld.

Virginia Supreme Court Upholds Death Sentence for 16-Year-Old

Chauncey Jacob Jackson v. Commonwealth of Virginia, 255 Va. 625, 499 S.E.2d 538, (1998)

Mr. Jackson was tried as an adult and convicted of capital murder and five related felonies which were committed when he was sixteen years old. He was sentenced

to death. Upon appeal, Mr. Jackson raised several claims including that the imposition of the death penalty upon a sixteen year old juvenile is cruel and unusual punishment and that the use of testimony from a court appointed psychologist in his case was prejudicial to the case. The Supreme Court of Virginia disagreed and affirmed his death sentence. The court reviewed Virginia case law and statutes and concluded that a sixteen year old person who is convicted of capital murder may be subjected to capital punishment.

Although Jackson never called his own witness in mitigation, he called Dr. Nelson as a witness on his own behalf in the penalty phase of the trial.

Furthermore, Jackson objected to a request to undergo a psychological examination. However, because Jackson had filed notice of intent to present psychological evidence in mitigation, the court ordered Jackson to submit to an evaluation by a court appointed forensic psychologist, Dr. Nelson. Although Jackson never called his own witness in mitigation, he called Dr. Nelson as a witness on his own behalf in the penalty phase of the trial. Nonetheless he complained that the court erred in several respects by ordering his evaluation. The court rejected Jackson's contention that the court-ordered evaluation violated his Fifth Amendment privilege against self-incrimination and his Sixth Amendment right to a fair trial.

Jackson further argued that the court erroneously allowed Dr. Nelson to testify in the penalty phase. The court disagreed and refused to allow the defendant to obtain an advantage from an error that he injected into the record by calling Dr. Nelson as his own witness.

Additionally, the court noted that Dr. Nelson's testimony related only to the risk factors associated with the violence that Jackson's personality exhibited. Dr. Nelson further testified that he could not say that Jackson would be a danger in the future; however, he noted that Jackson exhibited more of the risk factors for future violent acts than many other criminal defendants he had evaluated. The court found Dr. Nelson's testimony admissible because his testimony did not lead to the ultimate issue in the case. The court also stated that the jury could disregard an expert's opinion regarding the defendant's future dangerousness and that there was sufficient evidence to permit a reasonable person to conclude beyond a reasonable doubt that Jackson would be dangerous in the future.

Pathological Intoxication due to Voluntary Intoxication no Basis for Insanity Defense in Virginia

Nathaniel Lee Downing v. Commonwealth of Virginia, 26 Va.App. 717, 496 S.E.2d 164, (1998)

Nathaniel Downing was arrested and indicted for the murder of his sister-in-law, Kristina King. King was found dead with forty-seven stab wounds in Downing's apartment. During his initial trial, Downing moved for the court to appoint at the Commonwealth's expense a psychologist to help him prepare for trial as well as a neurologist. Dr. William Stejskal examined Downing and concluded that Downing was suffering from pathological intoxication at the time of the offense. Pathological intoxication occurs when a person experiences an altered mental state and a violent, uncharacteristic reaction in response to alcohol that may often result from a neurological abnormality.

> Pathological intoxication is "merely a form of temporary insanity triggered by voluntary intoxication..."

Dr. Stejskal testified that a neurological examination would be helpful but not a necessary component in determining the cause of Downing's pathological intoxication. The doctor further testified that his opinion that Downing was legally insane at the time of the offense would not change depending the outcome of the neurological examination. The trial court granted the motion for the appointment of Dr. Stejskal, but denied the motion for the appointment of the neurologist because it was neither necessary to Dr. Stejskal's diagnosis nor to the defense.

The trial court ruled as a matter of law that pathological intoxication by voluntary intoxication cannot be admitted into the court on the issue of insanity. Furthermore, the court found that Downing was not so intoxicated that he could not deliberate and premeditate his actions. Consequently, Downing was found guilty of first degree murder and was sentenced to forty years incarceration.

In this appeal, the Virginia Court of Appeals noted that the Supreme Court of Virginia had stated "voluntary intoxication is not a defense unless it produces a permanent insanity in the defendant." The court held that pathological intoxication is "merely a form of temporary insanity triggered by voluntary intoxication and that is, therefore, prohibited under Virginia law." Furthermore, Downing failed to demonstrate a "particularized need" for the appointment of the neurologist. The Court of Appeals held that the trial court properly struck evidence of the

pathological intoxication and properly denied the appointment of the neurologist, and thus upheld Downing's conviction.

Statement of a "Mentally Slow Individual" Deemed Involuntarily Given

Commonwealth of Virginia v. Leonard Carl Ferguson, 1998 WL 267290 (Va.App. 1998)

Responding to a summons from investigators, Leonard Ferguson went to the Attorney General's Office. Entering the building, he passed an armed guard and was met by two investigators who separated him from his family. The investigators led him to a conference room and closed the door. Ferguson was not allowed to leave the room unaccompanied, even to go to the bathroom, as the investigators informed him that they did not want him to become lost in the maze of offices.

As a result of the setting, Ferguson believed that he was not free to leave and was compelled to give his statement. A Virginia Court of Appeals found that Mr. Ferguson was "a rather unsophisticated mentally slow individual with no apparent prior criminal history and no evidence of any understanding of the Constitutional rights protected under Miranda"who would "not feel free to exercise unconstrained choice but would feel obliged to submit to the demands of the investigators." Ferguson's statement was held to be involuntary, and suppressed.

Testimony on Mental Condition Admissible to Aid Self-defense Claim

David Toran Peeples v. Commonwealth of Virginia, 1998 WL 663335 (Va.App. 1998)

David Peeples was charged and convicted of aggravated malicious wounding and use of a firearm. In this appeal, Peeples argued the trial court erred in not allowing expert mental health testimony regarding his state of mind at time of offense.

The psychologist who had examined Peeples was apparently prepared to testify that Peeples was mildly mentally retarded, and that as a result "he has extreme difficulty correctly interpreting social situations." Peeples argued that such testimony was relevant to his claim of self-defense, as it bears directly on whether he reasonably feared death or bodily injury at the time of the shooting.

The court acknowledged self-defense as a recognized defense in Virginia. The court noted that the critical issues are how the situation at the time appeared to the defendant, and the defendant's "state of mind at the time of the shooting", both of which are inherently subjective legal tests.

The Court of Appeals held that the Virginia Supreme Court's decision in *Stamper v. Commonwealth,*

228 Va. 707 (1985), was inapplicable, since Peeples' mental state was properly at issue. The court in this case held that the rule in *Stamper* is limited to cases where mental state is not properly at issue. *Stamper* has been read to prohibit the admission of expert psychiatric evidence unless insanity has been raised as a defense. However, the Court of Appeals held that this was an incorrect interpretation of *Stamper*.

The court held that it was error to refuse to admit such testimony in the instant case, as it was directly relevant to the material issue of "state of mind" as well as credibility of Peeple's testimony. The case was reversed and remanded for a new trial.

[*Editor's note*: The Virginia Court of Appeals granted a petition for rehearing en banc, staying the decision reported above pending the decision en banc.]

Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law. In addition, *Developments* welcomes suggestions regarding possible topics, issues of interest, or rising concerns in the field which might be addressed in future issues.

The typical article is 10 to 15 pages long, without substantial footnoting. The reading audience is multi-disciplinary, typically with legal or mental health training, but not necessarily both. Therefore, *Developments* seeks articles which are useful to a general audience interested in mental health law. The focus is generally on articles that will be useful to practitioners in the field, providing information or stimulating discussion on a wide variety of topics.

You may contact *Developments in Mental Health Law* by several methods:

1) The preferred method of submitting articles is to submit a short query by email, describing the topic and general thesis. Send email to: dmhl-editor@Virginia.edu, with a subject line of "Article Query."

2) Additionally, query letters can be mailed to the attention of the editor: Developments in Mental Health Law, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901.

Please do not initially send a copy of your article. The editor of *Developments* will contact authors if there is an interest in using or developing your piece. The fastest way for the editor to contact you is by e-mail, so please include an e-mail address, if possible.

In Other State Courts

For Tort Liability, Failure to Warn Must Be Proximate Cause of Harm to Victim

Brenda D. Bishop, as guardian ad litem for Bobbi Hatley Robertson v. South Carolina Department of Mental Health, 331 S.C. 79, 502 S.E.2d 78 (S.C. 1998)

On March 1, 1990, Brenda Bishop (grandmother) signed an affidavit alleging that her daughter, Tammi Lee Hatley (mother), had made threats against Bobbi Lee Hatley, the three year old daughter of Tammi Lee. At the time of the affidavit, Ms. Bishop had legal custody of Bobbi Lee. As a result of her mother's affidavit, Tammi Lee was committed to a psychiatric hospital for examination and observation. She was examined by two designated examiners who determined that she was not mentally ill. The mother was released the next day pursuant to a court order.

On March 3, 1990, Tammi Lee appeared at the home of the grandmother. Ms. Bishop allowed Tammi Lee to enter her home and to visit with Bobbi Lee for several hours. Tammi Lee then asked Ms. Bishop for permission to have custody of her daughter for a specific period of time. Ms. Bishop granted the request and the granddaughter left with her mother. When the mother returned Bobbi Lee to Ms. Bishop, the grandmother noticed that her granddaughter had ink marker markings on her arms and body, including her abdominal and vaginal areas.

