A Quarterly Publication of the Institute of Law, Psychiatry & Public Policy at the University of Virginia

Developments in Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 2 No. 1 Jan.-March 1982

The Implications Of Estelle For The Mental Health Professional

by Christopher Slobogin*

The Supreme Court's recent decision in **Estelle v. Smith**[1] considered the impact of the Fifth Amendment's privilege against self-incrimination and the Sixth Amendment's right to counsel on the conduct of pretrial mental evaluations of capital defendants who neither initiate the evaluation nor plan to introduce "clinical"[2] evidence at sentencing. The Court held that expert testimony about such a defendant's dangerousness at the capital sentencing proceeding is constitutionally inadmissible if the defendant has not been warned, before being evaluated, of his right to remain silent. It also held that the defendant's attorney must be notified about the evaluation before it takes place. The Court in **Estelle** did not consider the application of these constitutional principles to forensic evaluations that address only the offender's mental state at the time of the offense and his competency to stand trial. This article will attempt to explain how **Estelle** affects the conduct of these more typical pretrial forensic evaluations as well as examine its impact on the type of assessment at issue in **Estelle** itself.

The Opinion

The facts of **Estelle** are crucial to understanding the decision. Under Texas law, the death penalty must be imposed if the jury affirmatively answers three questions, one of which focuses on whether there is a "probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society."[3] At the sentencing phase of Ernest Smith's trial for capital murder, the prosecution's only witness was Dr. Grigson. He testified, **inter alia**, that Smith was a "severe sociopath" who is "going to go ahead and commit other similar or same criminal acts if given the opportunity to do so" and who has no "regard for another human being's property or for their life, regardless of who it may be."[4] The jury answered the dangerousness question and the two other questions in the affirmative, and the judge imposed the death penalty.

Dr. Grigson had been ordered informally to perform an evaluation of Smith by the trial judge prior to the trial. The judge requested only that Grigson assess Smith's competency to stand trial, yet Grigson's letter to the judge went far beyond the limited range of the court order. In the letter, Grigson observed that: "It is my opinion that Ernest Benjamin Smith, Jr. is aware of the difference between right and wrong . . . "; he also referred to Smith as a "severe sociopath," although he did not make any explicit reference to Smith's dangerousness.[5] On appeal, it was stipulated that neither the prosecutor nor Dr. Grigson had obtained permission from the defense to examine Smith. Nor did Smith's attorneys know that Dr. Grigson would evaluate Smith's mental state at the time of the offense and his dangerousness, as well as his competency. Apparently, Smith himself was told nothing about the purpose of the evaluation or the "risks" that it entailed.[6]

It was not until the sentencing proceeding that Smith's attorneys discovered that Dr. Grigson would be a witness for the prosecution and that he would testify about Smith's dangerousness.[7] At no point during the sentencing proceeding did the defense offer clinical testimony of its own on the issue of dangerousness or on any other issue.[8]

The first part of the Supreme Court's opinion held that, given the "gravity of the decision to be made at the [death] penalty phase,"[9] Fifth Amendment protection must be accorded a defendant at the sentencing as well as the guilt phase of a capital murder trial. Chief Justice Burger, writing for a unanimous court, stated:

> When Dr. Grigson went beyond simply reporting to the court on the issue of competency and testified for the prosecution at the penalty phase on the crucial issue of respondent's

Continued

*Mr. Slobogin, J.D.,LL.M., is a professor at the University of Virginia School of Law.

Also In This Issue

3/ Proposal To Abolish Insanity Defense
5/ In The United States Supreme Court

Continued from page 1

> future dangerousness, his role changed and became essentially like that of an agent of the State recounting unwarned statements made in a post-arrest custodial setting. During the psychiatric evaluation, respondent assuredly was "faced with a phase of the adversary system" and was "not in the presence of [a] person acting solely in his interest." [Citing **Miranda v. Arizona**, 384 U.S. 436, at 469.][10]

Since Smith had not been "warned" that his disclosures during his interview with Grigson would be used as a basis for testimony at his capital sentencing hearing, he did not voluntarily and intelligently waive his Fifth Amendment right to remain silent. Grigson's testimony was therefore inadmissible.

The second part of **Estelle** dealt with the Sixth Amendment right to assistance of counsel. The Supreme Court found constitutionally impermissible the state's failure to inform Smith's attorneys that Dr. Grigson's examination would encompass the issue of dangerousness because it thereby denied Smith the advice of counsel at a "critical stage" of the adversary proceeding against him.[11] The Court held that Smith should have had the opportunity to consult with lawyers about whether to submit to the examination and, if so, the extent to which he should cooperate.[12]

Estelle is a logical extension of the Supreme Court's decisions regarding the Fifth and Sixth Amendments. In a long line of cases,[13] the Court has established that a defendant is entitled to warnings and the advice of counsel at any point in the criminal process which could lead to the overpowering of his will through coercion or deception by state agents. While a forensic clinician is not in business to coerce confessions, his traditional image as a member of a "helping" profession and his professional inclination to obtain as much information as possible make it likely he will coax information that is of an incriminating nature from a defendant.[14] The forensic evaluation obviously carries risks for the defendant if these disclosures can be used by the prosecution as part of its case against him. Accordingly, the Court held that when the evaluation is not defense-requested and when the defendant has not

Smith should have had the opportunity to consult with lawyers about whether to submit to the examination and, if so, the extent to which he should cooperate.

indicated an intention to introduce clinical evidence of his own, the state should have to apprise the defendant and his attorney about the nature of the evaluation before it takes place, and the defendant should have the right to refuse to cooperate with the evaluation if its results could be used to address the dangerousness issue at capital sentencing.

The Ramifications of Estelle

Estelle made clear that the Fifth Amendment privilege is not only implicated by pretrial evaluations focusing on the defendant's dangerousness but also when the defendant undergoes competency assessments and "reconstructive" evaluations of his mental state at the time of the offense.[15] But it did not discuss how the privilege should be implemented in these more common evaluation contexts.

It should be noted at the outset that warnings—to the effect that the defendant has the right to remain silent and that anything he says may be used against him—are not the ideal method of protecting a defendant's Fifth Amendment interests. It is doubtful that many of the defendants evaluated on issues involving mental state are fully competent to understand and waive their rights, and the task of ascertaining whether this is so would be a cumbersome one at best. Moreover, clinicians may be loath to give such warnings because they create an adversarial atmosphere in the clinical setting and may inhibit the information-gathering process. Although, as discussed later in this article, some form of pre-evaluation "warnings" are clearly necessary, for ethical[16] as well as constitutional reasons, the standard **Miranda** litany is neither legally nor clinically practical and should be avoided if possible.

The **Estelle** Court emphasized repeatedly that its holding requiring such warnings applied solely to the fact situation before it, one which involved (1) an indigent defendant (2) whose attorneys never sought clinical advice. It thus left open the question of how the defendant's Fifth Amendment interests are to be protected when the defendant is not indigent or when the defendant who is indigent requests the evaluation. The Court's caution probably reflected its recognition that the appropriate method of safeguarding the privilege against self-incrimination may vary depending upon the type of defendant and the legal issue involved.

For the defendant who can afford and obtains a private evaluation, for instance, the "**Miranda** warnings" make no sense. Until the defendant decides to introduce clinical testimony, the data obtained from such an examination will be protected by the attorney-client privilege, which makes confidential any communication by the client to the attorney or his agent (here the forensic clinician).[17] In this context, telling the defendant he has the right to remain silent would be counterproductive and unnecessary, since he and his attorney retain control of the evaluation results until such time as they decide to introduce evidence of mental abnormality.

The indigent defendant is in a somewhat different posture, since he must usually rely on state resources if he is to explore the possibility of a clinical defense. In some states, the state-employed clinician is considered an agent of the attorney and his conclusions are protected by the attorney-client privilege in the same way the private clinician's are protected.[18] However, in many states the state clinician is required to send his report to all parties, including the prosecutor, whether or not the defendant has decided to introduce clinical testimony.[19] In these states, precautions are needed in order to insure that the clinical evaluation will not become an investigative device for the prosecutor seeking incriminating leads or state-

Continued on page 4

Proposed Federal Criminal Code Reform Would Abolish Insanity Defense

The Senate version of the proposed Criminal Code Reform Act of 1981 (S. 1630) was reported to the full Senate on December 22, 1981 (S. Rept. 97-307). While for the most part the bill represented over fifteen years of work, that portion concerning the insanity defense is a relatively recent and potentially controversial addition to the bill.

S. 1630 would abolish in federal court the insanity defense as it is today used in all federal courts and most state courts. In its place, S. 1630 provides that where "the issue of insanity is raised" by the defense, prosecution, or the court, "the jury may return a special verdict of 'not guilty only by reason of insanity'. " **See** Section 3612(b).

"Insanity" is defined by Section 3617(a) (1) to mean "a mental disease or defect as a result of which a person lacked the state of mind required as an element of the offense."

S. 1630 proposes in Section 302 to require for most federal crimes proof of one of four different culpable states of mind at the time of the offense. Depending on the offense, the prosecution must prove that it was done "intentionally," "knowingly," "recklessly," or "negligently." This is a substantial improvement over present federal law which contains seventy-nine different states of mind.

A successful "insanity defense" under S. 1630 would consist of failure of the prosecution to prove the required culpable state of mind beyond a reasonable doubt. This essentially is the "**mens rea**" defense available under current law independent of the separate American Law Institute insanity defense.

Today, even where a defendant benefits from the federal A.L.I. insanity defense, there exists no federal procedure for committing the defendant to a mental health or mental retardation facility. At the same time that S. 1630 abolishes the traditional insanity defense, it enacts a post-acquittal by reason of insanity commitment procedure in Section 3613.

Within forty days of the acquittal by reason of insanity, the court, under Section 3613, must conduct a hearing. The government must prove by clear and convincing evidence that the defendant is

> **presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to the property of another.**

If the government succeeds in its proof, the defendant is committed, preferably to a state mental health or mental retardation facility. There he stays until he persuades the court that he is no longer dangerous, or until he is conditionally discharged.

At the same time that S. 163 abolishes the traditional insanity defense, it enacts a post-acquittal by reason of insanity commitment procedure.

The insanity defense provision of S. 1630 does not really limit the kind of psychiatric evidence a defendant may introduce in his defense. Nor is it necessarily easier for the prosecution to prove a required state of mind beyond a reasonable doubt than it is to overcome the A.L.I. insanity defense, even where the burden of disproving insanity is placed on the prosecution. But it will be easier under S. 1630 for the court or prosecution to impose an insanity defense on a defendant with the aim of committing him for an indefinite period of time.

Other sections address the hospitalization of persons after a finding of incompetency to stand trial, after conviction but before sentencing, after sentencing, and at the end of a sentence.

A person found incompetent to stand trial under Section 3611 may be held initially for four months to determine whether "there is a substantial possibility that in the foreseeable future he will attain" competency to stand trial. If there is that probability, he may be held for an "additional reasonable period of time" until restored to competency. If there is no probability of recovery, he may be civilly committed, according to Section 3616, in the same manner as a prisoner approaching the end of his sentence. This procedure is nearly identical to that used to civilly commit and discharge a person acquitted by reason of insanity.

Section 3614 requires the court to commit a convicted defendant to a hospital instead of a prison if after a hearing it finds by a preponderance that the defendant is mentally ill or mentally retarded and "should" be so committed.

Section 3615 is triggered only by both the objection of a prisoner to a "suitable facility for care or treatment" **and** the motion of the government for a hearing on the prisoner's mental state, which motion the government, it seems, need not file. If a hearing is held, the prisoner is committed on a showing by a simple preponderance that the defendant is "presently suffering from a mental disease or defect for the treatment of which he is in need of custody or treatment in a suitable facility."∎

Continued from page 2

ments. The defense attorney requesting a competency, "reconstructive," or capital sentencing evaluation of an indigent client (or responding to a prosecution motion for such an evaluation) must either coach his client to refrain from making damaging disclosures or seek assurance that use of the evaluation's results will be limited to the issue which the court has ordered the clinician to address. The first course may protect the defendant from self-incrimination, but it smacks of gamesmanship and will deprive the attorney (as well as the prosecutor) of useful information regarding his client's future behavior. The latter course is better from the defense perspective, since it gives the attorney the clinical information he needs to make an informed decision about his client's case, and at the same time it safeguards against state use of "confessions" or other damaging information to prove at trial that the defendant committed the act in question.[20]

Thus, if the evaluation of the indigent defendant focuses on competency, the order should prohibit use of the evaluation's results on any other issue. If the assessment is of the defendant's mental state at the time of the offense, the order should limit use of the results to that issue and, further, should proscribe such use until the defendant himself elects to introduce clinical testimony at trial. If the evaluation focuses on capital sentencing issues, the order should similarly restrict use of the results until the defendant introduces clinical evidence. In effect, such a procedure gives the court-appointed attorney the same control of the evaluation that a retained attorney, relying on the attorney-client privilege, exercises.

In many jurisdictions, the attorney seeking an evaluation of the indigent client may not need to obtain a protective order, since statutory or judicial law fulfills the same function. For instance, the Model Penal Code formulation, which has been adopted in seven states, reads:

> **A statement made by a person subjected to a psychiatric examination or treatment ... shall not be admissible in evidence against him in any criminal proceeding on any issue other than that of his mental condition. ...**[21]

The evaluator must be sure to tell the defendant about the implications of the evaluation.

A second example of this stance is found in the Fourth Circuit's opinion in **Gibson v. Zahradnick**[22] which held that the Fifth Amendment bars use of information obtained during a pretrial forensic evaluation to prove the defendant's guilt.

The defendant's Fifth Amendment interests thus may be effectively safeguarded in a variety of ways: the attorney-client privilege, appropriately drafted judicial orders, or statutory and case law. The "**Miranda** warnings" referred to in the first part of **Estelle** will be appropriate only when one of these protections is not available.

This does not mean, however, that **Estelle** will have no effect on the forensic evaluation process. As noted earlier, the decision has made clear that the Fifth Amendment applies to that process and that some means of implementing the Amendment's guarantees—be it with warnings or something better—must be established. Moreover, the second part of **Estelle** regarding notification of the defense attorney will insure that the attorney has the opportunity to seek a protective order if one is required.

Of course, **Estelle** does not prevent the state from seeking its own evaluation when the defendant already has an expert and has raised a clinically-based defense. Any attempt by defense counsel to muzzle the defendant during such an evaluation through reliance on the Fifth Amendment would probably backfire. As the Supreme court noted in **Estelle**,[23] many jurisdictions sensibly bar the introduction of clinical evidence if the defendant does not cooperate with the state's efforts to procure rebuttal testimony.[24]

The Role of the Clinician After Estelle

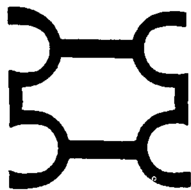
Ultimately, the judge, the prosecutor, and the defense attorney must insure that the defendant's Fifth and Sixth Amendment rights are not violated. But the evaluator who is unable to obtain guidance from the legal system or who is in a position to make suggestions to an attorney or the court should be aware of certain fundamental steps which ought to be taken to prevent unnecessary infringement of these rights.

The first step an evaluator should take after receiving an evaluation order is to ascertain whether the defendant's attorney has been notified about the impending assessment. Of course, if the order indicates that the defendant himself requested the evaluation, then such notification is unnecessary. But if the prosecution, or the court acting alone, is the motivating agency behind the order, the defense attorney may not be aware of the evaluation. Since, after **Estelle**, the attorney should have the opportunity to advise his client before such an evaluation takes place, he must be told about it, by the evaluating clinician if by no one else.