Ms. Bishop filed suit against the South Carolina Department of Mental Health (DMH) for the negligent release of the mother, specifically for the failure to warn the grandmother of Tammi Lee's release and for failing to properly diagnose and treat the mother.

The trial court dismissed the case, holding that not only did the Department not have a duty to warn the grandmother of the release, but also that the grandmother was well aware of the threats that had been made at the time she turned custody of the granddaughter over to the mother. The Court of Appeals affirmed the decision of the trial court. The Supreme Court of South Carolina heard the appeal from the decision of the Court of Appeals.

In order for the grandmother to maintain a negligence claim against the DMH, the Department must owe a legal duty of care to the grandmother. Under South Carolina law, there is no general duty to warn of the dangerous propensities of others unless a person has the ability to monitor, supervise, and control another's conduct. When a person is in such a position, there is a common law duty to warn the potential

victims of the other individual's dangerous conduct. Furthermore, when the defendant has a special relationship to someone whose conduct needs to be controlled, the duty of care may be imposed upon the defendant to protect threatened third parties from harm.

In the case at hand, the South Carolina Supreme Court held that the DMH had a special relationship with the mother. Since the Department knew or should have known of specific threats made by the mother, a duty arose to warn Bobbi Lee or her custodian of Tammi Lee's release because a specific threat had been made by the mother to harm a specific individual. Nonetheless, the decision of the lower court was affirmed because the failure of the Department to warn of the mother's release was not the proximate cause of the harm suffered by the victim.

The evidence demonstrated that the intervening negligence of Ms. Bishop relieved the Department of its potential liability. Ms. Bishop was aware of the threats that had been made by the victim. When Tammi Lee appeared at her house, Ms. Bishop was obviously aware of her release from custody. Ms. Bishop also allowed the mother to enter the home, to visit with the child, and to take the victim away for an unsupervised visit. Consequently, the court found that Ms. Bishop had enough information, without a warning from the Department, to make an informed decision about whether or not to allow the granddaughter to visit with the mother. Thus, Ms. Bishop's intervening negligence severed the causal connection between the Department's failure to warn of the mother's release and the harm suffered by the victim.

Additionally, the plaintiff had argued that the Department had breached a duty to the child, in failing to properly treat and diagnose the child's mother. The court held that no such duty was owed to the child in this case, and that such duties are typically owed only to the patient.

Juvenile Competency Requirement Is No Less Than That of an Adult

In the Matter of the Welfare of D.D.N., 1998 WL 461907 (Minn. App.)

D.D.N. was charged by petition with first-degree attempted burglary, for which he was subsequently adjudicated delinquent. D.D.N., in this appeal, challenged a ruling that found him competent to stand trial.

Minnesota Supreme Court precedence, as well as rules of court, hold children and adults to the same standard for trial competence. The child must be able to "understand the nature of the proceedings against [them] and to participate in [their] own defense."

The prosecution argued that the rehabilitative focus of juvenile

proceedings and the availability of short-term sanctions justify a lower level of competence. However, the court disagreed, holding that fundamental fairness required the same protection offered to adults.

However, the court did not reverse the finding. The court held that a review of the record indicated that the trial court properly inferred the juvenile was competent, despite narrow areas of difficulty, principally communication. In their decision, the court discussed the testimony of two clinical psychologists, one of whom testified that D.D.N. could participate in his defense, while the other expressed some doubts, but acknowledged that D.D.N. had the cognitive capability to participate.

Virginia Supreme Court Endorses Medical Confidentiality Claim

By Paul A. Lombardo, PhD, JD

Virginia's law of medical confidentiality has seen major changes in the past two years. In 1997, a new statute declaring a right to privacy in medical information went into effect. The Patient Records Privacy Act provided long overdue clarification concerning the boundaries around confidential communications that take place in the clinical context. Less than a full year after the Privacy Act was adopted by the General Assembly, the legal significance of medical confidentiality was again highlighted. In the case of *Curtis v. Fairfax Hospital*, the Virginia Supreme Court for the first time recognized the right of a patient to sue when medical records were wrongfully disclosed

The Malpractice Case

The Curtis case was triggered by the tragic death of Jessica Curtis. Jessica was born in 1989; her mother suffered from diabetes. Though the birth was "uneventful," concerns about the potential for hypoglycemia related to maternal diabetes led doctors to place Jessica in a neonatal intensive care unit to monitor her progress. On the day she was scheduled for discharge, Jessica was found lying face down in full cardiopulmonary arrest. She was found "with her nose flattened, her face pushed in, and blue in color."

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A neonatologist who treated Jessica said she was in cardiopulmonary arrest for at least ten and perhaps as many as forty minutes before she was found; a second doctor said she had suffocated in her blanket. Though she was resuscitated, Jessica suffered extensive brain damage, dying four months later.

Patricia Curtis, Jessica's mother, eventually filed a malpractice claim, charging that Jessica's death was the result of medical negligence. The hospital responded that Jessica's death resulted from a near Sudden Infant Death Syndrome event related to maternal risk factors. Jessica's mother suffered seizures, had difficulty controlling her diabetes and smoked during pregnancy. This strategy did not convince the trial jury, which eventually awarded Ms. Curtis $500,000 for the wrongful death of her daughter Jessica.

The Wrongful Disclosure Lawsuit

In the midst of the malpractice case, Ms. Curtis' medical records describing treatment just prior to Jessica's birth and years earlier were retrieved from Fairfax and other hospitals. According to her lawyer, when Ms. Curtis' deposition was taken "very abusive questions" about "highly personal matters" were asked and it was apparent that lawyers for the hospital and other defendants had been privy to those records.

The events surrounding the Curtis deposition led to a second lawsuit, filed even as the first was awaiting trial. In that case, Ms. Curtis claimed that the hospital had conspired to commit medical malpractice by wrongfully disclosing her confidential medical records to the director of legal affairs for the hospital's parent corporation and to a nurse who was also a defendant in the first malpractice suit. The allegations made by Curtis included the charge that the hospital had intended to use confidential information "to gain an advantage in the underlying malpractice action, [concerning the death of Jessica Curtis] and to otherwise harass and disturb Curtis."

The hospital responded, arguing that a legal claim against a health care provider for unauthorized disclosure of confidential medical information has never been recognized in Virginia. Additionally, the hospital claimed that as owner of the records it could not be guilty of wrongfully mishandling its own property. A trial court judge turned those assertions aside, noting that the hospital was "merely a repository" for patient records, and that a legal claim for wrongful disclosure was valid.

Attorneys for Ms. Curtis and Fairfax Hospital disagreed over whether a suit could be properly sustained in Virginia for breach of medical confidentiality, but there was no dispute over how Ms. Curtis's records had been disclosed. The case was eventually submitted to a judge for resolution of the legal question alone. Did Virginia's privilege law (Virginia Code section 8.01-399) allow a health care

provider to unilaterally disclose medical records to people other than the patients to whom the records pertain?

The privilege statute protects physician-patient communications from compelled disclosure in a civil case. However, patients who put their physical or mental condition "at issue" by filing a malpractice suit are considered to have waived the privilege, and their records may be subject to court ordered disclosure. The trial court judge concluded that the Curtis malpractice lawsuit was brought on behalf of Jessica Curtis, and the circumstances surrounding her death were at issue. In contrast, the condition of Patricia Curtis was "not inherently at issue" and thus there was no justification to release records "simply to hunt for a grounds of defense." Finding that there is a "potential for abuse" when court oversight of record disclosure is absent, the judge concluded that Fairfax Hospital was liable for damages of $100,000.

The privilege statute protects physician-patient communications from compelled disclosure in a civil case. However, patients who put their physical or mental condition "at issue" by filing a malpractice suit are considered to have waived the privilege, and their records may be subject to court ordered disclosure.

Curtis in the Virginia Supreme Court

Fairfax Hospital appealed the decision to the Virginia Supreme Court. In its opinion, that Court noted the hospital's concession that it "unilaterally disseminated the plaintiffs medical records to an attorney and a nurse" without permission from the patient or a judge's order. The Court analyzed that event within the context of traditional state law on the duties of doctors to patients.

> In our jurisprudence, a health care provider owes a duty of reasonable care to the patient. Included within that duty is the health care provider's obligation to preserve the confidentiality of information about the patient. . . . Indeed, confidentiality is an integral aspect of the relationship between a health care provider and a patient and, often, to give the health care provider the necessary information to provide proper treatment, the patient must reveal the most intimate aspects of his or her life to the health care provider during the course of treatment.

The Court concluded that the duty of maintaining patient confidences had been breached and announced a clear rule of liability for the hospital and others who fail to protect patient records:

> [A] health care provider owes a duty to the patient not to disclose information gained from the patient during the course of treatment without the patient's authorization, . . . violation of this duty gives rise to an action in tort.

Emphasizing that this decision is consistent with decisions of most other states that have faced the question, the Court underlined the need for judicial approval for such disclosures. The hospital's defense had included the assertion that this disclosure was made within the judicial context, that is, as part of a lawsuit. But the Court nevertheless found the fault in this case to be that "an independent judicial officer, not the Hospital or the director of legal affairs for the Hospital's parent company" should have reviewed the relevance of patient records to the lawsuit before any such records were released. The Court repeated its finding that "if the patient did not manifestly place his or her medical condition at issue, . . . then the statute required a determination by a judicial officer" to make that determination.

Conclusion

The version of the privilege statute applied to the facts in *Curtis* has been amended several times in the intervening years since the events leading to that lawsuit. The statute now specifically allows for disclosure of records when necessary to the protection of the physician's legal rights, for example, in preparation for malpractice lawsuits. But the language of the privilege statute and its relation to other parts of the law is far from clear; many questions surrounding the proper handling of medical records remain.

Nevertheless, several issues are clarified by the Curtis decision. The idea that medical records exist as the property of health care providers to be released at their convenience has been explicitly rejected by Virginia's highest court. Providers have no absolute right to patient information; they hold medical secrets as trustees or fiduciaries. Providers also face significant liability when a breach of confidentiality occurs. Successful lawsuits can and will be brought in the future when inappropriate disclosures of medical information occur. Records of mental health treatment are considered a part of the medical record.

The Curtis case makes it all the more important to understand and observe boundaries of patient confidentiality as well as the range of disclosures permitted by law during litigation and at other times. It also finally clarifies the importance of medical confidentiality in Virginia, not merely as a rhetorical aspiration, but as both an ethical imperative and a legal mandate.

1998 Summary of Virginia Sex Offender Registration Statutes

In January of 1998, the Virginia General Assembly passed laws that amended the existing registration requirements for sex offenders. In addition to amending the existing law, the General Assembly added §19.2-390.2 which provides the standards by which schools and child care centers can obtain information from the Registry. The Sex Offender Registration requirements are provided in the following statutes.

§19.2-298.1

Under this section, registration is required for the violation or attempted violation of a list of sex offenses, sexually violent offenses, or offenses where the victim is a minor, physically helpless, or mentally incapacitated.

Every person convicted after July 1, 1997, including juveniles tried in the circuit court, is required to register as part of the sentence imposed upon conviction. The court is obligated to remand the person to the custody of the local law-enforcement agency for the purpose of obtaining the necessary information. The local law-enforcement agency is then required to forward such information to the State Police for inclusion in the Sex Offender and Crimes Against Minors Registry.

Furthermore, every person serving a sentence of confinement or under community supervision on July 1, 1997 for an offense for which registration is required shall be required to register and given appropriate notice of their duty to register.

Upon release from confinement, or if not confined from the date of suspension of sentence, a person will have ten days to register. If a person attempting to establish residence in the Commonwealth has been convicted of similar offenses in other state or federal courts, he or she must register within ten days of establishing residence in the Commonwealth. Anyone under a duty to register must re-register within ten days of changing their address. The registration shall include the offender's name, known aliases, date and locality of conviction, fingerprints, photograph, date of birth, social security number, current address, description of the offense for which convicted, and information related to prior convictions.

Sexually violent offenders must re-register every ninety days by confirming their address and providing the police with identifying information. All other offenders required to register must re-register annually. Failure to comply with the registration requirements constitutes a Class 1 misdemeanor or a Class 6 felony.

Sexual Offenses requiring registration under Code of Virginia § 19.2-298.1

Offenses for which registration is required are as follows:

1). A violation or attempted violation resulting in the following charges:
Carnal knowledge of child between thirteen and fifteen years old, Carnal knowledge of certain minors, Marital sexual assault, Aggravated sexual battery (under §18.2- 67.3 (A)(2)), Attempted aggravated sexual battery, Entering dwelling house, etc., with the intent to commit rape, Taking indecent liberties with children, or Taking indecent liberties with children by person in custodial or supervisory relationship;

2). A "sexually violent offense", as defined below ; or

3). Where the victim is a minor or is physically helpless or mentally incapacitated as defined in §18.2-67.10 (where the accused knew or should have known that the victim was: unable to understand the nature or consequences of the sexual act; unconscious; or any condition which renders the victim physically unable to communicate an unwillingness to act), a violation or attempted violation of:
Kidnapping or attempted kidnapping; Abduction of any child under sixteen years of age for the purpose of concubinage or prostitution; Crimes against nature against child or grandchild or Incest with child or grandchild; or Accosting, enticing or soliciting a person less than eighteen years of age with intent to induce or force such person to perform in or be a subject of sexually explicit visual material.

"Sexually violent offense" is defined as a violation or attempted violation of:

1). Abduction with intent to defile; Rape; Forcible Sodomy; Object sexual penetration; Aggravated sexual battery where victim is less than thirteen years of age; or Attempted rape, attempted forcible sodomy, attempted object sexual penetration; or

2). Conviction of any of the offenses requiring registration (but not defined as sexually violent) shall be deemed a sexually violent offense *only if* the person has been convicted of any two or more such offenses occurring within a ten-year period, provided that person had been at liberty between such convictions.

§19.2-298.2

Under this section, sexually violent offenders are required to re-register for life. A sentence that imposes confinement tolls the registration period and extends the duty to register until the person is released. Other offenders required to register or re-register must do so for a minimum of ten years from initial date of registration.

§19.2-298.3

Anyone convicted of two or more offenses for which registration is required or for any sexually violent offense shall not be granted a petition for expungement from the Registry. All other offenders may petition the circuit court for expungement after ten years from the initial date of registration, and may re-petition every two years thereafter.

§19.2-298.4

Under this section, after three years those convicted of sexually violent offenses may petition for relief from the requirement to re-register every ninety days. The court will then hold a hearing to determine if the person suffers from a mental abnormality or personality disorder that makes the person a menace to health and safety of others or impairs the ability to control his or her sexual behavior. The court must order a comprehensive assessment by three certified sexual offender treatment providers. If the court finds by clear and convincing evidence that the person does not suffer from a mental abnormality or personality disorder, the duty to re-register every ninety days is terminated and that person's information is removed from the State Police's Internet system. The sexually violent offender has a continuing duty to re-register annually. Appeals from a denial of relief go directly to the Supreme Court of Virginia. A person cannot file a petition for relief within three years of a previous denial of relief.

§19.2-390.1

The State Police must maintain a Sex Offender and Crimes Against Minors Registry for the purpose of assisting the efforts of law-enforcement agencies to protect communities from repeat offenders and to protect children. The Registry is to include the conviction data from the courts, including disposition records if the offender is a juvenile. The State Police must notify the chief law-enforcement officer of the county, city, or town listed as the offender's address in the registration as well as anyone who has requested automatic notification under §19.2-390.2. Furthermore the State Police must notify the Federal Bureau of Investigation for the inclusion of the information in the National Sex Offender Registry.

Information may be disseminated by filing a direct request to the State Police or via a request made through a local agency. The information from the Registry is to be used for the purposes of administration of criminal justice or screening potential employees or volunteers for the protection of the general public and children in particular. Use of the information for unauthorized purposes is prohibited and a willful use of the information for purposes of harassment or intimidation is punishable as a Class 1 misdemeanor.

Information will be disseminated upon the receipt of an official request that shall include a statement of the reason for the request, the name and address of the person requesting information, the name, address and social security number (if available) of the person about whom the information is sought, as

well as other information that the State Police may require to ensure reliable identification.

Before January 1, 1999, the State Police are required to develop and maintain a secure and regularly updated system of Registry information on violent sexual offenders via the Internet. The information contained within the Internet system is to be available to the public, and will include information such as name, aliases, address, photograph, and date of birth. [*Note*: That system may be accessed at: *www.vsp.state.va.us*]

No liability shall be imposed on any law-enforcement official who disseminates information based on a good faith action. However, this provision does not grant immunity for gross negligence or willful misconduct.

§19.2-390.2

After January 1, 1999, any public, parochial, denominational or private elementary or secondary school and any state-regulated or state-licensed child caring institution, child day center, child day program, family day home, foster home or group home may request from the State Police electronic notification of the registration or re-registration of any sex offender. Agencies that lack electronic capabilities are eligible for written notification. The State Police must notify the entities requesting notification who are in the same zip code area as the offender within three business days of receipt by the State Police of the registration information. The State Police can establish guidelines governing the automatic dissemination of Registry information including the payment of a fee used to maintain the costs of the electronic notification system.

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Medical Ethics and Human Rights In Psychiatric Care

by Richard J. Bonnie

I. Introduction

This paper explores normative connections between human rights and medical ethics. My interest in this topic was first stimulated in 1988 when I became involved in the investigation of medically unwarranted psychiatric hospitalization of political and religious dissidents in the Soviet Union. (See Bonnie, 1990). From the beginning, it seemed to me that the human rights objections to this practice needed to be disentangled from objections grounded in medical ethics. On the one hand, detention of a person for the purpose of suppressing unorthodox political or religious expression is a violation of human rights, whether it occurs in a jail or a hospital, and whether or not the person has a mental disorder. On the other hand, coercive hospitalization without a medical basis violates medical ethics even if detention for punitive or incapacitative purposes is otherwise justified. The Soviet practice of hospitalizing mentally healthy dissidents solely for criticizing the regime was clearly objectionable on both grounds.

My interest in these overlapping and interacting normative systems was further aroused by a 1992 report on medicine and human rights entitled *Medicine Betrayed*, prepared by a Working Party of the British Medical Association. I was asked to write an editorial for the *British Medical Journal* commenting on the report's chapter on the death penalty. (See Bonnie, 1992). In this chapter, the Working Party expressed reservations about numerous forms of medical participation in the judicial and correctional processes, ranging from the gruesome task of carrying out the punishment (e.g., by preparing and administering a lethal injection) to less direct forms of involvement such as assessing and treating allegedly incompetent condemned prisoners. I was struck by the intertwining of medical ethics and human rights concerns in the Working Party's analysis. Ultimately, I concluded that the Working Party's recommendations cannot be defended solely within the normative logic of

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medical ethics and that some of its proposals were rooted in an abolitionist stance toward the death penalty.