Assuming that the defense attorney has requested the evaluation or has been notified about it and either agrees to it or fails in his efforts to prevent it from occurring, the clinician still needs to be sensitive to the defendant's Fifth Amendment interests. In those situations where the attorney-client privilege does not apply and the defense attorney has not already sought Fifth Amendment protection, the clinician might want to obtain, through the defense attorney, the prosecutor, or the court, a protective clause of the type described earlier (prohibiting use of the evaluation's results on any legal issue other than the defendant's mental condition). It may be wise to include this clause in the order even when statutory or judicial pronouncements make it technically unnecessary, as a reminder that the evaluation is not to be utilized as an investigative tool for the state but rather as a method of seeking psychological information about the defendant.

Continued on page 6

In The United States Supreme Court



Forensic Training

In March, 1980, the Virginia General Assembly passed House Joint Resolution No. 22, calling for the initiation of an experimental outpatient evaluation system for the criminal courts. In order to implement this system, the General Assembly requested the Department of Mental Health and Mental Retardation to establish a Forensic Evaluation Training and Research Center. The Center, under the direction of Christopher Slobogin, has now been in operation for two years and has trained over 50 community mental health professionals to perform evaluations of criminal defendants. Those professionals who are trained by the Center are entitled to either $100 or $200 remuneration for each evaluation they perform, depending upon the type of evaluation, pursuant to regulations promulgated by the Department of Mental Health and Mental Retardation and the Executive Secretary's Office of the Virginia Supreme Court. The course consists of six days of training at the Center's facilities in Charlottesville and another day's training at Central State Hospital under the supervision of Dr. James Dimitris. Trainees are provided a 350 page manual containing materials concerning the Virginia criminal justice system, competency to stand trial, the insanity defense, sentencing issues, juvenile courts, expert testimony, and other issues.

Community mental health professionals who desire such training and who would be willing to utilize the training in performing evaluations for the courts in their locale should contact Mr. Slobogin at Box 100, Blue Ridge Hospital, Charlottesville, Va. 22901; Phone (804) 924-5435.

Cases Decided

During the October 1980 Term and the early months of the 1981 Term, the Supreme Court decided several cases involving mental health law issues. **Estelle v. Smith** is discussed at length by Christopher Slobogin on page 1 of this issue. **Halderman v. Pennhurst** turned back an attempt to force deinstitutionalization of the residents of a state mental retardation facility. **See also** 1 **Developments in Mental Health Law** 17 (1981) for a discussion of **Schweiker v. Wilson**, decided in the October 1980 Term.

Most recently the court handed down a decision in **Eddings v. Oklahoma** which requires explicit consideration of mitigating psychiatric conditions of an adolescent sentenced to death.

States not required to provide minimally restrictive environment for the retarded

• In **Halderman v. Pennhurst**, 101 S.Ct. 1531 (1981), the Supreme Court in a 6-3 opinion by Justice Rehnquist reversed the Third Circuit's judgment, reported at 612 F.2d 84 (3rd Cir. 1979) **(en banc)**.

Justice Rehnquist held that Section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. Sections 6001-6080 (D.D. Act), does not create substantive rights for retarded individuals requiring the states to provide treatment and/or habilitation in the least restrictive environment. Justice Rehnquist characterized the D.D. Act as a funding statute enacted through Congress' spending power and not pursuant to its power to enforce the 14th Amendment. Thus he found that Section 6010 and the statutory "Bill of Rights" were merely an expression of a Congressional preference, not a Congressional mandate, for certain kinds of treatment.

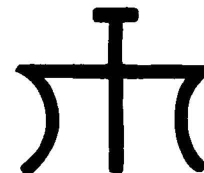
Most commentators agree that the Supreme Court's ruling failed to provide needed guidance on rights of persons institutionalized in state mental retardation facilities to appropriate treatment, especially where minimally appropriate treatment seems to require the creation of an alternative less restrictive than institutionalization.

Some patients' rights advocates are hopeful that **Pennhurst** will be read narrowly to leave open several alternative theories on which to pursue these rights. Specifically, other sections of the D.D. Act or other federal statutes might provide relief. Unanswered questions include the following: (1) whether Section 6010 of the D.D. Act, when read in conjunction with Sections 6063 and 6011, creates additional obligations on states; (2) whether Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, imposes some affirmative obligations on recipients of federal funds; (3) whether plaintiffs have an implied right of action under the D.D. Act; and (4) whether plaintiffs can bring a civil rights suit under 42 U.S.C. Section 1983.

Other remaining theories which might provide relief for **Halderman** plaintiffs include: (1) a Fourteenth Amendment right to nondiscriminatory habilitation; and (2) state statutes, such as the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S., Section 4201, which arguably grants an affirmative right to minimally adequate habilitation.

There is virtually no possibility that Congress will amend the D.D. Act to require more effectively that states provide minimal habilitation.

Continued on page 7



Continued from page 4

Moreover, the evaluator must be sure to tell the defendant about the implications of the evaluation. As implied earlier, the type of "warning" the evaluator should give the defendant before beginning the interview depends upon whether the law has made any provision for restricting state use of the evaluation's results. If not, the clinician must inform the defendant that anything he says might be used against him to prove his guilt at trial, or (if relevant) his dangerousness at a capital proceeding. On the other hand, if the state is barred from utilizing disclosures made during a clinical evaluation to address non-clinical issues, the evaluator can assure the defendant that his statements will be used against him to prove his competency (or incompetency), his sanity, or his dangerousness only if those issues are properly raised and that under no circumstances may his statements legitimately be used for other purposes.

If the clinician makes sure that the defendant's attorney has been notified about the evaluation, seeks protection against collateral use of the evaluation results if such protection does not already exist, and is careful to apprise the defendant about possible uses of his statements, he will have fulfilled the consitutional requirements that **Estelle** has imposed upon the evaluation process.[25] Although the legal system bears primary responsibility for meeting these requirements, the mental health professional can provide valuable assistance in upholding the defendant's Fifth and Sixth Amendment interests by performing the functions described above.

Conclusion

Estelle should be viewed as setting forth the minimum requirements for the application of the Fifth and Sixth Amendments to the forensic evaluation process. Whenever the evaluation is at the behest of, or is performed by, agents of the state, the defense must be notified of the nature of the evaluation. The defendant must also be warned of his right to remain silent unless, as should be the case, assurance has been sought from the judge that any disclosures by the defendant cannot be used by the prosecution as part of its case-in-chief or unless there is statutory provision or court rule to this effect. If these latter options are available and utilized, the defendant seeking clinical expertise can be told that disclosures he makes during the evaluation will not be used at trial or sentencing unless he and his attorney raise a psychological "defense," and the defense attorney can acquire the comprehensive clinical information he needs to make an informed decision as to whether to pursue such a "defense" or make a motion for a competency hearing. These procedures will insure that both the defendant's Fifth Amendment privilege against self-incrimination and his Sixth Amendment right to effective assistance of counsel will be given full recognition without damage to the evaluation process. ■

Notes

1. 101 S.Ct. 1866 (1981).
2. The terms "clinical" and "clinician" will be used throughout this article to connote the fact that many types of non-psychiatrists, including psychologists and social workers, may perform evaluations for the courts.
3. Tex. Code Crim. Proc., Art. 37.071(b) (Vernon Supp.) (1980).
4. Appellant's brief at 17-26.
5. **See** 101 S.Ct. at 1866, at 1870.
6. 101 S.Ct. at 1895.
7. 101 S.Ct. at 1871. Dr. Grigson's name did not appear on the witness list submitted by the prosecution upon order of the trial court. The trial judge denied a defense motion to exclude Dr. Grigson's testimony on this ground. 101 S.Ct at 1871.
8. Id.
9. 101 S.Ct. at 1873. The Court stated, "Just as the Fifth Amendment prevents a criminal defendant from being made 'the deluded instrument of his own conviction' ..., it protects him as well from being made the 'deluded instrument' of his own execution." **Id.**
10. 101 S.Ct. at 1875.
11. 101 S.Ct. at 1877. The "critical stage" analysis was enunciated in Coleman v. Alabama, 399 U.S. 1 (1970) and is one of the analytical models used by the court to determine when a defendant is entitled to the assistance of counsel. See Whitebread, Criminal Procedure, §25.03(b).
12. The Court cautioned, however, that the Sixth Amendment only requires **notice** of the evaluation. It does not necessarily guarantee counsel's presence during the evaluation, 101 S.Ct. at 1877 n. 14.
13. **See**, e.g., Miranda v. Arizona, 384 U.S. 436 (1966); Kirby v. Illinois, 406 U.S. 682 (1972); Brewer v. Williams, 430 U.S. 387 (1977).
14. **See** Meister, "Miranda on the Couch," 11 Colum. J.L. & Soc. Prob. 403, 413-19, for more discussion of this issue.
15. 101 S.Ct. 1866 at 1873; note 9, **supra**.
16. The clinician is ethically required to inform any person he evaluates about the nature of the evaluation and how its results will be used. See, e.g., American Psychological Association, "Ethical Principles of Psychologists," 36 Am. Psychol. 633, (1981).
17. **See**, e.g., United States v. Alvarez, 519 F.2d 1036 (3rd Cir. 1975); Houston v. State, 602 P.2d 784 (Alaska 1979).
18. **See**, e.g., Fla. Code Crim. Proc. 3.216.
19. Goldstein, A., The Insanity Defense, 132 (1967).
20. Suppose the judge refused to issue such a protective order in a jurisdiction which did not have the statutory or judicial protections described below. Several courts have held that failure to raise an insanity defense when it could colorably be raised constitutes ineffective assistance. **See**, e.g., Wood v. Zahradnick, 578 F.2d 980 (4th Cir. 1978); Brooks v. Texas, 381 F.2d 619 (5th Cir. 1967); McLaughlin v. Royster, 346 F. Supp. 297 (E.D. Va. 1972). Yet the defense attorney can argue that, without a protective order, to proceed with the evaluation would impermissibly expose his client to the risks of self-incrimination **before** the decision regarding such a defense has been made. Thus, denial of a protective order motion would create an intolerable tension between two constitutional rights—the right to effective assistance of counsel and the privilege against self-incrimination.
21. Model Penal Code §4.09 **(Proposed Official Draft, 1962). See also Colo. Rev. Stat.** §16-8-107 (1973); Ill. Ann. Stat. ch. 38 §115-b (Smith-Hurd 1973); Mass. Gen. Laws Ann. ch. 233, §23B (West Supp. 1979).
22. 581 F.2d 75, 78-79 (1978); see also United States v. Reifsteck, 535 F.2d 1030, 1034 n.l (8th Cir. 1976); United States v. Alvarez, 519 F.2d 1036, 1042 (3d Cir. 1975).
23. 101 S.Ct. 1866, at 1874.
24. **See** cases cited at 1866 S.Ct. 1874.
25. There may be additional constitutional requirements imposed on the evaluation process in some states, requirements the **Estelle** Court did not address because they were not directly raised by that case. Two that should be mentioned here are (1) preventing state access to the evaluation's results until a defense is raised and (2) permitting the presence of the defense attorney during the evaluation. Arguably, given the potential incriminating aspects of the defendant's disclosures during an evaluation, the prosecutor not only should be barred from using these disclosures until a defense is raised but also should be barred from access to those disclosures until notice is given. See, e.g., proposed §19.2-169.1 (e), Va. Code Ann. Strong arguments can also be made that the defense attorney has the right to be present during the evaluation so as to be able to represent effectively his client at trial. **See**, e.g., Comment, "The Right to Counsel During Court-Ordered Psychiatric Examination of Criminal Defendants," 26 Vill. L. Rev. 135 (1980).

Developments in Mental Health Law

is distributed as a public service by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health and Mental Retardation. The opinions expressed do not necessarily reflect the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge on a quarterly basis. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100 - Blue Ridge Hospital, Charlottesville, Virginia 22901. We also welcome your suggestions and comments.

Editor
Willis J. Spaulding
Managing Editor
Elaine M. Hadden
Assistant Managing Editor
Pamela M. Benner
Law Student Contributors
Henry E. Howell, III
Kathleen Miles

Continued from page 5

All mitigating evidence to be considered before imposition of death penalty

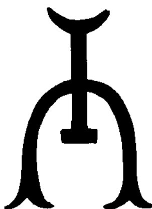
• **Eddings v. Oklahoma**, 50 U.S.L.W. 4161 (Jan. 19, 1982), involved a sixteen year-old youth sentenced to death by an Oklahoma trial judge. The adolescent, tried as an adult, had killed a highway patrolman with a shotgun. The Court, in an opinion written by Justice Powell, joined by Justices Brennan, Marshall, Stevens, and O'Connor, reversed and remanded with the instruction that the state courts consider all the relevant mitigating evidence, including "the background and mental and emotional development of (the) youthful defendant . . ." 50 U.S.L.W. 4161, 4164.

The trial court had announced extemporaneously from the bench that "following the law, (it could not) consider the fact of this young man's violent background." The Supreme Court interpreted the trial court's decision as an unconstitutional failure to consider all mitigating circumstances before imposing the death sentence.

Although in granting certiorari the Court had limited its "consideration to whether the Eighth and Fourteenth amendments prohibit the imposition of a death sentence on an offender because he was 16 years-old . . .", 50 U.S.L.W. 4161, 4165, the Court in its opinion did not decide that issue but instead focused on the state court's failure to consider mitigating circumstances.

The Court's majority was impressed by testimony at the trial level "that Eddings' mental and emotional development were at a level several years below his chronological age" 50 U.S.L.W. 4164. It therefore emphasized that the sentencing court must consider more than just the chronological age of the defendant in considering whether to impose the sentence; it should also consider the actual level of maturity in light of all developmental factors. For Eddings, these factors included serious emotional problems and "a neglectful, sometimes even violent, family background." **Id.**

Three Justices joined the Chief Justice in a dissenting opinion, contending that the trial court and the Oklahoma Court of Criminal Appeals had sufficiently weighed all mitigating factors. The four dissenters would have affirmed the sixteen year-old defendant's death sentence.



Cases Pending

So far this Term, the United States Supreme Court has agreed to review three cases affecting the rights of mentally disabled patients. **Mills v. Okin**, No. 80-1417, considers an involuntarily committed patient's right to refuse treatment. In **Youngberg v. Romeo**, No. 80-1429, the Court is asked whether a mentally retarded resident of state facilities has a right to be protected from harm and to receive treatment. And **Jones v. United States** asks whether a patient committed to St. Elizabeth's Hospital after acquittal by reason of insanity on a charge of petit larceny sixteen years ago may continue to be held without regard to the maximum length of imprisonment for petit larceny.

Must patients in state hospitals accept prescribed treatments?

• In **Mills v. Okin** (**cert. granted** 4/20/81), the Supreme Court is deliberating on the constitutionality of the forcible administration of antipsychotic drugs to patients in a state mental hospital. The lawsuit was brought by mental patients at Boston State Hospital. The Court heard oral arguments for more than an hour on January 13, 1982. **See** 50 U.S.L.W. 3583. The primary question is when do state interests override a patient's liberty interests and justify the state's use of its police power or **parens patriae** power to administer forcibly antipsychotic drugs.

The court below, in **Rogers v. Okin**, 634 F.2d 650 (1st Cir. 1980), held that the decision to administer drugs forcibly should be left to the state physician who must balance the individual patient's interest in refusing antipsychotic drugs against the state's and patient's interests in preventing violence. The physician must also rule out less intrusive means of preventing violence.

The First Circuit also said that the state may use its **parens patriae** power to administer drugs forcibly if there has been a judicial determination that the patient lacks the capacity to decide for himself whether he should take the drugs. In that court's opinion, alternative procedures less formal than judicial proceedings are appropriate for determining incompetency when exigencies, such as the threat of significant deterioration of the patient's health, make a judicial determination impractical. The physician, however, must apply a "substituted judgment" standard in using the **parens patriae** power and try to make the decision that the patient would were he competent. The court suggested that the physician's peers could review the physician's decisions to insure he is meeting the "substituted judgment" standard.

Finally, the First Circuit found that the voluntary patient has only the choice of accepting a prescribed treatment, even antipsychotic drugs, or leaving the state hospital. He does not have constitutional protections unless his status is changed to that of an involuntary patient.

Do patients' rights include protection and habilitation?

• In **Youngberg v. Romeo**, No. 80-1459 (**argued** Jan. 11, 1982), the Supreme Court may answer some of the questions it did not address in **Halderman v. Pennhurst**. Both cases arose from complaints over conditions in Pennhurst State School and Hospital, a large Pennsylvania mental retardation facility. In **Halderman** the plaintiffs argued that their right to minimally adequate habilitation required the state to close Pennhurst and place its residents in community facilities. The Court denied that such a right existed

Continued

Continued from page 7
under the federal Developmentally Disabled Assistance and Bill of Rights Act, but it refused to say whether that right could be found in the due process clause of the Fourteenth Amendment.

In **Youngberg v. Romeo**, the plaintiff, Romeo, speaking through his mother, admits that Pennhurst is the proper placement for him, but he argues that his constitutional right to minimally adequate habilitation and treatment was violated when the hospital allowed him to be injured on over seventy occasions, shackled him to a bed or chair for long periods of time, and failed to provide him with habilitation.

The trial court held the Pennhurst administrators to the Eighth Amendment standard of care applicable in prison settings. Romeo failed under this standard to convince the jury that the administrators had been "deliberately indifferent to his serious medical needs."

The Third Circuit, sitting **en banc**, held that the "deliberate indifference" standard, based on the Eighth Amendment prohibition of cruel and unusual punishment, was not applicable outside of correctional settings. Instead, the Circuit Court of Appeals found in the due process clause of the Fourteenth Amendment a right to habilitation and protection from harm. Under that court's ruling, the Pennhurst officials would have the burden of justifying the lack of protection that resulted in Romeo's injuries, the need to keep him in shackles, and the lack of adequate treatment. And, among alternative modes of treatment, the Court said the constitution entitled Romeo to the "least intrusive" one available. The Third Circuit Court of Appeals opinion is reported at 644 F.2d 147 (3d Cir. 1980).

The questions of the Supreme Court during oral argument suggest that the Court may be unwilling to make a ruling on whether there is a constitutional right to minimally adequate habilitation and treatment before the case has been retried in a manner consistent with the Third Circuit's opinion. **See** 50 U.S.L.W. 3581 (Jan. 26, 1982).

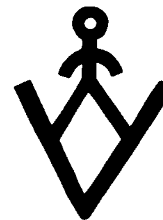
The Commonwealth of Virginia has joined several other states in an **amicus** brief, supporting the Pennhurst administrators in their argument that the constitution only requires a "rational relationship" between the services (e.g., food and shelter) it provides Romeo and the purpose of his commitment to Pennhurst.

May hospitalization terms exceed maximum sentence terms?

• **Jones v. United States**, No. 81-5195 (**cert. granted** Jan. 11, 1982), reviews the District of Columbia Court of Appeals opinion reported at 432 A.2d 364 (D.C. 1981).

Jones was acquitted by reason of insanity on a charge of petit larceny sixteen years ago and committed to St. Elizabeth's Hospital. He argued that the length of his hospitalization may not exceed the maximum sentence of one year he might have received on conviction of petit larceny.

The D.C. Court of Appeals disagreed, ruling that the hospitalization had legitimate non-punitive purposes distinct from the purposes of a criminal sentence. ■



Second Semi-Annual Forensic Symposium

The Forensic Evaluation Training and Research Center will be sponsoring its second Forensic Symposium on May 19, 1982, at the Institute of Law, Psychiatry and Public Policy's Blue Ridge Hospital facilities. Those professionals who have attended past training programs at the Center are welcome to attend. Topics will include the amendments to Section 19.2-169 of the Virginia Code and dangerousness evaluations.

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
Charlottesville, VA. 22901

Non-Profit Organization
U.S. Postage Paid
Permit No. 160
Charlottesville, Virginia
22901

A Quarterly Publication of the Institute of Law, Psychiatry & Public Policy at the University of Virginia

Developments in

Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 2 No. 2 April-June 1982

Forensic Psychological Evaluation Law Rewritten

Among the bills involving mental health law passed by the General Assembly in the 1982 session, the most significant is Senate Bill 417 (1982 Va. Laws ch. 653). This new statute governs the procedures to be followed in obtaining psychological evaluations of and treatment for criminal defendants. Effective July 1, 1982, it revises substantially provisions currently found in Sections 19.2-169 through 19.2-176 of the Virginia Code. The statute was drafted by a twelve-member Task Force appointed by former Secretary of Human Resources Jean Harris in May 1981. Although the General Assembly made several modifications in the draft submitted by the Task Force, only a few were significant (see footnotes to commentary, page 16).

The primary objectives of the new statute are (1) to simplify the statutory language; (2) to redefine the prerequisite qualifications of mental health professionals who may perform evaluations for the courts; (3) to require that, when feasible, evaluation of fitness to stand trial or insanity at the time of the offense be conducted in the community rather than in a distant state hospital; (4) to insure that defendants who need emergency psychiatric hospital treatment prior to trial obtain such treatment; and (5) to accord defendants who are evaluated and treated under these provisions certain procedural protections not provided in the present statute.

The full text of the statute begins on page 16. In addition, a commentary prepared by Christopher Slobogin, a member of the Task Force, is provided. Although this commentary is not the official view of either the General Assembly or the Task Force, it may assist the reader in understanding the purpose and logic behind the various provisions of the statute.

Unofficial Commentary

Section 19.2-168.1

This section is added to the present Section 19.2-168, which provides that the defendant must notify the prosecution about his intent to raise a psychiatric defense ten days prior to trial. Once the defendant formally raises a psychiatric defense under Section 19.2-168, the prosecution should be entitled to obtain its own evaluation. See **Gibson v. Zahradnick**, 581 F.2d 75 (4th Cir. 1978); **United States v. Albright**, 388 F.2d 719 (4th Cir. 1968). The new statute provides that if the defendant refuses to cooperate with the prosecution's expert during this evaluation, the court may prohibit presentation of all clinical testimony at trial. See **Estelle v. Smith**, 451 U.S. 454, 465-66 (1981). The question of what constitutes non-cooperation is left to the court, but its decision will usually be based upon the clinician's description of the defendant's actions during the evaluation.

If and when the state's clinician reaches a conclusion about mental state at the time of the offense, the defense as well as the state should receive the report in time to permit adequate preparation for trial.

Continued

Also In This Issue,

1982 Legislative Changes In

11/ Civil Commitment
17/ Ombudsman Powers
19/ Medicaid
19/Patient Records
Plus Drunk Driving, Right To Die, Reimbursement Rules, Psychotherapists' Privilege, Psychologists' Licensure . . .
And
13/ Text of the Forensic Evaluation Law
18/ Recommendations on Forensic Services

Continued from page 9

Section 19.2-169

(A) It is well settled that if there is reason to believe the defendant is incompetent to stand trial at any time up to and including the trial itself, constitutional due process requires that the court take appropriate steps to determine whether the defendant is competent. **Drope v. Missouri**, 420 U.S. 162, 181 (1975); **Pate v. Robinson**, 383 U.S. 375, 385 (1966). Given these due process considerations, any party to the criminal action, whether it be the court, the attorney for the commonwealth, or the attorney for the defendant, may raise the issue. However, since a competency evaluation may result in a deprivation of liberty, the court or the commonwealth should not be able to raise the issue until the defendant has obtained an attorney who can assist the defendant during the competency determination. This subsection recognizes all of these considerations by permitting the issue to be raised at any time by any party after counsel for the defendant has been obtained and before the end of trial.

This subsection also sets out the standard for ordering a competency evaluation (probable cause to believe the defendant is unable to understand the proceedings against him or to assist in his own defense), which is based loosely on the standard announced by the Supreme Court in **Dusky v. United States**, 363, U.S. 162 (1960). As in **Dusky**, the statute makes no mention of "mental disease or defect" as a predicate for seeking such an evaluation; the competency standard is purely a functional one. Of course, if the defendant is unfit to stand trial, it is likely that his dysfunction will be due to some sort of mental abnormality, which the mental health professional is best qualified to discern and explain.

The forensic evaluator should be acquainted with forensic issues through training and experience. **See** Group for the Advancement of Psychiatry, 8 **Misuse of Psychiatry in the Criminal Courts: Competency to Stand Trial** 894 (1974); Report of the Task Force on the Role of Psychology in the Criminal Justice System, 33 **Am. Psychologist** 1099, 1105 (1978). Following the trend in several states (e.g., Tennessee, New York, Michigan, California), the statute permits doctorate and master's level clinical psychologists, as well as psychiatrists, with such training and experience to conduct competency evaluations.[1]

(B) This paragraph as well as subsection A of Section 19.2-169.5 (on evaluations of mental state at the time of the offense) express a preference for outpatient evaluations in the community. Prolonged inpatient evaluation is unnecessary for all but a small fraction of defendants. Roesch & Golding, **Competency to Stand Trial**, 188 et seq. (1980); de Grazia, E. "Diversion from the Criminal Process: The 'Mental Health' Experiment," 6 **Conn. Law. Rev.** 432, 436 n. 14 (1974); Stone, A.A., **Mental Health and the Law: A System in Transition**, at 209-10 (1975). Moreover, unnecessary hospitalization violates the defendant's right to be evaluated and treated in the least restrictive environment, as well as his right to bail. **See** Janis, N.R., "Incompetency Commitment: The Need for Procedural Safeguards and a Proposed Statutory Scheme," 23 **Catholic University Law Rev.** 720, 738 (1974); Steinberg, M.I. "Summary Commitment of Defendants Incompetent to Stand Trial: A Violation of Constitutional Safeguards" 22 **St. Louis University Law Journ.** 1, 11-20 (1978). Finally, outpatient evaluations should save the state money both in hospitalization and transportation costs. **See** Roesch & Golding, supra, at 188; Annual Report of the Forensic Evaluation Training Center, August 1, 1981, Appendix 6.

If inpatient evaluation is necessary, it should take no longer than thirty days. See above references. In fact, most competency evaluations, even in complicated cases, should last no longer than a day.

(C) Adequate evaluations cannot be performed without sufficient information. Sadoff, R., **Forensic Psychiatry**, at 19 (1975); Pollack, "Psychiatric Consultation for the Court," 1 **Bull. Am. Acad. Psych. & L.** 267, 274 (1973). Without Items 1, 2, and 3 as listed in the statute, the evaluators will be unable to assess the defendant's knowledge of the legal system, the charges against him, and his ability to assist his attorney in representing him on the alleged charges. Item 4 gives the evaluator information on what triggered the evaluation. This can be obtained by requiring the party moving for the evaluation to submit a written motion explaining the reasons for the request and by then forwarding that motion to the evaluators.

(D) This subsection establishes rules governing the competency report and lays out the specific areas the evaluators are to address. Of special note is the requirement that the evaluators reach an opinion on the treatment (i.e., restorability) of the defendant thought to be incompetent.

The final sentence in this subsection is designed to implement the defendant's fifth amendment privilege against self-incrimination. A competency report can address the defendant's ability to assist his attorney, including his ability to remember the alleged offense, without stating explicitly what he said to the evaluators about the offense. On the other hand, inclusion of such disclosures might give the prosecution investigative clues which could lead to the defendant's conviction. **See Blaisdell v. Comm.** 364 N.E. 2d 171 (Mass. 1977); Berry, F.D., "Self Incrimination and the Compulsory Mental Examination: A Proposal," 15 **Arizona Law Rev.** 919 (1973). This provision should also encourage communication between the evaluators and the defendant.

(E) This subsection requires that the court's conclusion about competency be made promptly to expedite the process and protect the defendant's speedy trial right. A hearing on the competency issue will usually be unnecessary. However, if the commonwealth or the defense object to the report or if it appears that the defendant may be hospitalized based on a finding of incompetency (and thus deprived of liberty), a hearing is required and should accord the defendant the due process rights outlined in this subsection. **State ex rel. Matalik v. Schubert**, 57 Wis. 2d 316, 204 N.W. 2d 13 (1973); **see also Pate v. Robinson, supra**, at 384. The burden of proof is placed on the party asserting incompetency because competency will often result in a deprivation of liberty. **See** Mental

Continued on page 12

In The Virginia General Assembly—1982

Civil Commitment Reforms Pursued

This year the General Assembly took another step toward requiring screening of persons facing involuntary commitment by community mental health programs. The 1982 amendments to Section 37.1-67.3 also permit courts to appoint licensed clinical psychologists to examine the defendant in an involuntary commitment proceeding if no psychiatrist is available. 1982 Va. Laws ch. 471.

Effective July 1, 1982, the court for the first time is required to appoint a psychiatrist, if one is available. If no psychiatrist is available the court must appoint either a physician skilled in diagnosis or a licensed clinical psychologist.

The requirements for prescreening apply only where the court does not appoint a psychiatrist or a psychiatrist is not otherwise involved in the treatment or evaluation of the defendant. If no psychiatrist is involved, the court must request a prescreening report from the local community services board.

The court may not commit without the report, unless the services board has failed to provide the report within 48 hours of the request, or 72 hours if that period expires on a weekend.

Since the court's authority to commit expires an identical period after the initial temporary detention of the defendant, the report should be requested before or at the same time the temporary detention order is issued. A court, for example, which requests a report 24 hours after detention could find itself 24 hours later without a report, and without the authority either to proceed without a report or to commit more than 48 hours after temporary detention.

The new law requires the community services board to prepare the report upon court request. But no incentives are provided to encourage or compel compliance with the request, either by way of fees for preparing the reports or of fines or contempt citations for failure to prepare the report.

Psychiatrists, clinical psychologists, and those community mental health professionals who prepare the prescreening report will henceforth play a more important role in civil commitment proceedings.

In other 1982 amendments to the Virginia civil commitment laws:

- Special justices and magistrates may now issue temporary detention orders for minors. 1982 Va. Laws ch. 683.
- City and town police may now detain persons under the authority of a temporary detention order. 1982 Va. Laws ch. 38.
- Temporary detention costs must be reimbursed first from third party payors. The state's liability for any costs remaining will be subject to ceilings to be set by State Board of Health regulations. 1982 Va. Laws ch. 435.
- Special justices, substitute judges, and court appointed attorneys will now receive a fee of $25 each for hearings under Section 37.1-134.2 (which allows the court to authorize medical treatment where the patient is unable to give consent). 1982 Va. Laws ch. 454.

Psychotherapist's Privilege Extended

The 1982 General Assembly enacted new Section 8.01-400.2 which renders "privileged" information provided by clients to licensed counselors, social workers, or psychologists in certain legal proceedings.

An existing privilege statute, Section 8.01-399, made privileged communication to a licensed physician or other "licensed practitioner of any branch of the healing arts," specifically including licensed clinical psychologists.

Like Section 8.01-399, Section 8.01-400.2 sharply limits the circumstances under which the privilege may be asserted. For example, no privilege exists if

- the psychotherapist is not licensed;
- the information was not given to the psychotherapist in confidence or was not necessary for treatment;
- the psychotherapist is asked to testify in a criminal trial, or in a civil action in which child abuse is a question;
- the psychotherapist is asked to testify in a civil action in which the client's physical or mental condition is a question, even if the client did not raise the question; or
- the judge in any case decides that disclosure is "necessary to the proper administration of justice."

The privilege consists of an evidentiary rule applicable in trial which allows the client, at his option, to prohibit the psychotherapist from testifying. The extent of the privilege does not affect the psychotherapist's duty to maintain confidentiality or his right to make disclosure in some instances without client consent. 1982 Va. Laws ch. 537.