These speculations about Soviet psychiatry and medical participation in punishment led me to think more systematically about the normative connections between human rights and medical ethics. At the outset, we should note two similarities between these two normative systems. First, according to contemporary thought, medical ethics and human rights both purport to represent universal normative requirements. The ethical tradition of medicine is generally thought to be independent of particular cultures, representing universal ideas about the nature and purposes of medicine. Similarly, according to the prevailing point of view, norms of human rights are also universal and are not dependent upon the legal traditions and values of particular cultures. Although the idea that all states are bound to respect certain rights of the individual has deep roots in human history, it was strongly reinforced by the Nuremberg trials and is now embedded in numerous international legal documents.

The second point is that norms of medical ethics and human rights are not static; they evolve over time, reflecting transcultural changes in technology and human values. For example, ethical ideas about abortion and about the physician's obligations to dying patients have changed significantly in the past two decades. In the sphere of human rights, ideas regarding the acceptability of different forms of punishment have changed, and there is now a worldwide debate on whether caning and other forms of corporal punishment (as well as the death penalty) are any longer acceptable under contemporary standards of decency.

We see, then, that although medical ethics and human rights reflect separate normative traditions, each body of ideas and norms is influenced by underlying changes in human circumstances. Moreover, these normative traditions affect one another. For example, evolving norms of medical ethics relating to patient autonomy have been influenced by deepening respect for the dignity of the individual in human rights law. This is why it is not possible to talk fully about patients' rights without also talking about medical ethics and vice versa.

Against this background, I think we can identify three important normative connections between medical ethics and human rights. First, adherence by physicians to patient-centered ethical norms of the medical profession provides a very important safeguard for human rights. Second, the excessively paternalistic orientation of medicine in many countries is incompatible with contemporary norms of human rights. (I will also argue, however, that it would be a mistake for medical ethics to fully embrace the principle of patient autonomy whenever it collides with the principles of beneficence.) Finally, because inadequate care is a paramount human rights

concern, psychiatrists should accept the ethical responsibility to become advocates for their patients as a primary professional mission. I will take up each of these points in turn.

II. Medical Ethics as a Safeguard for Human Rights

The duty to serve the well-being of the patient stands at the center of therapeutic ethics. Patients are at grave risk whenever the state (or any other powerful institution) tries to use the tools of medicine for its own, non-medical purposes -- i.e., to promote societal interests rather than to serve the interests of the patient. Thus, the patient-centered norm of medical ethics is an important source of protection for the human rights of patients.

Human Experimentation

We are able to see most clearly how the norms of medical ethics protect the human rights of patients when physicians fail to adhere to them. The most notorious examples are those that involve the use of patients as subjects of medical experiments without their knowledge or without valid consent. Much has been written about the experiments of the Nazi doctors. But serious breaches of medical ethics have also occurred in other countries, including the United States. In the most well-known example, the natural progression of syphilis was studied in a group of poor, black, rural subjects in Alabama who were left untreated, even after penicillin became available. In another well-known case, retarded children admitted to Willowbrook State Hospital in New York were given hepatitis virus as part of a study of the development of the disease and the effects of gamma globulin in reducing its occurrence. And as recently as 1995, the people of the United States have been told of experiments during the Cold War which exposed patients to therapeutically unwarranted doses of radiation. (Advisory Committee on Human Radiation Experiments, 1995).

In all these situations, the well-being of the patients was wrongly subordinated to the society's legitimate interest in advancing knowledge. Human experimentation is necessary to medical progress, but it also presents grave threats to human rights. Ultimately, continued acceptability of the social practice of medical experimentation, including clinical trials, depends on public trust in the ethical integrity of the scientific community. The simple truth is that subjects have no other means of protection. If public trust is lost, and political and legal safeguards come to be seen as necessary to protect subjects of research, the game is lost -- and medical progress will come to a halt. If scientific progress is to continue, we must depend primarily on the ethical norms of the research community to protect the rights of subjects.

Researchers must always be aware of the inherent conflicts between their scientific goals and the interests of their subjects. Researchers and their sponsors

must be ever vigilant to assure that subjects are not exposed to unreasonable risk of harm and that informed consent is obtained from the subject or a properly authorized surrogate. In research, as in any bureaucratized practice, there is an inevitable drift toward routinization. But this slide toward insensitivity is dangerous to human rights. Researchers and their sponsors must be ever on their guard to prevent it.

Compulsory Treatment

In the context of psychiatric care, the most controversial human rights issues concern compulsory treatment. By itself, coerced psychiatric treatment is *not* a violation of human rights. This is because coerced treatment is sometimes justified by the need to protect the patient or society. Coerced treatment is also compatible with medical ethics so long as the treatment is expected to benefit the patient. The problems arise when treatment is being sought *not* for the patient's benefit, but *only for society's benefit*. As I noted earlier, the most well-known cases have been those in which psychiatric hospitalization has been used to suppress political and religious dissent. Everyone now recognizes that this is a violation of human rights and a violation of medical ethics. It is a violation of human rights to incarcerate dissidents for the mere expression of political and religious ideas. Incarcerating them in psychiatric hospitals compounds repression with moral fraud. It devalues their ideas by psychiatric labeling and deploys psychiatric treatment as punishment -- in the Soviet hospitals healthy prisoners were subjected to painful and unneeded drugs and other medical procedures. These are profound violations of individual dignity and privacy. Further, it is a blatant violation of medical ethics for psychiatrists to allow hospitalization and treatment to be used exclusively as tools of repression or punishment.

This analysis has some direct implications for the daily practice of psychiatry, especially in hospitals or prisons. Obviously one of the legitimate social purposes of psychiatric hospitalization is to protect society from patients who may be dangerous to themselves or others. But the use of the tools of psychiatry should always be directly connected to the medical needs of the patient. Thus, I would argue that it is unethical for psychiatrists to hospitalize a person (even if the person is mentally ill) for the *exclusive* purpose of social control. It is unethical to give a person psychotropic medication for the *exclusive* purpose of behavioral management or intimidation. Involuntary psychiatric treatment is permissible only if the treatment is medically appropriate for the patient's condition.

These points may seem self-evident, but they have direct bearing, it seems to me, on some controversial laws that have been enacted in the United States and in other countries for the purpose of achieving indeterminate detention of dangerous offenders. In the U.S. for example, many states have enacted so-called "sexually violent predator" laws. After a sex offender has fully served a criminal

sentence for the offense, he is subject to an indeterminate term of confinement in a psychiatric hospital if he is found to have a "mental abnormality" or "personality disorder" and a propensity for violent sexual assaults.

Putting a person in prison to punish him for a dangerous sex offense is not a violation of human rights. Moreover, confining such a person for a reasonable period of time solely to prevent him from behaving dangerously in the future (for "incapacitation" and not for "punishment") is probably not *per se* a violation of human rights (although long-term preventive detention raises many controversial questions). I would argue, however, that it *is* a violation of human rights to prolong the period of incapacitation beyond that which is otherwise authorized as a criminal sentence on the ground that the person has a mental disorder unless there is an established medical basis for such a diagnosis. Moreover, it is a violation of human rights *and* of medical ethics to confine a prisoner in a psychiatric hospital for involuntary psychiatric treatment if he has no treatable mental illness. [*Editor's note*: The United States Supreme Court recently upheld a "Sexually Violent Predator" law, as described herein, as constitutional. *See, Kansas v. Hendricks*, 117 S.Ct. 2072 (1997).]

Punishment

From time to time, doctors have participated in the practice of torture -- either by assessing the prisoner's "fitness" for torture or by monitoring its infliction to say whether and when the prisoner is being harmed more than intended by his torturers. Everyone agrees, of course, that this form of medical participation in the practice of torture is forbidden, but we should ask, "why?" The easiest answer is that torture is a violation of human rights and that a doctor who participates in this practice for the purpose of facilitating it becomes an accomplice to a violation of human rights. The interesting question is whether there is some other objection to medical involvement derived from principles of medical ethics rather than from norms of human rights.

To probe this question, we must identify a punitive practice that does *not* violate prevailing standards of human rights. Consider, for example, some forms of whipping or caning, or isolation in dark cells. These are controversial punitive practices, but they are not now universally recognized as violations of human rights. Thus, let us assume, *arguendo*, that a society may utilize these forms of punishment without running afoul of recognized norms of human rights. If medical participation in these otherwise permissible social practices is forbidden, the objections must derive from principles of medical ethics. What is the applicable principle?

The objection to medical participation in caning or whipping cannot be derived from the principle of non-maleficence (i.e., do no harm). This is because medical participation in the administration of potentially injurious forms of punishment can actually *enhance* the prisoner's well being; medical assessment of

the prisoner's fitness for these punishments, and medical monitoring of their administration, can prevent injury and suffering more extreme than legally authorized or intended. So what is the basis for the widespread view that medical participation in these social practices is unethical?

The answer is that serving as an agent of the repressive or punitive apparatus of the state is not an appropriate social role for a doctor. Medical skills and knowledge are held in trust for the well-being of the public. Allowing these skills to be appropriated to the tasks of punishment is incompatible with the supreme aspiration of the profession and would eventually erode the public's trust in the caring role of the doctor. Public trust in the benevolence of physicians is the medical profession's most important asset.