Community Service Board Members May Be Compensated

Newly enacted Section 37.1-196.1 authorizes counties and cities to pay each member of their Community Services Boards up to $600 per year for attending Board meetings. These Community Services Boards, sometimes referred to as Chapter 10 Boards, direct the provision of mental health, mental retardation, and substance abuse services at the local level. 1982 Va. Laws ch. 23.

More on page 17

Continued from page 10
Health Law Project, Legal Issues in State Mental Health Care: Proposals for Change—Incompetency to Stand Trial on Criminal Charges, 2 **Mental Disability Law Reporter**, 617, 624 (1978).

The second paragraph is designed to give the judge guidance on two relatively common, and often troublesome, issues. That amnesia per se is not a bar to a competency finding is well established. **Comm. v. Price**, 421 Pa. 396, 218 A. 2d 758 (1966); **United States v. Sermon**, 228 F. Supp. 972 (W.D. Mo., 1964); **Hansford v. United States**, 124 U.S. App. D.C. 387, 364 F. 2d 920 (1966). The judge, however, should be cognizant of the defendant's disability during trial. **See Wilson v. United States**, 391 F. 2d 460 (1968). Most courts today also hold that a defendant who is medicated can and should be found competent. **United States v. Hayes**, 589 F 2d 711 (5th Cir. 1979); **People v. Dalfonso**, 26 Ill. App. 3d 48 (1975); **State v. Hampton**, 218 So. 2d. 311 (1969). In fact, psychotropic medication is often the only means of restoring a defendant to the semblance of normality necessary to insure an understanding of the charges and an ability to communicate with others. Winick, B.J. "Psychotropic Medication and Competency to Stand Trial," 1977 **American Bar Found. Research Journ.** 769 (1977); Group for the Advancement of Psychiatry, supra, 901. Only a few states still do not permit the trial of a medicated defendant. Winick, supra, at 774-76. Unresolved by this statute is whether the state may administer medication to the incompetent defendant over his objection.

Section 19.2-169.2

If the court finds the defendant incompetent, it may order the defendant to undergo treatment to restore his competency under the authority of this subsection. Again, least restrictive alternative considerations should be paramount in the judge's decision regarding treatment [see references in commentary to Section 19.2-169.1 (B)]. Subsection B requires the director of the facility that is treating the defendant to notify the court as soon as the defendant is believed to be restored so that charges against the defendant can be disposed of as quickly as possible. The court need not hold a hearing to determine whether the defendant is in fact restored unless one is requested by one of the parties, pursuant to section 19.2-169.1 (E).

Section 19.2-169.3

This section's treatment of the nonrestorable incompetent defendant is consonant with **Jackson v. Indiana**, 406 U.S. 715 (1972), which forbids the detention of a defendant found incompetent "beyond a reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future." Id. at 731-39. Several commentators have suggested that a reasonable period of time in this context be defined as a maximum of six months. Group for the Advancement of Psychiatry, supra, at 907; Stone supra, at 212; Burt, R.A. and Morris, N.

If the court finds the defendant incompetent, it may order the defendant to undergo treatment to restore competency.

"A Proposal for the Abolition of the Incompetency Plea," 40 **Univ. of Chicago Law Rev.** 66, 90-2 (1972). However, the General Assembly preferred to keep the hospitalization period open-ended, provided the judge continues to find the defendant foreseeably restorable.[2]

Also in line with **Jackson**, this section indicates that the nonrestorable defendant must either be released outright or civilly confined when the court finds that the defendant is not restorable. Since Virginia's civil commitment statute does not provide for the confinement of those who are mentally retarded but not mentally ill, a group which is much more likely to be nonrestorable, this subsection also permits the judge to certify a defendant to an institution for the mentally retarded under Section 37-65.1. However, since Section 37-65.1 permits institutionalization only if the defendant or his guardian and the institution's director assent to it, the alternative provided by Section 19.2-169.3 may not always be a feasible one.

Subsection A deals with the defendant who is so mentally deficient that there is no point in trying to restore him, even over a six month period. Subsection B outlines the procedure to be followed in those cases when a longer period of time is necessary to restore the defendant to competency. Subsection C provides for the dismissal of charges against the unrestorable defendant, on the ground that a defendant who is truly incompetent should not have unproven criminal charges permanently hanging over his head. See Ohio Rev. Code Ann. Section 2845.38. Of course, once charges are dismissed, the state no longer has authority to hospitalize the defendant for purposes of restoring him to competency.

Section 19.2-169.4

This subsection rephrases in understandable language what the current Section 19.2-169 provides. See also Model Penal Code Section 4.04 (3); California Penal Code Section 1368.1. It is up to the court to decide what types of motions are susceptible to determination without the personal participation of the defendant.

Section 19.2-169.5

(A) This section sets out the requirements for an evaluation of mental state at the time of the offense, regardless of who requests the evaluation. It provides that Ph.D. clinical psychologists, as well as psychiatrists, are qualified to perform such evaluations, a position endorsed by several state courts, e.g. **Simmons v. Mullen**, 231 Pa. Super. 199, 331 A. 2d 892 (1974); **People v. Lyles**, 526 P. 2d 1332 (Colo. Sup. Ct. 1974); **Hogan v. State**, 496 S.W. 2d 594 (Tex. Crim. App. 1973), cert den. 414 U.S. 862 (1973); **State v. Robertson**, 278 A. 2d 842 (R.I. Sup. Ct. 1971), as well as most federal courts. **See, e.g., United States v. Green**, 373 F. Supp. 149 (E.D. Pa. 1974), aff'd per curiam, 505 F. 2d 731 (3d Cir. 1974);

Continued on page 15

Forensic Evaluation Law

The full text of the revised forensic evaluation law, 1982 Va. Laws ch. 653, is reprinted below. For commentary, see article beginning on page nine.

Approved April 21, 1982

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-175 and 19.2-176 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 19.2-168.1 and 19.2-169.1 through 19.2-169.7 as follows:

§ 19.2-168.1. Evaluation on motion of the Commonwealth after notice.—A. If the attorney for the defendant gives notice pursuant to § 19.2-168, and the Commonwealth thereafter seeks an evaluation of the defendant's mental state at the time of the offense, the court shall order such evaluation to be performed by one or more mental health professionals, one of whom is either a psychiatrist or a clinical psychologist with a doctorate degree. Evaluators who perform the evaluation shall report their opinion to the Commonwealth and the defense.

B. If the court finds, after hearing evidence presented by the parties, that the defendant has refused to cooperate with an evaluation requested by the Commonwealth, it may bar the defendant from presenting expert psychiatric or psychological evidence at trial on the issue of his mental state at the time of the offense.

§ 19.2-169.1. Raising question of competency to stand trial or plead; evaluation and determination of competency.—A. Raising competency issue; appointment of evaluators.—If, at any time after the attorney for the defendant has been retained or appointed and before the end of the trial, the court finds, upon hearing evidence or representations of counsel, that there is probable cause to believe that the defendant lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense, the court shall order that a competency evaluation be performed by at least one psychiatrist or clinical psychologist who is qualified by training and experience to perform such evaluations.

B. Location of evaluation.—The evaluation shall be performed on an outpatient basis at a mental health facility or in jail unless the court specifically finds that outpatient evaluation services are unavailable or unless the results of outpatient evaluation indicate that hospitalization of the defendant for evaluation on competency is necessary. If either finding is made, the court, under authority of this subsection, may order the defendant sent to a hospital designated by the Commissioner of Mental Health and Mental Retardation as appropriate for evaluations of persons under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's competency, but not to exceed thirty days from the date of admission to the hospital.

C. Provision of information to evaluators.—The court shall require the attorney for the Commonwealth to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) a copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant, and the judge ordering the evaluation; (iii) information about the alleged crime; and (iv) a summary of the reasons for the evaluation request. The court shall require the attorney for the defendant to provide any available psychiatric records and other information that is deemed relevant.

D. The compentency report.—Upon completion of the evaluation, the evaluators shall promptly submit a report in writing to the court and the attorneys of record concerning (i) the defendant's capacity to understand the proceedings against him; (ii) his ability to assist his attorney; and (iii) his need for treatment in the event he is found incompetent. No statements of the defendant relating to the time period of the alleged offense shall be included in the report.

E. The competency determination.—After receiving the report described in subsection D, the court shall promptly determine whether the defendant is competent to stand trial. A hearing on the defendant's competency is not required unless one is requested by the attorney for the Commonwealth or the attorney for the defendant, or unless the court has reasonable cause to believe the defendant will be hospitalized under § 19.2-169.2. If a hearing is held, the party alleging that the defendant is incompetent shall bear the burden of proving by a preponderance of the evidence the defendant's incompetency. The defendant shall have the right to notice of the hearing, the right to counsel at the hearing and the right to personally participate in and introduce evidence at the hearing.

The fact that the defendant claims to be unable to remember the time period surrounding the alleged offense shall not, by itself, bar a finding of competency if the defendant otherwise understands the charges against him and can assist in his defense. Nor shall the fact that the defendant is under the influence of medication bar a finding of competency if the defendant is able to understand the charges against him and assist in his defense while medicated.

§ 19.2-169.2. Disposition when defendant found incompetent.—A. Upon finding pursuant to § 19.2-169.1 E that the defendant is incompetent, the court shall order that the defendant receive treatment to restore his competency on an outpatient basis or, if the court specifically finds that the defendant requires inpatient hospital treatment, at a hospital designated by the Commissioner of Mental Health and Mental Retardation as appropriate for treatment of persons under criminal charge. Any reports submitted pursuant to § 19.2-169.1 D shall be made available to the director of the treating facility.

B. If, at any time after the defendant is ordered to undergo treatment under paragraph A of this section, the director of the treatment facility believes the defendant's competency is restored, the director shall immediately send a report to the court as prescribed in § 19.2-169.1 D. The court shall make a ruling on the defendant's competency according to the procedures specified in § 19.2-169.1 E.

§ 19.2-169.3. Disposition of the unrestorable incompetent defendant.—A. If, at any time after the defendant is ordered to undergo treatment pursuant to § 19.2-169.2 A, the director of the treating facility concludes that the defendant is likely to remain incompetent for the foreseeable future, he shall send a report to the court so stating. The report shall also indicate whether, in the director's opinion, the defendant should be released, committed pursuant to § 37.1-67.3 of the Code, or certified pursuant to § 37.1-65.1 of the Code in the event he is found to be unrestorably incompetent. Upon receipt of the report, the court shall make a competency determination according to the procedures specified in § 19.2-169.1 E. If the coqrt finds that the defendant is incompetent and is likely to remain so for the foreseeable future, it shall order that he be (i) released, (ii) committed pursuant to § 37.1-67.3, or (iii) certified pursuant to § 37-65.1. If the court finds the defendant incompetent but restorable to competency in the foreseeable future, it may order treatment continued until six months have elapsed from the date of the defendant's initial admission under § 19.2-169.2 A.

B. At the end of six months from the date of the defendant's initial admission under § 19.2-169.2 A if the defendant remains incompetent in the opinion of the director, the director shall so notify the court and make recommendations concerning disposition of the defendant as described above. The court shall hold a hearing according to the procedures specified in § 19.2-169.1 E and, if it finds the defendant unrestorably incompetent, shall order one of the dispositions described above. If the court finds the defendant incompetent but restorable to competency, it may order continued treatment under § 19.2-169.2 A for additional six-month periods, provided a hearing pursuant to § 19.2-169.1 E is held at the completion of each such period and the defendant continues to be incompetent but restorable to competency in the foreseeable future.

C. If not dismissed at an earlier time, charges against an unrestorable incompetent defendant shall be dismissed without prejudice on the date upon which his sentence would have expired had he been convicted and received the maximum

Continued

Continued from page 13

sentence for the crime charged, or on the date five years from the date of his arrest for such charges, whichever is sooner.

§ 19.2-169.4. Litigating certain issues when the defendant is incompetent.—A finding of incompetency does not preclude the adjudication, at any time before trial, of a motion objecting to the sufficiency of the indictment, not does it preclude the adjudication of similar legal objections which, in the court's opinion, may be undertaken without the personal participation of the defendant.

§ 19.2-169.5. Evaluation of sanity at the time of the offense; disclosure of evaluation results.—A. Raising issue of sanity at the time of offense; appointment of evaluators.—If, at any time after the attorney for the defendant has been retained or appointed and before trial, the court finds, upon hearing evidence or representations of counsel, that there is probable cause to believe that the defendant's actions during the time of the alleged offense may have been affected by mental disease or defect, the court shall order that an evaluation of the defendant's sanity at the time of the offense be performed by at least one psychiatrist or psychologist with a doctorate degree in clinical psychology who is qualified by training and experience to perform such evaluations.

B. Location of evaluation.—The evaluation shall be performed on an outpatient basis, at a mental health facility or in jail, unless the court specifically finds that outpatient services are unavailable, or unless the results of the outpatient evaluation indicate that hospitalization of the defendant for further evaluation of his mental state at the time of the offense is necessary. If either finding is made, the court, under authority of this subsection, may order that the defendant be sent to a hospital designated by the Commissioner as appropriate for evaluation of the defendant under criminal charge. The defendant shall be hospitalized for such time as the director of the hospital deems necessary to perform an adequate evaluation of the defendant's mental state at the time of the offense, but not to exceed thirty days from the date of admission to the hospital.

C. Provision of information to evaluators.—The court shall require the party making the motion for the evaluation, and such other parties as the court deems appropriate, to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) copy of the warrant or indictment, (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant and the judge ordering the evaluation, (iii) information pertaining to the alleged crime, including statements by the defendant made to the police and transcripts of preliminary hearings, if any, (iv) a summary of the reasons for the evaluation request, and (v) any available psychiatric, psychological, medical or social records that are deemed relevant.

D. The report.—The evaluators shall prepare a full report concerning the defendant's mental state at the time of the offense, including whether he may have had a significant mental disease or defect which rendered him insane at the time of the offense. The evaluators shall also prepare a summary of their conclusions which shall not include any statements by the defendant about the time period of the alleged offense. The full report and the summary shall be prepared within the time period designated by the court, said period to include the time necessary to obtain and evaluate the information specified in subsection C.

E. Disclosure of evaluation results.—The summary of the evaluators' conclusions described in subsection D shall be sent to the attorney for the Commonwealth and the court. The full report described in subsection D shall be sent solely to the attorney for the defendant and shall be deemed to be protected by the lawyer-client privilege; however, the Commonwealth shall be given the report and the results of any other evaluation of the defendant's mental state at the time of the offense after the attorney for the defendant gives notice of an intent to present psychiatric or psychological evidence pursuant to § 19.2-168 of the Code.

§ 19.2-169.6. Emergency treatment prior to trial.—A. Any defendant who is not subject to the provisions of § 19.2-169.2 may be hospitalized for psychiatric treatment prior to trial if the circuit or general district court judge with jurisdiction over the defendant's case, or a judge designated by such judge, finds clear and convincing evidence that the defendant: (i) is being properly detained in jail prior to trial; (ii) is mentally ill and imminently dangerous to self or others in the opinion of a qualified mental health professional; and (iii) requires treatment in a hospital rather than the jail in the opinion of a qualified mental health professional. The attorney for the defendant shall be notified that the court is considering hospitalizing the defendant for psychiatric treatment and shall have the opportunity to challenge the findings of the qualified mental health professional. If the court decides to hospitalize the defendant, it shall also indicate in its order whether the admitting hospital should evaluate the defendant's competency to stand trial and his mental state at the time of the offense pursuant to §§ 19.2-169.1 and 19.2-169.5.