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Some commentators have taken the position that it is unethical for a doctor to use his or her specialized knowledge and skills for *any* non-medical or non-therapeutic purpose, but this argument goes too far. For example, it is clearly ethical for a doctor to evaluate a person's mental or physical condition for "forensic" purposes, i.e. to assist the courts and other decision-makers who apply the law. These practices do not erode public trust in the caring role of the doctor and they also contribute to the public good. In short, participation in the administration of justice is an acceptable social role for a doctor, although participation in punishment is not.

Turning to the controversy surrounding medical participation in the death penalty, I think we can now see the ethical lines pretty clearly. In countries where capital punishment is not considered to be a violation of human rights, objection to the medical involvement must be derived solely from principles of medical ethics. Two boundaries are clearly marked. On the one hand, participation in the administration of punishment by preparing the lethal solution, setting up the intravenous lines or injecting the solution is not permissible. On the other hand, participation in the administration of justice -- by conducting pre-trial forensic assessment of the defendant's competence, responsibility and other issues bearing on sentencing -- is ethically permissible.

What about assessing the mental competency of a prisoner on death row? Is this task ethically permissible? It depends. It is not ethically acceptable if the doctor is, in effect, certifying the prisoner's "fitness" for capital punishment -- saying "yea" or "nay" to the executioner. But it is acceptable if the doctor is providing a forensic assessment as part of the judicial process, and if the court

bears the ultimate responsibility for making the decision regarding the defendant's competence. In this situation, execution competence assessment is not different in principle from any other type of forensic assessment performed in a capital case.

Issues also arise in connection with treatment of condemned prisoners. Suppose that an incompetent prisoner under sentence of death is hospitalized for psychiatric treatment to restore his competency. What should the psychiatrists do? Should they administer anti-psychotic medication knowing that the likely consequence of doing so is to remove a legal obstacle to the prisoner's execution? This question has been a controversial one. For present purposes, it is enough to say that everyone agrees on one point: it is unethical to treat a prisoner for the *sole* purpose of readying him for execution -- that is, if the purpose of the treatment is not to benefit the patient but only to enable the state to kill him. If the condemned prisoner does not request treatment and is not in acute distress, prison doctors should say "no."

Confidentiality

Some of the most perplexing ethical problems in mental health care involve the disclosure of information about the patient obtained during the course of treatment. According to prevailing ethical analysis, the psychiatrist has a presumptive duty to preserve the confidentiality of the patient's disclosures -- although this duty can be overridden if the reasons for doing so are strong enough, such as a clear threat to the health and safety of another person. This strong ethical duty to preserve patient confidences is also an important safeguard of human rights. The state and other powerful social institutions have a voracious appetite for information about the mental health of individuals (and other intimate subjects). Individuals should not have to yield to the state information about their most intimate thoughts and beliefs. A circle of private space is an essential element in the idea of freedom. So when individuals choose to disclose such information to a trusted person, such as a spouse, priest, lawyer, or doctor, this information should not automatically become accessible to the state (or to anyone else), and, in the absence of compelling necessity, should be disclosed only with the individual's consent.

Empowering Doctors to Say "No"

I have mentioned several situations in which society aims to use the tools of medical treatment for its own purposes, not for the benefit of patients. In many of these situations, involvement by physicians violates medical ethics as well as the human rights of the individuals. The key point is that ethical behavior by doctors is an essential safeguard for human rights. Even when the law directs compliance, doctors should say no.

In a free society, absolute refusal by medical professionals to perform an ethically proscribed social role is likely to embarrass the government and to dissuade it from trying to accomplish its repressive objective. It is conceivable, of course, that the state might accomplish its goals by other means: the dissident might be sent to a labor camp rather than a hospital, and the government might get someone other than a doctor to inject the fatal dose of barbiturates. Adherence to medical ethics by physicians cannot prevent oppression by the state, but it does provide an important safeguard against it.

The independence of the medical profession is the most important safeguard for human rights. History shows well enough that the costs of saying "no" can be high under a repressive regime because the social power of the medical profession may not be great enough to shield its members from punishments. This was the underlying problem in the former USSR, when very few psychiatrists were willing to defy the regime, and the profession had no identity apart from the state. Similarly, the medical profession in South Africa came under persistent international criticism in South Africa during apartheid.

No system of medical ethics can fairly demand heroism. The lesson of recent history is that future abuses of human rights can be prevented by strengthening and preserving the independence of the medical profession, especially psychiatry, and by establishing and reinforcing patient-centered norms of medical ethics, especially in mental health care. These are the main goals of efforts to reconstruct psychiatry in the former Soviet world.

III. Medical Paternalism and Human Rights

Up until now, I have been discussing the ways in which medical ethics promotes human rights. I now turn to the possible conflicts between patient-centered medicine and human rights. I am now assuming, in other words, that the doctor has a therapeutic motivation and is acting in what he or she perceives to be the patient's best interests. However, benevolent intentions do not guarantee that the doctor's actions will be respectful of the patient's rights *or* that they will be ethical. The underlying issue is the conflict between medical paternalism and evolving norms of patient autonomy.

Norms of medical ethics as well as those of human rights have changed over the past several decades. A common element of changes in both spheres is a shift from an extreme form of medical authoritarianism to a body of rights and obligations grounded in respect for patient autonomy. In the United States and many other countries, the transition first appeared in legal norms, which affirmed the legal right of patients to make medical choices. The law imposed on doctors an obligation to disclose information about the risks and benefits of the therapeutic alternatives in order to enable patients to make informed choices. This legal doctrine of "informed consent" in turn helped to shape the

fundamental ethical norm of respect for the patient's prerogative to make medical decisions.

These ideas soon penetrated psychiatric practice, the most paternalistic branch of medicine. Before this change in legal and ethical norms, psychiatric patients were routinely assumed to lack the competence to make any decisions, including those relating to their treatment. As a result, patients were not consulted, and their objections to treatment were routinely overridden. Evolving ethical and legal norms have gradually shifted the presumption in the direction of greater participation by psychiatric patients in treatment decisions and also toward increased respect for the patient's prerogative to refuse recommended treatment. This norm of patient autonomy is clearly reflected in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care approved by the U.N. General Assembly in December, 1991 (United Nations, 1991). All over the world, new mental health legislation is being enacted to reflect the new participatory model of mental health care and to displace the traditional paternalistic model.

Under the influence of evolving norms of human rights, the law has now taken over the responsibility for defining the conditions under which patients may refuse treatment or, conversely, may be treated over their objection. In many countries, this has led to restrictive criteria for civil commitment and to rules that allow committed patients to refuse treatment believed by psychiatrists to be medically necessary.

It thus appears that norms of human rights have overridden or displaced the ethical principle of beneficence. In fact, a review of contemporary ethical commentary suggests that prevailing norms of medical ethics have absorbed and embraced the principles of patient autonomy. I believe this is a mistake. Do doctors have the *ethical duty* to stand by and watch their patients suffer or die whenever the patients are competent to make their own decisions? Are doctors *ethically* bound to respect patients' wishes? Are doctors *ethically* obligated to facilitate informed decision making by patients so as to enable them to make autonomous decisions in accord with their own preferences?

Consider the following vignette. Suppose a depressed patient who admitted herself into the hospital objects to continued hospitalization. Although she is not presently suicidal, the doctor believes that the patient would benefit from continued hospitalization. Under the governing law she has a right to leave, although she appears to be unaware of this right. Is the doctor obligated to tell her that she has a right to leave? From a human rights perspective, the patient may be entitled to know that she is free to leave. But does it follow that modern principles of medical ethics obligate the doctor to respect her wishes? Would silence be an acceptable instance of paternalism?

I think it is a mistake for medical ethics to fully embrace the principle of patient autonomy so that it always overrides or displaces beneficence. Respect

for the patient's autonomy should be incorporated into ethical norms insofar as it obligates the doctor to involve the patient in decision-making and to ascertain the patient's wishes. Respecting the patient's wishes is therapeutically useful because it helps the doctor understand the patient's needs better than otherwise would be possible. I do not think, however, that the doctor should be *ethically* required to adhere to the patient's preferences when he or she believes that this course of action will be harmful to the patient. The doctor may be *legally* obligated to do so because the law has accepted a particular understanding of human rights -- but this requirement is extrinsic to medical ethics and should not be embraced by doctors as an ethical obligation.

IV. Advocacy as an Ethical Duty

Inadequate care is the most pervasive threat to the dignity and well-being of persons who suffer from mental disorders. Shortages of staff and medication in public hospitals and clinics are problems in most countries. Inadequate access to treatment is a growing problem in private-sector care in the United States and other countries. Efforts of insurers to "manage" care, and thereby reduce its costs, can result in a denial of payment (and therefore a denial of access to care) for patients who are in genuine need.

Advocacy on behalf of neglected and forsaken patients, and on behalf of patients who have otherwise been wronged, should be an obligatory role of psychiatrists and other care-givers. By advocacy, I mean to include filing grievances, appeals or complaints with the organizations that manage or supervise care or that are responsible for allocating resources. I also mean helping the patient gain access to disability benefits and other resources or services to which he or she may be entitled. I mean, in short, that the psychiatrist should speak for the patient to counteract the inevitable tendencies of financially constrained organizations to neglect vulnerable populations who have no political voice. Further, the profession has a collective obligation to stand up for needs of patients -- to raise its voice in the political process and in the court of public opinion.

Inadequate care is the most pervasive threat to the dignity and well-being of persons who suffer from mental disorders.