B. A defendant subject to this section shall be treated at a hospital designated by the Commissioner as appropriate for treatment and evaluation of persons under criminal charge. The director of the hospital, within thirty days of the defendant's admission, shall send a report to the court with jurisdiction over the defendant addressing the defendant's continued need for treatment as mentally ill and imminently dangerous to self or others and, if so ordered by the court, the defendant's competency to stand trial, pursuant to § 19.2-169.1 D, and his mental state at the time of the offense, pursuant to § 19.2-169.5 D. Based on this report, the court shall either (i) find the defendant incompetent to stand trial pursuant to § 19.2-169.1 E and proceed accordingly, (ii) order that the defendant be discharged from custody pending trial, (iii) order that the defendant be returned to jail pending trial, or (iv) make other appropriate disposition, including dismissal of charges and release of the defendant.

C. A defendant may not be hospitalized longer than thirty days under this section unless the court which has criminal jurisdiction over him, or a court designated by such court, holds a hearing at which the defendant shall be represented by an attorney and finds clear and convincing evidence that the defendant continues to be (i) mentally ill, (ii) imminently dangerous to self or others, and (iii) in need of psychiatric treatment in a hospital. Hospitalization may be extended in this manner for periods of sixty days, but in no event may such hospitalization be continued beyond trial, nor shall such hospitalization act to delay trial, so long as the defendant remains competent to stand trial.

§ 19.2-169.7. Disclosure by defendant during evaluation or treatment; use at guilt phase of trial.—No statement or disclosure by the defendant concerning the alleged offense made during a competency evaluation ordered pursuant to § 19.2-169.1, a mental state at the time of the offense evaluation ordered pursuant to § 19.2-169.5, or treatment ordered pursuant to § 19.2-169.2 or § 19.2-169.6 may be used against the defendant at trial as evidence or as a basis for such evidence, except on the issue of his mental condition at the time of the offense after he raises the issue pursuant to § 19.2-168.

§ 19.2-175. Expenses of physicians, etc.—Each expert or physician or clinical psychologist skilled in the diagnosis of insanity or mental retardation or other physician appointed by the court to render professional service pursuant to §§ 19.2-168.1, 19.2-169.1, 19.2-169.5 or paragraphs (1) and (2) of § 19.2-181, who is not regularly employed by the Commonwealth of Virginia except by the University of Virginia School of Medicine and the Medical College of Virginia, shall receive a reasonable fee for each such examination and report thereof to the court. The fee shall be determined in each instance by the court which made the appointment in accordance with the relevant regulations promulgated by the Department of Mental Health and Mental Retardation. In no event shall a fee exceed $200, but in addition if any such expert be required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of fifty dollars for each day during which he is required so to serve. Itemized account of expense, duly sworn to, must be presented to the court, and when allowed shall be certified to the Supreme Court for payment out of the state treasury, and be charged against the appropriation made to pay criminal charges. Allowance for the fee and for the per diem authorized shall also be made by order of the court, duly certified to the Supreme Court for payment out of the appropriation to pay criminal charges.

§ 19.2-176. Determination of insanity after conviction but before sentence.—If, after conviction and before sentence of any person, the judge presiding at the trial shall find reasonable ground to question such person's mental state, he may order an evaluation of such person's mental state by at least one psychiatrist or clinical psychologist who is qualified by training and experience to perform such evaluations. If the judge, based on the evaluation, and after hearing representations of the defendant's counsel, finds clear and convincing evidence that the defendant (i) is mentally ill, and (ii) requires treatment in a mental hospital rather than the jail, he may order the defendant hospitalized in a facility designated by the Commissioner as appropriate for treatment of persons convicted of crime. The time such person is confined to such hospital shall be deducted from any term for which he may be sentenced to any penal institution, reformatory or elsewhere.

2. That §§ 19.2-169, 19.2-170, 19.2-171, 19.2-172, 19.2-173, 19.2-174 and 19.2-182.1 of the Code of Virginia are repealed. □

Continued from page 12
Jenkins v. United States, 113 U.S. App. D.C. 300, 307 F. 2d 637 (D.C. Cir. 1962). In **Rollins v. Commonwealth**, 207 Va. 575, 151 S.E. 2d 622 (1966), the Virginia Supreme Court held that a master's level clinical psychologist who had completed all the requirements for a Ph.D. and who had practiced forensics for eight years was qualified to express his opinion as to the defendant's mental condition. To date, however, case law has not supported the expert qualification of a master's level psychologist who does not have such educational or experiential attainments; under the statute, such an individual would only be qualified to perform competency evaluations, although he could certainly assist in any type of evaluation.

(B) For reasons discussed in the commentary to Section 19.2-169.1, this section also calls for outpatient evaluations whenever possible. While a mental state at the time of the offense evaluation is more complicated than a competency assessment, it too can be conducted in a short period of time when adequate information is provided. See Sadoff, supra. Again, if the inpatient evaluation is necessary, it is limited to thirty days.

(C) The informational requirements listed in this subsection are similar to those described in the competency statute, with the addition of a provision requiring the production of various records which are relevant to a mental state at the time of the offense evaluation. **See** Sadoff, supra; Pollack, supra. The primary responsibility for providing this information is placed on the referring party, although the court may require other sources, including the opposing party, municipal and state agencies, and out of state facilities to provide relevant data as well.

(D) Based on Virginia law, **see** e.g., **Dejarnette v. Comm.**, 75 Va. 867 (1881); **Thompson v. Comm.**, 193 Va. 704, 70 S.E. 2d 284 (1952); **Snider v. Smith**, 187 F. Supp. 299 (E.D. Va. 1960), an evaluation of the defendant's "sanity"[3] at the time of the offense should address whether (1) the defendant was suffering from a **significant** mental disease or defect at the time of the offense (2) that affected his actions at the time of the offense so as to (3)

No rights of the defendant are jeopardized by sending the prosecution a summary of the psychological evaluation which does not contain self-incriminating information.

cause significant cognitive or volitional impairment. The evaluators' opinions on these issues should be included in the summary report, which usually will be only one or two paragraphs long. Data supporting these opinions, including offense-related information from the defendant, should be confined to the full report. The reasoning behind this procedure is explained below in the commentary to subsection (E).

(E) The defendant has a sixth amendment right to explore the possibility of a psychological defense. **Wood v. Zahradnick**, 578 F. 2d 980 (4th Cir. 1978). He should also have a right, under the fifth and sixth amendments, to investigate that possibility without fear that what he says will go to the prosecution if he does not raise a defense; otherwise he might decide not to seek an evaluation for fear of revealing incriminating material which could form the basis for investigative leads, even if it cannot be used directly on the issue of guilt. See Berry, supra. Recognizing these principles, several states extend the attorney-client privilege to the results of an exploratory evaluation until such time as the defendant raises a defense. **See**, e.g. Florida Rules of Criminal Procedure 3.216(a). However, no rights of the defendant are jeopardized by sending the prosecution a **summary** of the evaluation which does not contain self-incriminating information. Nor are the defendant's rights violated by allowing the prosecution access to the **full** report once a defense has been raised. **C.f. Estelle v. Smith**, 451 U.S. 454 (1981). **See also**, Section 19.2-168.1 allowing the prosecution to obtain its own evaluation once notice of a defense is given.

Section 19.2-169.6

(A) Frequently, defendants who have been confined need emergency hospital treatment. Such treatment may be necessary regardless of whether the defendant is competent or incompetent to stand trial. Under the previous statute, judges had no statutory authority to hospitalize such defendants and thus often hospitalized defendants summarily with no due process. This subsection provides such authority as well as the necessary procedural protections.

First, given the emergency nature of the proceeding, the judge with criminal jurisdiction over the defendant may authorize another judge (e.g., a special justice) to conduct the hospitalization hearing. Second, the presiding judge must find that the defendant is **properly** detained (i.e., ineligible for bond or release on personal recognizance) before he can consider hospitalizing the defendant. Otherwise, the appropriate procedure for hospitalizing the defendant should be civil commitment under Section 37.1-67.1 et seq. Third, the judge must obtain an evaluation by a qualified mental health professional on the second and third issues set out in the statute. The professional need not be a psychiatrist since dangerousness and **need** for hospital treatment (as opposed to the **administration** of it) are issues which other mental health professionals can address. Fourth, the judge must find all three criteria present by clear and convincing evidence. **Addington v. Texas** 441 U.S. 418 (1979). Fifth, the court must notify the defense attorney about the professional's findings and allow him to challenge them. All of these procedures are designed to balance the defendant's right to avoid unnecessary hospitalization, see **Vitek v. Jones**, 100 S. Ct. 1254 (1980); **Jackson v. Indiana**, 406 U.S. 715 (1972), with society's need to treat the mentally ill defendant under secure conditions. The Task Force rejected the idea of utilizing the civil commitment statute in this situation because its "voluntary" option and its use of least restrictive alternative language made it inappropriate for the defendant who has been denied bond.

Continued

Continued from page 15

Finally, as provided in this subsection, the court should indicate to the admitting hospital whether evaluation, as well as treatment, is necessary, and on what issues.

(B) If a defendant is admitted under subsection (A), he can be hospitalized for up to thirty days, at which time the **committing** court must decide which of the four indicated dispositions of the defendant's case is appropriate.

(C) Further sixty day hospitalizations may occur only if the procedures in this subsection are followed. Such a proceeding may be held at the hospital if the original court authorizes it. However, the statute makes clear that hospitalization under this subsection is not to be used as a method of delaying trial of the competent defendant

Section 19.2-169.7

This provision incorporates the holding of the Fourth Circuit in **Gibson v. Zahradnick**, 581 F.2d 75 (1978), a holding followed by several other courts and the Model Penal Code. Model Penal Code Section 4.09 (Proposed Official Draft, 1962); Colo. Rev. Stat. Section 16-8-107 (1973); Ill. Ann. Stat., ch. 38, Section 115-b (Smith-Hurd 1973); Mass. Gen. Laws Ann., ch. 233, Section 23B (West Supp. 1979). It goes beyond Gibson, however, in providing that the only issue upon which the defendant's evaluation statements can be used as evidence is mental state at the time of the offense, after that issue has been properly raised by the defendant himself. Thus, such information cannot be used to impeach the defendant on other issues, nor can it be used as an investigative tool by the state. Again, this provision is necessary to protect the defendant's fifth and sixth amendment rights, insure open communication between the evaluator and the defendant, and relieve the professional of ethical qualms concerning the use of the evaluation results.

Section 19.2-175

The amendment to this section requires the court to abide by regulations promulgated by the Department of Mental Health and Mental Retardation fixing compensation, on a flat fee basis, for psychological evaluations. One such regulation, which will go into effect shortly, is found in footnote 4.

Section 19.2-176

The redrafting of this section was necessary in light of its reference to the old Section 19.2-169. It deals with the rare circumstance in which a convicted defendant needs emergency treatment prior to being sentenced. ☐

Forensic Training

Under a contract with the Department of Mental Health and Mental Retardation, the Forensic Evaluation Training and Research Center is offering training designed to acquaint mental health professionals with the Virginia criminal justice system and the types of evaluations requested by the criminal courts. Successful completion of the training and a nationally validated forensic examination are necessary in order to obtain a certificate from the Center indicating that the professional has passed the course.

The Training

The training lasts seven days. The first six days of training take place at the Center's facilities in Charlottesville, Virginia. The final day takes place at Central State Hospital in Petersburg. The following topics are covered: (1) Competency to Stand Trial, (2) Competency to Plead, (3) Mental State at the Time of the Offense Doctrines, (4) Juvenile Delinquency Jurisdiction, (5) Sentencing, (6) Report Writing, and (7) Expert Testimony. In addition, trainees participate in at least two supervised evaluations.

Prerequisites and Fees

Under direction from the Department, the Center's primary function is to train professionals affiliated with Community Mental Health Centers. Each Center is asked to send to the training at least two professionals, at least one of whom is a psychiatrist or Ph.D. clinical psychologist (given the courts' expert witness requirements). Professionals from the CHMC must pay for their travel expenses and a minimal fee to cover costs of the training materials.Private clinicians (i.e., those not affiliated with a CMHC) can participate in the training for a tuition fee.

Contact

The next training programs will take place on the following days:

Program VIII: July 19, 20, 21; 26, 27, 28
Program IX: Sept. 13, 14, 15; 20, 21, 22
Program X: Nov. 8, 9, 10; 15, 16, 17.

Contact Christopher Slobogin or Larry Fitch at (804) 924-5435, Forensic Evaluation Training and Research Center, Box 100-Blue Ridge Hospital, Charlottesville, Virginia 22901, for more information. ☐

NOTES

1. The original draft to the statute would have permitted master's level clinical social workers to perform competency evaluations as well, but the General Assembly preferred to restrict such evaluations to psychiatrists and psychologists.

2. The original draft provided that the state could confine an incompetent individual for six months, with a six month extension, at which time it would have to release him or hospitalize him under the civil commitment or certification provisions.

3. The original draft used the term "mental state" instead of "sanity" on the theory that the mental health professional's evaluation should encompass a complete investigation of the defendant's psychological functioning at the time of the offense. The General Assembly preferred the word "sanity," apparently as a means of emphasizing that under current Virginia law the primary legal issue to be resolved by such evaluations is whether the defendant was insane at the time of the offense.

4. The following is a portion of a regulation recently promulgated by the Department, the Supreme Court, and the Attorney General's office.

Reimbursement for Evaluation of Indigent Defendants

Section 19.2-175 of the Virginia Code authorizes payment of up to $200 per psychological evaluation and report, "in accordance with the relevant regulations promulgated by the Department of Mental Health and Mental Retardation." This memorandum establishes the fee schedule for psychological evaluations of indigent criminal defendants that are performed by CMHCs.

Upon submission of a written evaluation report on an indigent defendant to the court or to the initiating party, the CMHC shall be entitled to reimbursement according to the following schedule:

Evaluation	Fee
Competency Evaluation	$100
Competency Evaluation Plus Preliminary or "Screening" Evaluation of Mental State at the Time of the Offense	$150
Comprehensive Evaluation of Mental State at the Time of the Offense	$200
Pre-Sentence Evaluation:	
a. Only	$200
b. If Competency or Mental State at the Time of the Offense Evaluation Already Performed	$100

Reimbursement of evaluators not affiliated with a CMHC shall be governed by the provisions of Section 19.2-175 and the court's customary fee schedule. ☐

Continued from page 11

State and Local Reimbursement Rules Revamped

How much should the family of a mentally ill or mentally retarded recipient of state or local services be required to contribute to the high cost of providing those services? What family members should be responsible? Should the reimbursement practices of local providers follow the example of state hospitals?

The 1982 General Assembly sought to answer such questions by passing 1982 Va. Laws ch. 50, and in doing so they raised some new issues.

As amended, Sections 37.1-105 and 37.1-110, seem to require the following.

1) The patient is fully liable for the cost of his treatment in a state facility. Other previously enacted statutes, such as Sections 37.1-112 and 37.1-116, continue to give the state and the courts discretion to waive enforcement of this liability to avoid a hardship. Another statute, Section 37.1-117 limits the liability of the estate of a deceased patient to the cost of five years of state care or training.

2) The guardian or trustee of a patient with an income or estate is also fully liable for the cost of the patient's treatment. The fiduciary is directed by the new amendment to Section 37.1-105 to "apply such income and estate towards the expenses of the patient's care and treatment or training." This language might override the discretion given to a trustee in a "spendthrift" trust, i.e., a trust designed to allow a parent to leave to a mentally disabled child wealth which would not be subject to reimbursement claims and would not disqualify the child from welfare benefits. To the extent that this new law renders doubtful the effectiveness of such trusts, parents will be more inclined to disinherit their mentally disabled children.

3) Certain family members generally responsible for the patient's support under Section 20-61 (the state non-support law) are liable for the cost of the patient's treatment, but their liability can be limited to a total of 1,826 days of state and community treatment, if a payment or agreement to pay (not, apparently, necessarily by the family member) for 1,826 days of treatment had been made. The family members subject to Section 20-61 and thus entitled to this limitation on their liability are the spouse and the parents, unless the patient is a child receiving state or federal disability benefits.

4) Adult children continue to be liable for the cost of their parents' treatment at a state facility under Section 37.1-110. But since adult children have no support obligations under Section 20-61, they are not entitled to the 1,826 day limitation allowed by Section 37.1-105. However, a 1982 amendment to Section 20-88, which governs an adult child's liability for the support of a parent, achieves the same result by limiting the child's liability to the cost of sixty months of institutionalization, which presumably includes Medicaid-funded nursing home care. See also 1982 Va. Laws ch. 501, amending Section 32.1-74 to provide for a new program requiring reasonable contributions by adult children to the cost of providing Medicaid to their parents. The new amendments do not make the adult child of a community services board client liable for the expense of treatment not reimbursed by Medicaid, although in some circumstances such liability might be found under Section 20-88.

Some technical revisions of these new amendments are clearly in order. Reimbursement practice should be the same for both state and local services. Adult children should be allowed the same limitation on liability as given other responsible parties. Reasonably specific guidelines should be provided for allowing both the state and the community service board to forego collection of a patient debt in hardship cases.

The mandatory payment of treatment costs by a guardian or trustee raises more fundamental issues. Such a policy is unlikely to result in greater reimbursement to the state or community services boards. Rarely will a parent be able to place enough assets in the hands of a fiduciary so that something will remain to benefit a mentally disabled child after reimbursement and other support claims are satisfied. As a consequence, parents will write wills specificially disinheriting their mentally disabled child and will remove both the chance of increased reimbursement to the state and the provision to their child of those amenities not provided for indigent patients.

Some consideration needs to be given to legislation which would permit parents to bequeath to a disabled child small sums which would not be subject to reimbursement claims and would not disqualify the child from welfare.

Long-Term Care Ombudsman To Investigate Community Services

Two years after the Virginia legislature gave the Office on Aging's Long-Term Care Ombudsman the right to inspect the records of homes for adults, nursing homes, and state hospitals, a law has been enacted requiring the Office on Aging to

> **investigate complaints regarding community services which are designed to provide long-term care to the elderly and are rendered by the Department of Health, the Department of Social Services, the Department of Mental Health and Mental Retardation, the area agencies on aging or any private nonprofit or proprietary agency.**

1982 Va. Laws ch. 346, enacting Section 2.1-373.3.

But the new law gives the Office on Aging no new authority to investigate these complaints through examination of records or other means. Existing laws provide access to the records of homes for adults and nursing homes. Section 2.1-373.1. Other statutes such as the Virginia Privacy Protection Act of 1976 (Section 2.1-377 et seq.) and the Virginia Freedom of Information Act (Section 2.1-340 et seq.) may be helpful to the Ombudsman in obtaining access to public sector long-term

Continued on page 19

Commissioner's Committee On Forensic Services System

In early January 1982, Dr. Joseph J. Bevilacqua, Commissioner of the Department of Mental Health and Mental Retardation, established the Committee on Mental Health and Mental Retardation Forensic Services System to (a) review the Department's current forensic system, (b) examine specific issues of concern and (c) provide recommendations for solving existing problems and projecting future forensic activities. The Committee developed the following recommendations in order to assure the existence of a high-quality statewide system of mental health/mental retardation forensic services.

Evaluation of Forensic Patients

1. By March 1984, implement a graduated three-tiered statewide system for conducting **outpatient** forensic evaluations using community-based resources (Level I), regional civil hospitals (Level II), and the Central State Hospital Forensic Unit (Level III).
2. By March 1984, implement a graduated statewide system for conducting **inpatient** forensic evaluations using regional civil hospitals, at least one designated medium security forensic unit, and Central State Hospital Forensic Unit.
3. Plan and implement multidisciplinary training strategies to establish and promote the three-tiered evaluation system.
4. Implement an interim training and operations plan pending the establishment of the three-tiered evaluation system.
5. Develop a comprehensive forensic services fiscal plan to improve accountability and promote cost reimbursement.

The Forensic Treatment System

6. Develop a graduated four-tiered system for providing forensic treatment services incorporating community-based outpatient resources (Level I), regional civil hospitals (Level II), at least one medium security forensic unit (Level III), and the Central State Hospital Forensic Unit (Level IV).
7. Take necessary steps to establish a medium security forensic area at Western State Hospital and assess the need for similar units at other facilities.
8. Assure the existence of appropriate patient placement criteria, procedures for interfacility patient transfer, and staff training programs in forensic patient management.
9. Treat NGRI's in regional hospitals near their home community whenever possible. Periodically review the clinical and legal status of all NGRI's.
10. Provide additional instruction to facility-based forensic patient advocates.
11. Direct Community Services Boards to develop a plan for assuring the availability and utilization of local psychiatric services for mentally ill persons in police custody.

Assuring Adequate Forensic Treatment

12. Establish a study team to assess comprehensively Central State Hospital and Western State Hospital forensic area needs in order to assure the provision of adequate forensic treatment services.
13. Promote the use of Code sections 19.2-169.2 or -169.6 to assure the authority to treat forensic patients.
14. Apply Departmental hospitalization and treatment regulations, including those governing the use of seclusion and restraint, uniformly to forensic and civil patients.

Administrative Responsibility

15. Establish a high-placed, adequately supported Central Office position with singular responsibility for directing the statewide forensic services system.
16. Assign responsibility for statewide **policy-making** and **technical assistance** to the designated Central Office forensic component.

Forensic Information System

17. Develop and implement state facility and community-based Management Information Systems (MIS) that address forensic services data needs.
18. Encourage the development of a court-based MIS.
19. Identify and fund an organization to (a) provide technical assistance and coordination to groups involved in forensic MIS development and (b) implement an interim MIS.

Personnel Management

20. Seek legislation to permit master's level social workers and psychologists with specialized forensic training to provide court testimony on evaluation findings.
21. Promote the incorporation of forensic education and training experiences into the core curricula of mental health professional and legal education programs.
22. Support specialized postgraduate forensic training for mental health professionals, lawyers, and judges.
23. Consider establishing a program of forensic fellowships, sabbaticals, and research grants.
24. Implement a meaningful system for recognizing and rewarding meritorious forensic employee service. ☐

Developments in Mental Health Law

is distributed as a public service by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health and Mental Retardation. The opinions expressed do not necessarily reflect the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge on a quarterly basis. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100 - Blue Ridge Hospital, Charlottesville, Virginia 22901. We also welcome your suggestions and comments.

Editor
Willis J. Spaulding
Managing Editor
Elaine M. Hadden
Assistant Managing Editor
Pamela M. Benner
Law Student Contributors
Henry E. Howell, III
Vicki Epling

Continued from page 17
care providers, as long as the patient or guardian is willing and able to consent to the Ombudsman's access. Other statutes, such as Section 8.01-413 (discussed elsewhere in this issue), will provide access to health care providers in both the public and private sector, but only with the cooperation of the patient or, if he is incapacitated, his guardian or next-of-kin.

In general, however, the new law fails to give the Ombudsman the authority required to discharge his new oversight obligations. More importantly, the Ombudsman has been given no authority to resolve even those complaints he is capable of investigating. The Ombudsman, except for threatening bad publicity, can provide no incentive to a long-term care provider to cooperate with an investigation or respond to patient complaints.

Even if the Ombudsman had investigatory and enforcement authority, no guidelines are provided by this new law to assist the Ombudsman in determining the merits of a patient complaint. Thus, it is difficult to determine what exactly the Ombudsman's investigation would consist of and what kind of impact it could have on the quality of long-term care in the community, even with the cooperation of the provider and patient.

Virginia Laws Affecting Medicaid

With one exception, the aims of the 1982 legislation directed at the state medical assistance program, funded in part by Title XIX (Medicaid) of the Social Security Act, are to assure that benefits are received only by the "truly needy" and to reduce fraud by providers.

• The legislative action with the greatest potential significance is the move to require "reasonable contributions" to the cost of providing medical assistance to a patient by his adult children. The state's Medicaid plan in the future will provide for such a program of "family assistance." 1982 Va. Laws ch. 501, enacting paragraph D of Section 32.1-74. The statute governing the obligation of children to support their parents was also amended this year to require adult children to pay the costs of their parents medical assistance in accordance with the Medicaid plan or face criminal prosecution. 1982 Va. Laws ch. 472, amending Section 20-88. This amendment, as discussed elsewhere in this issue, limits the child's liability for the cost of institutional care to the cost of no more than sixty months of such care.

• Amendments were made to Section 20-88.01 which will make it easier for the state to obtain reimbursement for Medicaid and other benefits provided to persons who have recently transferred property to their children or others for less than fair market value. Such transfers might be made, for example, to qualify the property owner for Medicaid supported long-term care in a nursing home. The new amendments raise a rebuttal presumption that the transferee of the property, often a relative, intended to assist the transferor in qualifying for Medicaid or some other benefit requiring indigence. The transferee may then be liable to the state for the difference between the cost of the property to him and its fair market value, if that difference exceeds $8,000. 1982 Va. Laws ch. 592.

• The state is permitted to seek reimbursement for Medicaid costs from the estate of a deceased patient under a new statute, Section 32.1-75.1, enacted by 1982 Va. Laws ch. 215. This new law permits the state to waive its claim where collection would create a hardship on the heirs or dependents of the deceased.

• A new statute, Section 32.1-76.1, enacted by 1982 Va. Laws ch. 322, gives the state a lien on a nursing home operator's property to the extent that he has been reimbursed for the depreciation of that property by Medicaid.

• In 1981, the General Assembly, in passing Sections 32.1-310 et seq., gave the Office of the Attorney General a broad mandate to investigate and prosecute Medicaid fraud. This year the state legislature strengthened that mandate by calling for the creation of a special unit within the Office of the Attorney General to investigate and audit Medicaid reimbursed health care providers. Under the 1982 amendments, the role of the state Department of Health is confined to cooperating with and providing information to the Attorney General in these investigations. 1982 Va. Laws ch. 41.

• Finally, the state is now required to reimburse licensed clinical psychologists for services provided for in the state Medicaid plan if the psychologist is licensed to perform those services. 1982 Va. Laws ch. 517, amending Section 32.1-74.

Patient Access To Records Improved

In an amendment to Section 8.01-413 likely to make health care providers comply more readily with patient requests for records, the 1982 General Assembly authorized courts to award damages, including attorney fees, to patients forced to seek court assistance in obtaining their records. The patient may obtain damages where, after the patient's or his attorney's written request, the health care provider denies access "by willfully or arbitrarily refusing or by imposing a charge so high or to be clearly in excess of the reasonable expense of making the copies and processing the request for records." 1982 Va. Laws ch. 378.

Drunk Driving Penalties Stiffened

Following a national trend, the Virginia legislature this year increased the penalties for driving while intoxicated. 1982 Va. Law ch. 301, amending Sections 18.2-270 et seq.

The amended laws increase the maximum punishment and periods of license suspension a judge may order for first and subsequent offenses; at the same time, they decrease the authority of the sentencing judge to suspend a sentence or confinement in jail or loss of driving privileges.

The conditions and effects of participation in an Alcohol Safety Action Program (ASAP) are also changed.

Continued

Continued from page 19
Previously, participation in ASAP resulted in a continuance of the hearing on drunk driving charges and ultimately those charges could be dismissed or the defendant could be convicted of the lesser charge of "careless driving." Under the amended laws, the defendant must be convicted of drunk driving before admission to an ASAP program. The legal benefit an offender can now expect from successful participation in an ASAP program is only the possibility of a restricted license in lieu of total loss of driving privileges.

The 1982 amendments also limit ASAP participation to persons convicted of a first or second offense; offenders convicted for a third time are no longer eligible.

Finally, the statutory fee for ASAP participation has been raised from $200 to $250.

Detoxification Grants Authorized

Under a new law, cities and counties may apply for state grants to assist in the creation and operation of detoxification centers. See 1982 Va. Law ch. 666, enacting Section 9-173.1 and 9-173.2. Law enforcement officers can take persons charged with violating Virginia's public drunkenness law, Section 18.2-388, to such a center in lieu of arrest. However, no one may be involuntarily detained at a detoxification center.

The grant program will be implemented by state Department of Criminal Justice Services regulations to be promulgated no later than October 1, 1982.

Advocates In Special Ed. Hearings Need Not Be Lawyers

1982 Va. Laws ch. 21 amends Section 22.1-214 to permit both the parents of handicapped children and the school to be represented by non-lawyers in administrative hearings arising from disputes over placement, programming, tuition, and other matters. Previously, an advocate who might have expertise in special education but lacked a lawyer's license risked prosecution for the unauthorized practice of law if the advocate represented parents in a special education hearing.

Right To Die Subcommittee Created

House Joint Resolution No. 115, adopted by the 1982 General Assembly, calls for the creation of a thirteen member joint subcommittee "to study the rights of the terminally ill, the family and the medical profession in cases involving decisions on life and death of the patient."

Previous attempts to enact "right to die" legislation in Virginia (e.g., H.B. No. 872 in 1980) have failed. The new joint subcommittee is charged with completing its study in time for the 1983 Session of the General Assembly.

Critical issues of competency often are raised in such legislation. These include who may decide if a patient is competent to choose to die and who may appoint a substitute decision-maker for a patient who is determined not to be competent.

Members of Psychology Board Must Be Licensed

Section 54-937 of the Virginia Code has been amended to require all members of the state Board of Psychology to be licensed psychologists. The members, who serve for five years, include three licensed psychologists who teach psychology at a college or university in Virginia, one licensed clinical psychologist, and one licensed school psychologist. Previously the members of the Board could have been unlicensed as long as they were "qualified to be licensed." 1982 Va. Laws ch. 165. ☐

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
Charlottesville, VA. 22901

Non-Profit Organization
U.S. Postage Paid
Permit No. 160
Charlottesville, Virginia
22901

A Quarterly Publication of the Institute of Law, Psychiatry & Public Policy at the University of Virginia

Developments in

Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 2 No. 3 July-Sept. 1982

The Insanity Defense: Proposals For Reform

by Richard J. Bonnie*

Two fundamentally distinct questions are intertwined in discussions of the insanity defense. One is essentially dispositional and looks forward in time: what should be done with mentally disordered offenders, including those who are acquitted by reason of insanity, to minimize the risk of future recidivism? The other concerns the moral issue of responsibility, a question looking backward to the offender's mental condition at the time of the offense. Among the most fundamental principles of criminal law are that criminal punishment should be imposed only on those who are blameworthy and that even blameworthy offenders should not be subjected to punishment which is disproportionate to the degree of their culpability.

I want to address most of my prepared remarks to the question of responsibility. I will argue, in summary, that you should reject the sweeping proposals to abolish the insanity defense in favor of proposals to narrow it and shift the burden of proof to the defendant. The core of the defense must be retained, in my opinion, because some defendants afflicted by severe mental disorder who are out of touch with reality and are unable to appreciate the wrongfulness of their acts cannot justly be blamed and do not therefore deserve to be punished. The insanity defense, in short, is essential to the moral integrity of the criminal law.

Before presenting my views on the question of responsibility in greater depth, I would like to make several observations about the dispositional issues which have been raised during the Committee's previous hearings.

First, it is clear to us all that present dissatisfaction with the insanity defense is largely rooted in public concern about the premature release of dangerous persons acquitted by reason of insanity. However, increased danger to the public is not a necessary consequence of the insanity defense. The public can be better protected than is now the case in many states by a properly designed dispositional statute which assures that violent offenders acquitted by reason of insanity are committed to secure hospitals for long term treatment, including a period of post-discharge supervision or "hospital parole." I hope Congress will lead the way by enacting such a statute.