In an earlier part of this paper, when I was discussing issues of repression and abuse, I acknowledged that in repressive societies, a doctor who says "no" might endanger his own safety or well-being. This dilemma also arises in the present context, and it arises in all societies, not only repressive ones. Doctors who "fight the system" in order to advocate the interests of neglected or ill-served patients may be risking their jobs. I would not go so far as to say the doctor is obligated to sacrifice himself or herself for the betterment of the

patients. This would be an unduly heroic ethical standard, to say the least. But the question must nonetheless be put: when does continued participation in an inadequate or unjust system amount to complicity in its wrongs? This question is as pertinent to issues of social neglect as it is to issues of repression and abuse.

References

Advisory Committee on Human Radiation Experiments, *Final Report.* U.S. Government Printing Office, 1995.

Bonnie, Richard J., Soviet Psychiatry and Human Rights: Reflections on the Report of the U.S. Delegation, *Law, Medicine and Health Care* 18:123-131 (1990).

Bonnie, Richard J., The Death Penalty: When Doctors Must Say No (Editorial), *British Medical Journal* 305: 381-83 (1992).

United Nations, Principles for the Protections of the Mentally Ill and Improvement of Psychiatric Care, Annex to General Assembly Resolution 46/119 (adopted December 17, 1991).

Hendricks and the Future...by Eric S. Janus

-continued from page 3-

In theory, sex offender commitments end as soon as the detainee is no longer dangerous. In practice, committed sex offenders are almost never discharged. For example, in the two states with the longest contemporary commitment programs (both operating since about 1990), Minnesota and Washington, no individuals have been discharged from commitment, and only a handful are in transitional placements. Thus, sex offender commitment populations will continue to grow for the foreseeable future.

Sex offender commitments are expensive. The per diem for a committed sex offender in Minnesota is $344. For comparison purposes, the total 1998 Minnesota budget for sex offender treatment staff and support in prisons was $1.233 million. If the total prison treatment budget is spread across all sex offender inmates (1090), the per capita available for prison treatment amounts to about 1% of the amount currently spent for the civil commitment of one person.

II. The *Hendricks* case

In its 1997 *Hendricks* decision, the U.S. Supreme Court considered, and rejected, several constitutional challenges to the Kansas' Sexually Violent Predator Act. The Court's decision makes clear that there is nothing inherently unconstitutional about civilly committing mentally disordered sex offenders.

However, the decision suggests that the constitution imposes some limits on the scope of such commitments and the conditions of confinement.

Hendricks addressed two main constitutional challenges. The first set of arguments asserted that the Kansas scheme had a punitive intent, and therefore violated constitutional prohibitions on *ex post facto* laws and double jeopardy. The Court rejected this argument, holding that incapacitation is a legitimate goal of civil commitment, and that the treatment program furnished by the state, though skimpy, was nonetheless adequate to dispel any inference of punitive intent. The Court warned, however, that a different result might ensue if the conditions of confinement "suggest a punitive purpose."

The second group of arguments urged that sex offender commitments violate "substantive due process," in that they extend civil commitment beyond its constitutionally allowed area. (According to the Court's decision in Zinermon v. Burch, 494 U.S. 113, 125 (1990), substantive due process "bars certain arbitrary, wrongful government actions regardless of the fairness of the procedures used to implement them.") The Court stated that civil commitment is constitutionally limited to individuals who have a "mental disorder," and focused its inquiry on the constitutional meaning of this element. Without articulating any underlying theory, the Court seemed to make three points about mental disorder as a constitutional predicate for civil commitment. First, the mental disorder element must restrict civil commitment to a narrow band of dangerous individuals. Second, it must adequately distinguish persons subject to civil commitment from those subject only to the criminal justice system. Third, it was a particular form of mental dysfunction - the inability to control behavior - that legitimized the commitment of Leroy Hendricks.

From the *Hendricks* decision, we can draw several important lessons about civil commitment law. First, prior to *Hendricks*, some commentators argued that the state could preventively confine any dangerous individual, in much the same way that it could quarantine contagion and protect the public from nuclear waste. The Supreme Court clearly rejected this principle in *Hendricks*, stating, "A finding of dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment." Rather, the Court said, civil confinement "ordinarily" requires an "additional factor, such as a 'mental illness' or 'mental abnormality'."

"A finding of dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment." Rather, the Court said, civil confinement "ordinarily" requires an "additional factor, such as a 'mental illness' or 'mental abnormality'."

Second, prior to *Hendricks*, it was unclear whether states' use of civil commitment was limited to cases under the "*parens patriae*" power - the power of the state to intervene to protect individuals who lack the capacity to help themselves. Most sex offender commitments would not fit within this rationale, since the majority of sex offenders are mentally competent, and commitments are primarily aimed at protecting the public (rather than the detainee). The Court's opinion does not mention the *parens patriae* power. This suggests that the states' police power (the power to protect the health and safety of the public) can be constitutionally sufficient to support mental-health commitments. But the Court suggested that police power civil commitments must be narrow, and that states must somehow distinguish individuals who are subject to commitment from those for whom the criminal law is the appropriate intervention.

Third, *Hendricks* teaches that the role of the mental disorder element is to limit police-power civil commitment and prevent it from swallowing the criminal law. The "mental disorder" element represents legal, rather than medical categories. While recognizing that particular terms, such as "mental illness," have no "talismanic significance," and that states may adopt varying "nomenclature," the Court appears to reject the view that states have an unfettered right to define "mental disorder" as they please. Rather, the Court emphasizes the "narrow circumstances" that are appropriate for civil commitment. Kansas' definition of "mental abnormality" passes constitutional muster because it, like other traditional civil commitment definitions, "narrows the class of persons eligible for confinement to those who are unable to control their dangerousness."

The conventional wisdom is that "inability to control" is a highly confused concept with little or no meaningful content. Because the Court did not explain why it focused on this sort of dysfunction or how this dysfunction serves to limit and justify civil commitment, the constitutional significance of the "inability to control" rubric remains a subject of contention.

Fourth, *Hendricks* sheds some light on the legal significance of "treatment" in justifying civil commitment. Challengers argued that the sex offender commitment laws were unconstitutional because incarceration, rather than treatment, was the primary goal of the legislation. As restated by the Supreme Court, this argument took two forms.

> In the "punitive intent" argument, challengers argued:
>
> > ... the Act is necessarily punitive because it fails to offer any legitimate "treatment." Without such treatment, ... confinement under the Act amounts to little more than disguised punishment.
>
> The substantive due process argument asserts:

> If there is nothing to treat under [the statute], then there is no mental illness. In that light, the provisions of the Act for treatment appear somewhat disingenuous . . . Absent a treatable mental illness . . . Hendricks could not be detained against his will.

In rejecting these arguments, the Court noted that Kansas had provided *some* treatment. Thus, *Hendricks* does not shed any light on the constitutionality of a hypothetical "no-treatment, pure prevention" civil commitment system. But the Court quite clearly held that "amenability" to treatment is not a constitutional requirement, at least for police power commitments that are justified on the basis of severe dangerousness. In this way, *Hendricks* suggests that States may commit dangerous, mentally disordered individuals for whom no effective treatment exists. Some treatment, however, may be necessary. In determining whether the state acted with punitive *intent*, the Court seemed to use a "reasonable efforts" standard for treatment. The Kansas law mandated treatment "where possible," and the record failed to show that the state had unreasonably failed to implement that requirement. Conversely, the provision of treatment is not sufficient to guarantee the constitutionality of commitment. It was not the provision of treatment that brought the Kansas statute within the constitutional powers of the state, but rather a particular form of impaired mental functioning coupled with future danger.

Fifth, *Hendricks* confirms that a law's reliance on prediction of dangerousness does not render the law unconstitutional. Prediction is central to the operation of sex offender commitment schemes, and challengers asserted that the inherent inaccuracy of prediction renders sex offender commitments unconstitutionally arbitrary. But prediction is central in a broad range of legal settings - from death penalty proceedings to child custody -- so it is not surprising that *Hendricks* rejected this constitutional challenge.

III. Post-*Hendricks* Cases

Though *Hendricks* upheld the Kansas sex offender law against constitutional attack, the Court's language suggests quite strongly that states do not have limitless power to use civil commitment to achieve social control goals. As mentioned above, the Court stated explicitly that civil confinement normally requires proof of a mental disorder as well as dangerousness. Also, the Court made much of the assertion that civil commitment is addressed to a "narrow class of particularly dangerous individuals" and that the "mental disorder" requirement "narrows the class of persons eligible for confinement to those who are unable to control their dangerousness." Though sex offender commitments have been limited, in actual practice, to a comparatively small number of

individuals, the narrowness of application appears more to result from discretionary prosecutorial decisions than from limiting appellate court decisions.

Thus, one of the open questions after *Hendricks* is whether the courts will indeed enforce a constitutional definition of "mental disorder" that substantially narrows the states' ability to use civil commitment. The question is put most directly in a 1999 Minnesota Supreme Court case, *In re Linehan*. Minnesota's Sexually Dangerous Persons (SDP) Act allows the commitment of individuals who are predicted to be sexually dangerous. It requires proof of a mental or personality disorder that "results in" a likelihood of future sexual violence. However, the Act specifically states: "it is not necessary to prove that the person has an inability to control the person's sexual impulses."