Second, proponents of many recent reforms, including the "guilty but mentally ill" concept, claim that their goal is to facilitate treatment of mentally disordered offenders. This is a worthy objective and calls attention to the fact that our jails and penitentiaries now hold many mentally ill prisoners who are not adequately treated. However, the real issue here is not a legal one but a fiscal one. It also has little to do with the insanity defense, since most of the prisoners who need psychiatric treatment are those who become mentally ill while they are serving custodial sentences.

In any case, a separate verdict of "guilty but mentally ill," which has now been enacted in seven states, is an ill-conceived way of identifying prisoners

Continued

*Professor of Law, University of Virginia; Director, University of Virginia Institute of Law, Psychiatry and Public Policy; B.A. Johns Hopkins University; LL.B., University of Virginia. This article is drawn from the author's statement delivered August 2, 1982, to the Committee on the Judiciary of the United States Senate concerning the insanity defense and proposed bills S. 2572, S. 1558, S. 818, S. 1106, S. 2658, S. 2669, S. 2672, and S. 2678.

Also In This Issue. . .

23/Seven Recent Virginia Supreme Court Decisions Analyzed

25/The United States Supreme Court Rules in Youngberg v. Romeo

32/Sixth Annual Symposium on Mental Health & the Law Scheduled for December 9 & 10

Continued from page 21

who are amenable to psychiatric treatment. It surely makes no sense for commitment procedures to be triggered by a jury verdict based on evidence concerning the defendant's past mental condition rather than his present mental condition. Moreover, decisions concerning the proper placement of incarcerated offenders should be made by correctional and mental health authorities, not by juries or trial judges.

Third, it is often said that the participation of mental health professionals in criminal proceedings should be confined to the sentencing stage. I agree that clinical expertise is likely to be most useful on dispositional questions rather than on responsibility questions. Indeed, I hope the Committee recognizes that most clinical participation in the criminal process now occurs at the sentencing stage. However, I hope the Committee also recognizes that expert witnesses cannot be excluded from the guilt stage so long as the defendant's mental condition is regarded as morally relevant to his criminal liability. Even under the abolitionist proposals, expert testimony would be admissible on mens rea. My only disagreement, then, with the abolitionist view is a moral disagreement—I believe that a person's claim of inability to appreciate the wrongfulness of his conduct is morally relevant to his criminal responsibility. Let me now turn to this narrow, but critical, dispute.

The Options

You have basically three options before you.

1. The Existing (Model Penal Code) Law. One option is to leave the law as it now stands, by judicial ruling, in all of the federal courts (and, parenthetically, as it now stands in a majority of the states). Apart from technical variations, this means the test proposed by the American Law Institute in its Model Penal Code. Under this approach, a person whose perceptual capacities were sufficiently intact that he had the criminal "intent" required in the definition of the offense can nonetheless be found "not guilty by reason of insanity" if, by virtue of mental disease or defect, he lacked substantial capacity either to understand or appreciate the legal or moral significance of his actions or to conform his conduct to the requirements of law. In other words, a person may be excused if his thinking was severely disordered—this is the so-called cognitive prong of the defense—or if his ability to control his behavior was severely impaired—this is the so-called volitional prong of the defense.

2. Revival of **M'Naghten**. The second option is to retain the insanity defense as an independent exculpatory doctrine—independent, that is, of mens rea—but to restrict its scope by eliminating the volitional prong.[1] This is the approach that I favor, for reasons I will outline below. Basically, this option is to restore the **M'Naghten** test—although I do not think you should be bound by the language used by the House of Lords in 1843—as the sole basis for exculpation or ground of insanity. Although this is now distinctly the minority positon in this country—it is used in less than one third of the states—it is still the law in England.

. . .a separate verdict of "guilty but mentally ill". . .is an ill-conceived way of identifying prisoners who are amenable to psychiatric treatment.

3. Abolition: The Mens Rea Approach. The third option is the one I have characterized as abolition of the defense. Technically, this characterization is accurate because the essential substantive effect of the so-called "mens rea" approach (or "elements" approach) would be to eliminate any criterion of exculpation, based on mental disease, which is independent of the elements of particular crimes. To put it another way, the bills taking this approach[2] would eliminate any separate exculpatory doctrine based on proof of mental disease; instead mentally ill (or retarded) defendants would be treated just like everyone else. A normal person cannot escape liability by proving that he did not know or appreciate the fact that his conduct was wrong, and—under the mens rea approach—neither could a psychotic person.[3]

The Case Against the Mens Rea Approach

Most of the bills now before you would adopt the mens rea option, the approach recently enacted in Montana and Idaho. As I have already noted, this change, abolishing the insanity defense, would constitute an abrupt and unfortunate departure from the Anglo-American legal tradition.

If the insanity defense were abolished, the law would not take adequate account of the incapacitating effects of severe mental illness. Some mentally ill defendants—and by this I mean those who were psychotic and grossly out of touch with reality—may be said to have "intended" to do what they did but nonetheless may have been so severely disturbed that they were unable to appreciate the significance of their actions. These cases do not frequently arise, but when they do, a criminal conviction—signifying the societal judgment that the defendant deserves to be punished for what he did—would offend the basic moral intuitions of the community. Judges and juries would then be forced either to return a verdict of conviction which they regard as morally obtuse or to acquit the defendant in defiance of the law. They should be spared such moral embarrassment.

Let me illustrate this point with a real case evaluated at our Institute's Forensic Clinic in 1975. Ms. Joy Baker, a thirty-one-year-old woman, admitted killing her aunt. She had no previous history of mental illness, although her mother was mentally ill and had spent all of Ms. Baker's early years in mental hospitals. Ms. Baker was raised by her grandparents and her aunt in a rural area of the state. After high school graduation, Ms. Baker married and had two children. The marriage ended in divorce six years later, and Ms. Baker remarried. This second marriage was stressful from the outset. Mr. Baker was a heavy drinker and abusive to his wife. He also was extremely jealous and

Continued on page 28

In the Virginia Supreme Court

On June 18, 1982, and September 9, 1982, the Virginia Supreme Court handed down seven decisions of significance to mental health professionals

Guardianship

• In **Carter v. Cavalier Central Bank and Trust Co.**, 223 Va. _____ (1982), the Court, in an expansive reading of a guardian's statutory authority, ruled that a guardian may borrow money on the ward's behalf to pay for the ward's "necessaries."

C. Hill Carter had borrowed $15,600.05 from a bank to pay for the nursing home care provided to his mother, Emily H. Carter, for whom he had been appointed guardian pursuant to Virginia Code §37.1-132. The mother subsequently argued that she should not be obliged to repay the loan.

The Court acknowledged that the general rule was that a guardian could not bind the ward by contract, without prior court approval. But, the Court held, the guardian nonetheless could legitimately contract a debt where it was necessary to provide his ward with "reasonable and comfortable care." Indeed, where the ward's estate no longer contained funds which the guardian could draw upon, the Court suggested that the guardian had a duty to borrow in the ward's name, pending court approval of the sale of the ward's real property.

The Court, in its per curiam decision, did not address the question of whether a guardian, without judicial approval, could mortgage or sell the ward's real property to provide "necessaries."

Older decisions, like **Lake v. Hope**, 116 Va. 687 (1914), which ruled that the guardian had no authority to sell the ward's real property in the absence of a statute authorizing it, do not seem altogether consistent with the **Carter** case, where the debt incurred by the guardian ultimately was satisfied out of a sale of the ward's real estate. Nonetheless most guardians in Virginia can be expected to continue to seek prior judicial approval for such sales by one of two procedures available under Virginia Code §§8.01-68 and 8.01-78.

Child Custody

• In **Leisge v. Leisge**, 223 Va.____ (1982), the Court endorsed the application of the "tender years doctrine" in a custody dispute between a child's father and mother. The "tender years doctrine," derived from a long series of earlier decisions, provides that when the child is of "tender years" and the court determines that (1) both parents are fit and (2) all other things, e.g., home environments, are equal, "an inference arises that the mother should care for the child."

In **Leisge** the trial judge awarded the mother custody of her four year old child after concluding that her father was also a fit parent and that all other factors were equal. The Supreme Court refused to disturb the trial judge's factual determination that the mother's three suicide attempts, delusion that she had been raped, and psychiatric treatment did not render her an unfit parent or otherwise make the father the preferred custodial parent.

The Court also upheld the trial judge's refusal to allow the father to call expert witnesses to rebut the testimony of the mother's psychiatrist. The Court ruled that the trial judge had the power to avoid cumulative testimony; if the husband's attorney had felt that his expert witness would provide essential evidence he should have informed the court through a proffer of testimony.

Competency of Minors

• In **Green v. Commonwealth**, 223 Va._____ (1982), the Virginia Supreme Court upheld the conviction of a fifteen year old boy on three counts of robbery, two counts of grand larceny, and one count of attempted rape, for which he had received a total sentence of eighty years in the penitentiary.

Green's conviction was based in part on a confession he had made to the police. Green's counsel, in attempting to suppress this confession, relied on reports by psychologists and psychiatrists that characterized Green as having "low intelligence." These reports, however, had concluded that Green, despite his low intelligence, was competent to stand trial.

The forensic evaluation of competency to stand trial, the repeated **Miranda** warnings given to Green before he confessed, his understanding of the offenses with which he was charged, the "cunning" he displayed in committing his crimes, and "exposure" to the criminal justice system he had gained from being the subject of several prior delinquency petitions, all persuaded the Court that Green had "knowingly and willingly waived his privilege against self-incrimination."

The Court's discussion of Green's waiver of his right to remain silent ignored the overwhelming influence which his mother seems to have had on his decision to confess. His mother, whom one police officer described as "more than helpful," after consenting to a search of Green's room, instructed Green to give the police everything that did not belong to him. It was in apparent obedience to his mother's instruction that he began to incriminate himself. Thus, even if a fifteen year old mentally retarded child were in fact competent to waive his privilege against self-incrimination, a question as to the voluntariness of the waiver would be raised where it was made in response to an instruction from a parent who might legitimately enforce compliance through discipline, if not affection.

Criminal Intent

• Among the many complex issues confronted by the Court in the capital murder case of **Fitzgerald v. Commonwealth**, 223 Va.____ (1982), was whether the defendent, as a matter of law, lacked the intent to commit capital murder or first degree murder because of intoxication. The defendant claimed that because, at the time of the homicide, he had (voluntarily) ingested LSD, Tranxene, and beer, he was incapable of forming the intent required for capital murder or first degree

Continued

Continued from page 23

murder. This defense attempted to obtain a conviction on a lesser offense such as second degree manslaughter, rather than first degree, and is distinct from the insanity defense which seeks an acquittal on all charges.

In Virginia, voluntary intoxication, regardless of its severity, would not provide a basis for an insanity defense but might succeed in mitigating a charge of first degree or capital murder.

In **Fitzgerald** the prosecution called as an expert a professor of pharmacology at the Medical College of Virginia. He testified, in response to a hypothetical question, that neither LSD, Tranxene, or beer, "regardless of the dosage, could have produced the described behavior."

Fitzgerald called as an expert witness a psychiatrist who "described Fitzgerald as a chronic alcoholic with a paranoid personality, who had used LSD and other drugs since he was twelve." While the psychiatrist did testify that mental capacity could be "dulled or knocked out" by Tranxene and that the combination of beer and LSD could "result" in "unpredictable violence," he nonetheless admitted on cross-examination that the man described in the defense's hypothetical question was capable of premeditation.

The Court, in reviewing the evidence of intent, was impressed by Fitzgerald's complaint before the offense that the victim had "ripped him off" and his comment to a jailmate after his arrest that the victim had "snitched on him." It also noted Fitzgerald's continual directions to his accomplice, his selection of site for the murder, and his provisions for the bloody clothing of the victim and his accomplice. The fact that after the murder Fitzgerald tattooed a "one percenter mark" on his accomplice's arm to show that he was now a "total outlaw" further persuaded the Court that "there was ample evidence to support the jury's finding that he [Fitzgerald] had the requisite capacity to commit the capital offense."

Fitzgerald also claimed that the trial judge had erred in permitting the prosecution's expert witness, a pharmacologist, to testify on whether the effects of LSD, Tranxene, and beer precluded the formation of the required criminal intent. Fitzgerald argued that such testimony "invaded the province of the jury by deciding the ultimate issue in the case."

The Court, in rejecting this argument, approved such testimony stating that "the jury was entitled to have the expert opinion as to the cumulative effect of LSD, Tranxene, and alcohol" on capacity to form criminal intent. The qualifications of the pharmacologist to render such an opinion were not in this case contested.

In endorsing such testimony, the Court distinguished its decision in **Coppola v. Commonwealth**, 220 Va. 243, 252-53, 257 S.E.2d 797, 803-04 (1979), cert. denied 444 U.S. 1103 (1980), where it ruled that a defense psychiatrist who had observed the prosecution's key witness during trial could not testify that the witness's personality disorder prevented her from telling the truth. In **Coppola**, the Court said the defense psychiatrist's opinion concerned the credibility of a witness, an issue within the exclusive province of the jury. In contrast, the **Fitzgerald** decision acknowledged that mens rea, or criminal intent, was an issue on which the jury is "entitled" to the assistance of expert testimony. This language may lead defense attorneys to more frequently call expert witnesses to testify on the issue of mens rea, not only in first degree murder or capital murder cases, but perhaps in trial of lesser criminal charges as well.

Relevance

• In **Smith v. Commonwealth**, 223 Va.____ (1982), the defendant had been convicted in Franklin County Circuit Court of selling LSD and sentenced to twenty-five years in prison. During the trial, the prosecution called a chemist as an expert witness to identify a substance as LSD. The court, over the defense attorney's objection, asked the chemist what the effects of LSD were. The chemist testified:

> **The effect of LSD has been reported to cause a person from, or hallucinogenics in general, I should say have been, have made people go so far as to tear their eyes right out of the sockets, chew off an arm, jump out of windows, do some really... bizarre things.**

On appeal, the Virginia Supreme Court found this testimony irrelevant and prejudicial to the jury's determination of whether Smith had sold LSD. The Court reversed his conviction and remanded for a new trial. Smith's conviction for sale of marijuana was left intact.

Competency to Stand Trial

• At a pre-trial hearing on whether the defendant was entitled to be evaluated for competency to stand trial under Virginia Code §19.2-169 by a Spanish-speaking psychiatrist, the defendant himself had not been present. On appeal from his capital murder conviction in **Quintana v. Commonwealth**, 244 Va.____ (1982), he argued, inter alia, that this pre-trial hearing violated his rights under the Constitution and under Virginia Code §19.2-259 to be present at every stage of his trial. On this point the Court held that this pre-trial hearing was not a "stage of the trial proper" at which the defendant's presence was required.

Sovereign Immunity

• In 1980, the Virginia Supreme Court announced in **James v. Jane**, 221 Va. 43 (1980), that full-time faculty members at the University of Virginia School of Medicine were not entitled to the defense of sovereign immunity to claims of medical malpractice. This case appeared to be a departure from **Lawhorne v. Harlan**, 214 Va. 405 (1973), where a University of Virginia hospital administrator and surgical intern had both been found to be entitled to sovereign immunity.

This year, in **Banks v. Sellars**, 224 Va.____ (1982), the Court pumped new life into **Lawhorne**, when it found a Henrico County school superintendent and high school principal entitled to sovereign immunity in a claim of negligent failure to provide a safe environment at the school. These officials, sued in a state tort claim by a high school student who had been stabbed by another student, were determined by the court to have been acting in a "discretional and managerial" capacity and thus were entitled to sovereign immunity.