The SDP Act was challenged on the theory that its definition is too broad, violating the *Hendricks* principle that some traditional form of severe dysfunction - such as the inability to control impulses - is required for constitutionality. In the *Linehan* decision, the Minnesota Supreme Court agreed partially with this major premise, but rejected the argument's conclusion. The Minnesota Court read *Hendricks* as holding that only "some degree of volitional impairment must be evidenced to satisfy substantive due process." The actual language of the Minnesota law said that proof of "an inability to control" was not necessary, but the Court construed this as requiring proof that the individual's "present disorder or dysfunction does not allow them to adequately control their sexual impulses." The Court then examined the trial record, and held that evidence of impulsiveness in sexual behaviors and intermittent "abusive" behavior towards guards constituted sufficient evidence of "inability to exercise adequate control over his actions."

The Minnesota Court's decision stands for a broad conception of state power to use civil commitment. Most sex offenders - indeed, most criminals - are diagnosable with some form of mental or personality disorder. Further, a history of criminal activity certainly would satisfy the Court's "lacks-some-control" standard. If the Minnesota Court's decision stands, the conclusion will follow that the constitution imposes almost no restrictions on the *scope* of civil commitment.

A second significant post-*Hendricks* case is *Young v. Weston*, recently decided by the U.S. Court of Appeals for the Ninth Circuit. Unlike *Hendricks* and *Linehan*, which are direct appeals of judgments of commitment, *Young* is a federal habeas corpus action, thus allowing the court to examine the post-commitment conditions of confinement. The petitioner in *Young* raised a number of constitutional challenges to the Washington State Sexually Violent Predator Statute. The Court of Appeals reversed the dismissal of the petition, holding that Young's allegations, if proven, are sufficient to prove a violation of the Constitution. Young argued that the statute, as applied to him, is punitive and

thereby violates the *ex post facto* and double jeopardy protections of the constitution. The Court reviewed Young's factual allegations, and held that the following were sufficient to support a finding of unconstitutionality: "conditions of confinement . . .[that] are not compatible with the ... statute's treatment purposes" such as "conditions more restrictive than those placed either on true civil commitment detainees or even those placed on state prisoners;" placement of the treatment center "within the perimeter of a larger Department of Corrections facility and reli[ance] on the Department of Corrections for a host of essential services;" housing residents in units "clearly inappropriate for individuals in a mental health treatment program;" and the absence of "certified sex-offender treatment providers." *Young* thus suggests that the Constitution sets a floor on the conditions of confinement. Commitment programs that are housed within correctional facilities or that lack the differentiating indicia of traditional civil commitment confinement may be particularly vulnerable to attack.

IV. The Future of Sex Offender Commitment Schemes

As a matter of constitutional law, the future is bright for sex offender commitment schemes. At least to date, courts have imposed few real restrictions on the use of civil commitment to address problems that are the traditional concern of the criminal law. As with the first generation laws, the future trajectory of this second legislative experiment will depend mostly on social policy judgments by legislatures and administrators.

The goal of sex offender commitments - the prevention of sexual violence - is a compelling one. The detainees - mainly repeat sex offenders - engender little sympathy. And the logic of the programs - incapacitation of the "most dangerous" - seems self-evidently valid. Most certainly it will be the escalating cost of these programs that eventually will drive an examination of their wisdom.

Recently, a Minnesota Task Force estimated that the annual cost of "current practice" will increase by 450% (from $17 million to $76.9 million) in the twelve years from 1998 to 2010. At a legislative oversight hearing convened to hear the report, state Sen. Randy Kelly stated: "I'm very alarmed by those numbers and we have got to find some alternatives to bring those numbers down, because you will not be able to sustain this kind of an operation." The National Association of State Mental Health Program Directors, in their 1997 *Policy Statement on Laws Providing for the Civil Commitment of Sexually Violent Criminal Offenders*, warned that sex offender commitment programs "divert scarce resources away from people who have been diagnosed with a mental illness and who both need and desire treatment," and may "stigmatize the civil commitment process and people diagnosed with mental illnesses." While

millions are spent on these post-prison commitment schemes, the correctional systems remain the "point of greatest opportunity for the treatment of persons convicted of serious sex offenses." (P. M. Harris, *Prison-Based Sex Offender Treatment Programs in the Post -Sexual Psychopath Era*, 23 J. PSYCHOL. & L. 555, 569 (1995)). Yet the National Center for Missing & Exploited Children warns, "While community supervision and oversight is widely recognized as essential, the system for providing such supervision is overwhelmed," and "[s]tate-sponsored [sex offender] treatment programs are under attack and are disappearing around the country."

Other, less tangible side-effects of sex offender commitment laws may undercut the efficacy of sex-offender treatment and distort the community's response to sexual violence. Sex offender commitment laws abrogate the therapist-client privilege. Disclosures made in prison-based sex offender treatment form key ingredients in referrals for commitment and in the commitment case itself. Afraid that their participation in treatment may cement the case for commitment, prisoners may avoid the self-disclosure that is central to sex offender treatment. Will the creation of such a disincentive decrease treatment efficacy, thereby increasing recidivism?

As suggested above, sex offender commitment schemes adopt a mental-disorder explanation for sexual violence, and characterize sex offenders as "unable to control" their sexual impulses. Since sex offender treatment is based on the assumption that individuals can control their sexual offending, will these ascriptions undercut the efficacy of the treatment? Will they distort broader social understandings of sexual violence, suggesting that such violence is caused primarily by psychological abnormality, rather than social factors such as the prevalence of images of violence against women and attitudes in the society that condone such violence?

V. Conclusion

While the book on the constitutionality of sex offender commitments is not finally written, *Hendricks* suggests that few constitutional limitations will be imposed. The imbalance between commitments and discharges will cause commitment populations to grow over the foreseeable future. Eventually, the huge costs of commitment schemes will force serious assessment of whether the facial logic of these programs hides seriously distorted resource allocation and anti-therapeutic side-effects.

Book Reviews

The Right to Refuse Mental Health Treatment Bruce J. Winick, American Psychiatric Press, Washington, D.C., 437 pp.

reviewed by Joseph S. Jackson

The Right to Refuse Mental Health Treatment by Professor Bruce Winick is a prodigiously researched book on a complex and controversial topic. Involuntary treatment of the mentally ill has long been an accepted practice, yet runs counter to an equally longstanding tradition of respecting individual autonomy in decisions to accept or reject medical treatment. In this extended essay, Winick analyzes the available case law and draws on a wealth of information concerning the actual practice and effect of various forms of mental health treatment--from verbal psychotherapy to psychosurgery and electronic stimulation of the brain--to construct an argument in favor of a qualified right to refuse mental health treatment. In the final section of the book, Winick assesses this right to refuse mental health treatment through the lens of therapeutic jurisprudence, and discusses the practical and procedural aspects of recognizing such a right. A final chapter offers some thoughts on the utility of advance directives in securing protection of the right to refuse treatment, and argues that professional ethical standards should supplement the law in barring violations of the right.

In the seven chapters comprising the first part of the book, Winick describes a continuum of intrusiveness and risk that includes different modes of treatment, progressing from verbal psychotherapy, to behavioral therapy, psychotropic medication, electroconvulsive therapy (ECT), electronic stimulation of the brain, and ultimately, psychosurgery. These chapters are important to Winick's constitutional analysis, for it turns out that the more intrusive forms of treatment, such as psychotropic medication, intrude on constitutionally protected interests in ways that less intrusive forms of treatment, like psychotherapy, do not.

It is hard to disagree that physically, chemically, or electronically altering brain function is more intrusive than talk therapy. However, with regard to the other main aspect of these chapters--establishing the potential for abuse of the various methods of mental health treatment-- Winick's text may be somewhat misleading. Winick implies or at least permits the inference that abuses are ongoing today. However, the sources Winick cites primarily date from the 1970s. To be sure, the existence of abuses a generation ago is sufficient for Winick's purposes, for it establishes that the potential for abuse exists. Nevertheless, more current information on this important topic would surely bolster the argument.

Winick constructs his argument for a qualified right to refuse treatment in the second part of the book, in several stages. First, he shows that physically

intrusive forms of mental health treatment, from administration of psychotropic medication to psychosurgery, compromise fundamental liberty interests: the freedom of thought protected by the First Amendment, and the right to bodily integrity, privacy, and autonomy substantively protected by the Due Process Clause of the Fourteenth Amendment. By contrast, Winick concludes that psychotherapy and other non-invasive forms of treatment do not run afoul of these constitutional protections: freedom from governmental thought-control does not extend to insulation from governmental efforts to persuade, and the ability of patients to resist psychotherapy by withholding cooperation adequately preserves their interests in privacy and autonomy. Psychotherapy does not intrude on bodily integrity, but some aversive conditioning techniques used in behavior therapy may, and to that extent they raise constitutional concerns. Winick also examines other sources of constitutional protection--the Eighth Amendment's ban on cruel and unusual punishment, the First Amendment's protection of freedom of religion, and the Equal Protection Clause's proscription of arbitrary and invidious legislative classifications--but concludes that these essentially overlap the protections already considered.

Even fundamental constitutional rights are not absolute, however. Rather, they must yield to the extent necessary to achieve compelling governmental interests. Indeed, with regard to some contexts--such as prisons--courts adopt a more relaxed, deferential approach, and necessity need not be shown: rights yield when important governmental interests can be reasonably furthered. Thus, identifying viable sources of constitutional protection, and showing that they should apply in the context of involuntary mental health treatment, is only the first step in the legal analysis. One must also examine the importance of the governmental interests at stake, and (at least in those contexts in which courts do not adopt a deferential approach) assess whether they could be achieved in alternative ways. It is here, in two chapters addressing the governmental interests at stake, and considering alternative methods of achieving them, that we come to the crux of Winick's argument.

First, however, Winick addresses a preliminary matter: the standards by which courts should evaluate the justifications asserted for involuntary mental health treatment in different contexts. In *Washington v. Harper*, the Supreme Court applied a deferential standard to uphold involuntary administration of psychotropic medication in a prison setting. Winick argues that prisons are uniquely dangerous institutions, and that the approach used in *Harper* should be limited to the prison context. To support this claim, Winick relies heavily on the Supreme Court's decision in *Riggins v. Nevada*, which upheld the claim of a criminal defendant that the compulsory administration of mellaril during his trial rendered his conviction invalid. Winick notes that the Supreme Court's language here is dicta, unessential to the resolution of the case, but nevertheless contends that it suggests courts must apply a non-deferential standard of

necessity in the context of medication of jail inmates. Further, because the Supreme Court in *Riggins* makes no mention of its earlier decision in *Youngberg v. Romeo*, which applied a deferential "professional judgment" standard in the context of treatment decisions in a state institution for the mentally retarded, Winick suggests that (at least after *Riggins*, and outside the prison context) the deferential standard does not apply to the right-to-refuse-treatment question.

Winick's argument here is not entirely persuasive, however. In the first place, *Riggins* indicates merely that a showing of necessity would be *sufficient* to justify compulsory psychotropic medication, not that such a showing is *required*. Second, the context of *Riggins* was not simply compulsory medication of jail inmates, but of defendants during trial. The constitutional interests in preserving the fairness of the criminal trial process clearly entered into the Court's analysis; these interests generally are not at stake in mental hospitals or other contexts in which involuntary treatment occurs. It seems at least plausible that this special criminal trial context explains the Court's non-reliance on the "professional judgment" standard of *Youngberg v. Romeo*, rather than a general reluctance to apply that standard to right-to-refuse-treatment issues.

Turning to an analysis of the governmental interests served by involuntary mental health treatment, Winick clarifies the state's police power interests in public health, safety, and welfare from the state's *parens patriae* interests in protecting those who are unable to protect themselves. In the context of civilly committed patients, the interest in protecting public safety is adequately served by hospital confinement, and therefore does not justify intrusive treatment techniques. That such techniques might speed recovery and discharge, reduce costs, and improve the quality of care are legitimate concerns, but not "compelling" ones, Winick argues; they therefore are not sufficient grounds on which to overcome a patient's objection to intrusive treatment. On the other hand, at least in emergency situations, the need to protect patients from harming themselves, other patients, and staff does provide a sufficiently compelling justification for the administration of psychotropic medication.

With regard to the state's *parens patriae* interests, Winick argues that only patients who are truly incompetent to make treatment decisions may legitimately be compelled to accept treatment on this basis, and then only to the extent that the treatment is in their best interests. Neither a finding of mental illness alone, nor involuntary civil commitment based on mental illness plus dangerousness, is sufficient to establish a patient's inability to make treatment decisions. Thus, before involuntary treatment procedures are administered on the basis of the state's *parens patriae* interests, a separate determination of the patient's decisional incompetence should be required.

With regard to insanity acquittees, prison inmates, and those involved with the criminal justice system whose competency for trial or execution needs to be restored, Winick's analysis of the state's *parens patriae* interests is the same:

involuntary treatment should proceed only after a finding that the individual is incompetent to make treatment decisions, and then only to the extent that the treatment is in the individual's best interest. However, for prison inmates, the state's interest in preventing violence to staff and other inmates is just as compelling as in the civil context, but under *Washington v. Harper*, courts apply a more deferential approach in scrutinizing prison administration decisions that may compromise prisoners' constitutional rights. Thus, Winick suggests, even in non-emergency situations prisoners may be medicated over their objection, if therapeutically appropriate, in order to prevent violence. For defendants found incompetent to stand trial, the state's police power interest in enforcing its criminal laws provides a sufficiently compelling reason to justify involuntary intrusive treatment. Curiously, Winick concludes otherwise for the state's interest in restoring competence for execution, and instead treats such treatment as "medical punishment" that violates the requirement of "therapeutic appropriateness." But surely restoring a person's connection to reality with psychotropic medication is therapeutically appropriate regardless of the legal consequences of having that connection restored, and that fact that the ultimate purpose of restoring that connection is to enable criminal punishment to be imposed does not transform the medical treatment itself into a form of punishment.

With regard to insanity acquittees, and with regard to the treatment of convicted criminals for purposes of rehabilitation, he suggests that the state's interests in preventing recidivism may be deemed sufficiently compelling to justify medically appropriate, involuntary treatment. However, for insanity acquittees, the possibility of indefinite confinement sufficiently protects the community from future criminal conduct, so Winick concludes that intrusive treatment methods may be refused. For convicted criminals, Winick aptly points out that involuntary treatment for purposes of rehabilitation may be challenged if it is not medically appropriate, or if it is not reasonably well established as effective in achieving rehabilitative goals. Additionally, the use of intrusive treatment techniques not for purposes of treatment per se, but for purposes of preventing future criminal conduct, is ethically problematic and highly experimental. Ultimately, Winick suggests that the harms of future criminal conduct are too remote to justify the use of intrusive treatment techniques for rehabilitative purposes, but it is not clear how he squares this conclusion with the view that the state's interest in preventing recidivism is a compelling one.

Having examined both the individual's interests in refusing treatment and the government's interests in imposing it, Winick turns to a consideration of the means used by the government to accomplish its purposes. As noted above, outside the prison context the government is usually required to establish that its infringement of fundamental constitutional rights is necessary in order to achieve

compelling societal interests; if alternative methods of achieving those interests exist, the government must use the approach that intrudes least on constitutional values. Applying this principle to the context of treatment refusal, Winick suggests that efforts to treat with less intrusive techniques should be tried before more intrusive measures are undertaken, and that, in the context of restoration of trial competence, a defendant should be permitted to discontinue medication for a reasonable period prior to trial, to establish that he can proceed to trial in an unmedicated state; if the experiment fails, competence can again be restored by re-instituting the treatment regimen.

Having constructed an argument for a qualified right to refuse treatment, Winick sets out to show that recognition of the right would make the law more therapeutic. Winick argues that giving patients a legal say in the course their treatment takes promises to make that treatment more effective. The basis for this claim is the view "that patient choice increases the likelihood of treatment success and that coercion does not work as well." Winick acknowledges that further empirical research is needed to firmly establish this position, but even his tentative assertion seems to stretch the data. At one point he acknowledges that the conclusions he draws "are based on studies with less impaired populations" and that it may not be possible to generalize the results to more impaired patients, but in arguing that recognizing the right to refuse will have therapeutic consequences he overlooks this limitation of the data. At another point Winick notes that in some cases medication may be needed "to control symptoms that would prevent the patient from accepting other forms of therapy." In such cases, if medication cannot be administered as a result of the patient's right to refuse treatment, the result will be anti-therapeutic. In short, the claimed therapeutic benefits of recognizing a right to refuse treatment are less than clear.

Winick does not specifically address the implications of his argument for the system of involuntary civil commitment, but the consequences seem fairly clear. Dangerous mentally ill persons could still be confined; the police power interests in protecting against violence are compelling enough to sustain such laws. Further, for individuals truly incompetent to make treatment decisions, appropriate but intrusive treatment could be provided, so long as it was in the individual's best interest. For other patients, however, treatment would be limited essentially to psychotherapy, unless the patient consented to more intrusive forms of treatment. Winick's argument puts aside any beneficent justifications for imposing psychotropic medication or other intrusive treatment on those who have the capacity to make treatment decisions, regardless of the promise such treatment may have.

Internet Resources of Forensic Interest

As an occasional service, Developments in Mental Health Law will list web sites that may be of interest or assistance to our readers. If you have any suggestions for possible sites to include on this list, please feel free to send them by email to:

dmhl-editor@Virginia.edu

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services: http://www.dmhmrsas.state.va.us/
The departmental web site offers a variety of information about DMHMRSAS facilities and programs, as well as other items of interest.

Virginia General Assembly: http://legis.state.va.us/
The web site of the General Assembly allows you to track pending legislation, search the Code of Virginia, to view bills as they are passed and amended, and more. Informative.

National Association of State Mental Health Program Directors:
http://www.nasmhpd.org/
This web site offers a description of NASMHPD's Mission, Divisions and Councils, along with contact information and other items of interest.

Health Law and Policy Institute:
http://www.law.uh.edu/LawCenter/Programs/Health/health-law.html
This site is hosted by the University of Houston, and offers limited access to articles from their publication, *Health Law News*, on a variety of health law topics, including mental health.

PsychWeb: http://www.psywww.com/index.html
An all-around useful resource for psychological information.

Findlaw: http://www.findlaw.com/ An all-around useful resource for legal information.

Justice Information Center: http://www.ncjrs.org/
A service of the National Criminal Justice Reference Service, this site provides information on a variety of topics, including numerous DOJ studies and reports.

FBI Crimes Statistics and Reports: http://www.fbi.gov/ucr.htm
This Federal Bureau of Investigation site provides access to its Uniform Crime Reports and other data and reports of interest.

Tncrimlaw: http://www.tncrimlaw.com/law.html
A Tennessee law site, it provides numerous links to various forensic topics of interest, making it useful to all, not just Tennessee residents.

Institute of Law, Psychiatry & Public Policy: http://www.ilppp.virginia.edu/ilppp
The Institute web site provides information on upcoming training, faculty publications, and a variety of additional information including contact information.

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Introductory Risk Assessment: November 8th, Roanoke Area
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