Continued on page 31

In the United States Supreme Court

Right to treatment

• In a recent unanimous decision, **Youngberg v. Romeo**, 50 U.S.L.W. 4681 (June 15, 1982), the Supreme Court for the first time recognized a limited right of residents in state mental retardation facilities to receive treatment and habilitation. In doing so, however, the Court sharply restricted the remedies available to a resident who claims a violation of his right or of the right to liberty or protection from which it is derived.

The Court reasoned that a state prisoner constitutionally is entitled to freedom from unreasonable use of restraints and to protection from unreasonable risks of harm at the hands of other prisoners. A fortiori, Nicholas Romeo, a thirty-three year old resident of Pennsylvania's Pennhurst State School who had been injured on at least sixty-three occasions and routinely restrained for prolonged periods, had a right under the fourteenth amendment's due process clause to freedom from unreasonable restraint and protection from unreasonable risks of harm.

Insofar as treatment or habilitation was necessary to avoid violation of these rights to liberty and safety, the Court went on to rule, Romeo also had a right to treatment or habilitation.

Chief Justice Burger stressed in a separate concurring opinion that Romeo had no right to treatment or habilitation that was not required by the rights to freedom from unreasonable restraint and protection from unreasonable risk of harm. The Chief Justice would have held "flatly that respondent has no constitutional right to training or 'habilitation,' per se." 50 U.S.L.W. at 4686.

Justices Blackmun, Brennan, and O'Connor in another concurrence expressed a willingness to accord a resident a right to treatment or habilitation sufficient to maintain the self-care skills which the resident possessed when he entered the facility, even if his "safety and mobility were not imminently threatened" by the lack of treatment or habilitation. In this case, though, the record before the Court did not reveal whether Romeo was seeking this right and if so, whether he had any self-care skills when he entered Pennhurst.

Of potentially far greater significance to other mental disability law issues is the Court's formula for determining whether this limited right to treatment was violated. Emphasizing that "[p]rofessionals in the habilitation of the mentally retarded disagree strongly on the question whether effective training of all severely or profoundly retarded individuals is even possible," 50 U.S.L.W. at 4683, n. 20, the Court held that any treatment or habilitation decision

> **if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such judgment. [50 U.S.L.W. at 4685]**

The Court seemed to require lower courts to show the same nearly total deference to professional judgment in future claims based on the right to safety or freedom from restraint: if "professional judgment in fact was exercised," no right was violated.

In adopting this standard, the Court implicitly rejected the notion that restraints could be used only when they are the least restrictive method of handling or protecting the resident. The Third Circuit Court of Appeals had required Pennsylvania to demonstrate that its use of restraints on Romeo was justified by "compelling necessity" and was the least restrictive alternative available. While the Court in criticizing the "compelling necessity" standard did not discuss the doctrine of the "least restrictive alternative," it is fair to infer that its opinion also rejected that doctrine, or mandated so much deference to professional judgment as to make the doctrine of little use to residents alleging an abridgment of their liberty interests.

The Court's decision to give professionals a free hand in treating mentally disabled persons is based on several concerns. First, the Court reiterated its conclusion three years ago in a decision concerning the civil commitment of minors, **Parham v. J.R.**, 442 U.S. 584 (1979), that "there is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." 50 U.S.L.W. at 4685. Second, as in **Parham**, the Court here was impressed with the difficulty of the state's task in caring for its mentally disabled citizens and concluded that subjecting the state to frequent intervention by the federal judiciary and exposure to money damages well might make that task impossible.

So concerned was the Court about insulating the professional from liability that it took special care in providing that the professional would escape liability for damages, even for conduct falling below the low standard set by the court, if his shortcomings were attributable to "budgetary constraints." 50 U.S.L.W. at 4685.

Six days later, in **Harlow v. Fitzgerald**, 50 U.S.L.W. 4815 (June 24, 1982), the Court broadened further the shield of good-faith immunity to civil rights claims available to these professionals. Under **Harlow** the professional is entitled to summary judgment unless the plaintiff can show that at the time of the professional's alleged misconduct, he was violating settled constitutional law. In light of the easily satisfied but still ambiguous standard of conduct set out in **Youngberg v. Romeo**, it is difficult to imagine a civil rights complaint against such a professional proceeding to trial, much less succeeding on the merits.

The Supreme Court in **Youngberg v. Romeo** included in its definition of "professional" virtually any "person competent, whether by education, training, or experience, to make the particular decision at issue." Even with

Continued

Continued from page 25
respect to "long term treatment decisions" the Court was willing to designate as professional not only doctors and nurses but any staff person "with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded." The Court may have been willing to characterize as professional "day-to-day decisions" made by "employees without formal training but who are subject to the supervision of qualified persons." 50 U.S.L.W. at 4685.

Right to refuse treatment

• In another unanimous opinion, **Mills v. Rogers**, 50 U.S.L.W. 4676 (June 18, 1982), the Supreme Court vacated a lower court decision which had given mental patients a right to refuse treatment. The Court remanded that decision to the lower court to determine to what extent this right existed under state law. In doing so, the Supreme Court plainly implied that if such a right existed under federal law, it was subject to the same kind of broad professional discretion authorized in **Youngberg v. Romeo**.

Two weeks after **Mills** the Supreme Court granted certiorari in **Rennie v. Klein**, where the lower court also had recognized a right to refuse treatment. The Supreme Court summarily vacated that decision and remanded it for reconsideration in light of the recent ruling in **Youngberg v. Romeo**. 50 U.S.L.W. 3998.27 (July 2, 1982).

Thus the First and Third Circuit Courts of Appeal now must examine closely the Supreme Court's deferential approach to professional decision-making in **Youngberg v. Romeo**, and its predecessor, **Parham v. J.R.**, 442 U.S. 584 (1979).

In **Mills**, the Court contrasted this deferential approach with that of the Massachusetts Supreme Court in its treatment refusal decision of **In the Matter of Guardianship of Richard Roe, III**, 421 N.E. 2d 40 (1981).

In **Richard Roe, III**, the Massachusetts Supreme Court ruled that even though a guardian had been generally authorized to make treatment decisions for his ward (in this case the guardian's twenty-one year old son, recently discharged from a state hospital) the guardian first had to obtain special court approval to force antipsychotic medication on the ward.

The Massachusetts Supreme Court viewed antipsychotic medication as an extraordinary medical measure, "sufficient to undermine the foundations of personality." 42 N.E. 2d at 40. Thus the Massachusetts Court, in keeping with its earlier decisions regarding exceptionally intrusive medical care for mentally disabled patients, such as **Superintendent of Belchertown State School v. Saikewicz**, 370 N.E. 2d 417 (1977), ruled that the decision to force medication must be based on "substituted judgment."

"Substituted judgment" requires the decision-maker to put himself in the place of the patient and to attempt to make the decision the patient would make, if the patient were competent (but nonetheless cognizant of his disabled condition). "Substituted judgment," as it has been developed by the Massachusetts Supreme Court, basically entails consideration by the decision-maker of not just the "best interests" of the patient but his supposed preference as well, which might run counter to what is apparently in his "best interests."

If one accepts the **Roe** court's appraisal of antipsychotic medication and its controversial concept of "substituted judgment," it is easy to understand why the **Roe** court expressed a "preference for judicial resolution of certain issues arising from proposed extraordinary medical treatment." 420 N.E. 2d at 51, cited at 50 U.S.L.W. at 4680. A judge might be in the best position to make a "substituted judgment" where that judgment only indirectly requires clinical considerations of the patient's condition and may require a decision which is actually harmful to the patient.

In **Mills**, Justice Powell, speaking on behalf of all nine Justices, contrasted their assessment in past cases of the substantive federal liberty interests and the procedures required to protect those interests with the approach of the Massachusetts court in **Richard Roe III**.

Their 1979 decision, **Addington v. Texas**, 441 U.S. 418 (1979), would seem here to compel the conclusion that a patient had a liberty interest in being medicated over his objections, since his mental illness otherwise would impair his liberty. Justice Powell also noted that **Addington** would suggest to the Court that the uncertain effects of the medication weigh in favor of greater rather than lesser medical discretion. If physicians cannot diagnose the condition requiring medication, or the impact of the medication, the Court would decline to encase the patient's interest in avoiding medication in so much procedural protection that medication could never be given.

The Massachusetts requirement of "substituted judgment" indicated to the United States Supreme Court that the state might value the patient interest in avoiding medication more than the federal Constitution as interpreted by **Addington** and **Parham** would require.

The fact that "substituted judgment" necessitated maximum judicial involvement in the therapeutic setting also meant to Justice Powell that Massachusetts law well might offer

Continued

Developments in Mental Health Law

is distributed as a public service by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health and Mental Retardation. The opinions expressed do not necessarily reflct the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge on a quarterly basis. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100 - Blue Ridge Hospital, Charlottesville, Virginia 22901. We also welcome your suggestions and comments.

Editor
Willis J. Spaulding
Managing Editor
Elaine M. Hadden
Assistant Managing Editor
Linda P. Seaborn
Law Student Contributors
Henry E. Howell, III
Vicki Epling

Continued from page 26

more or, rather, a different form of procedural due process than the United States Supreme Court would, even if the latter court were to consider what federal due process procedural safeguard were required to protect state-created, enhanced interest in avoiding medication.

Here Justice Powell in **Mills** pointed to another case decided the same day, **Youngberg v. Romeo**, which, like **Parham**, had expressed a strong preference for clinical, non-judicial models of treatment decision-making.

If indeed Massachusetts law created substantive or procedural rights to refuse medication greater than those accorded by the United States Constitution, the **Mills** controversy would not require interpretation of federal law for resolution. Because the Massachusetts court in **Richard Roe, III**, had based its decision on an ambiguous amalgam of state and federal law, the United States Supreme Court sent the **Mills** case back to the First Circuit Court of Appeals with instructions to first determine precisely the scope of protection afforded the preferences of a patient who refuses medication under Massachusetts law. On remand, it is possible that this question will be referred to the Massachusetts Supreme Court for an advisory interpretation of state law.

Despite the procedural complexities of the **Mills** decision, the United States Supreme Court made its message relatively clear: like the liberty interests implicated by institutional use of restraint, injury by other patients, or denial of treatment discussed in **Romeo**, the Court will consign the patient's legal interest in avoiding treatment to the caretaking of his clinicians.

Right to a "free appropriate education"

• In **Board of Education v. Rowley**, 50 U.S.L.W. 4925 (June 28, 1982), the Supreme Court refused to compel a New York elementary school to employ a sign-language interpreter for Amy Rowley, a deaf student. In this decision by Justice Rehnquist, the Supreme Court for the first time interpreted the Education for All Handicapped Children Act of 1975, 20 U.S.C. § 1401 et seq. ("EAHCA").

The District Court had agreed with Amy Rowley's parents that EAHCA entitled Amy to an "opportunity to achieve full potential commensurate with the opportunity provided to other students." The District Court's approach was to look at the disparity between Amy's potential and her performance and to compare this shortfall of educational opportunity to that faced by non-handicapped students. In this case, although Amy's performance without an interpreter was outstanding, she understood less than half of what was said and consequently was falling far short of achieving her potential.

Justice Rehnquist, after a close reading of EAHCA's legislative history, rejected the District Court's formula for defining the "free, appropriate education" mandated by the Act. He reasoned that the touchstone of "equality," depending on how one applied it, could either give less assistance than EAHCA was intended to provide, or more. In any case, educational opportunity varies so much from student to student that it was impossible to measure, much less compare, handicapped and non-handicapped students.

Instead, the Court read "appropriate education" to mean one which was "reasonably calculated to enable [the handicapped student] to receive benefits." This interpretation reflected the Court's belief that the objective of EAHCA was to provide "meaningful access" to education for a group of children historically denied access altogether.

Based on this standard and the lower court's finding that "the evidence firmly establishes that Amy is receiving an 'adequate' education, since she performs better than the average child in her class and is advancing easily from grade to grade," the Supreme Court reversed the District Court and ruled that the school need not provide a sign-language interpreter.

The Supreme Court went on to extend to the state administrative determination of what education is "appropriate," the kind of presumptive validity it gave to professional decision-making in state mental retardation facilities in **Youngberg v. Romeo**. Justice Rehnquist directed the federal courts to exercise restraint in reviewing EAHCA controversies, since "adequate compliance with the procedures prescribed [by EAHCA] would in most cases assure much if not all of what Congress wished in the way of substantive content in an IEP." 50 U.S.L.W. at 4933. Practically, this will mean that in the future parents dissatisfied with an IEP can expect little relief from the District Court in which, under the provisions of EAHCA, they may contest an unfavorable state adminstrative decision.

Justice White, in a separate opinion joined by Justices Brennan and Marshall, dissented from both the majority's definition of "appropriate" and its restriction of the federal court's role in reviewing state administrative interpretations of that word. The dissenters would have accorded Amy Rowley "an educational opportunity commensurate with that given other children" and would have directed the lower courts to consider de novo claims by parents that this opportunity had been denied.

The dissenters' contention that the **Rowley** decision will offer students like Amy no more assistance than "a teacher with a loud voice," may be literally true in Amy's unusual case. But for students with other handicaps, such as mental retardation, the majority's aim of providing meaningful access to education will prove more beneficial than the "potential-maximizing" approach of the dissenters and the District Court. It is not difficult to imagine a handicapped student with little or no shortfall or disparity between his performance and his relatively speculative potential. If the school were only required to offer that student a "commensurate educational opportunity," it might in fact provide less, not more, than is required to insure meaningful access to an education. Similarly, the Court's focus on promotion from grade to grade as an indication of receiving an appropriate education may lead to successful claims by handicapped students who are not promoted that their education was not "appropriate."□

Virginia Seeks Director of Forensic Services

On the recommendation of the Commissioner's Committee on a Forensic Services System, whose report appeared in the April-June, 1982, issue of **Developments in Mental Health Law** (see page 18, paragraphs 15 and 16), the Virginia Department of Mental Health and Mental Retardation established recently the position of Director of Forensic Services and initiated a nationwide executive search for applicants.

As suggested by the Commissioner's Committee, the Director of Forensic Services is "a high-placed, adequately supported Central Office position with singular responsibility for directing the statewide forensic services systems."

Based on the experience of other states, applications from professionals in law, medicine, and psychology are anticipated. The Director's salary will depend at least in part on the salary histories of all qualified applicants for the job.

The search for the first Director of Forensic Services in Virginia follows the enactment of a new forensic evaluation law by the 1982 General Assembly. See **2 Developments in Mental Health Law 12 (1982).** Next year the General Assembly is expected to consider major changes in the nature of the insanity plea and the commitment of insanity acquittees in Virginia.

Applications and inquires should be made, before December 20, 1982, to:

Donna Shumate
Employment Supervisor, Personnel
Department of Mental Health and Mental Retardation
P.O. Box 1797
Richmond, Virginia 23214.

Continued from page 22

repeatedly accused his wife of seeing other men.

I will be describing the circumstances surrounding the offense as Ms. Baker reported them. There was no evidence inconsistent with her account. Indeed, no one who heard her has ever doubted that she was telling the truth.

The night before the shooting, Mr. Baker took his wife on a ride in his truck. He kept a gun on the seat between them and stopped repeatedly. At each place he told listeners that his wife was an adultress. He insisted his wife throw her wedding ring from the car, which she did because she was afraid of her husband's anger. The Bakers didn't return home until three in the morning. At that time Ms. Baker woke her children and fed them, then stayed up while her husband slept because she was afraid "something terrible would happen."

During this time and for the three days prior to the day of the shooting Ms. Baker had become increasingly agitated and fearful. Her condition rapidly deteriorated and she began to lose contact with reality. She felt that her dogs were going to attack her, and she also believed her children and the neighbors had been possessed by the devil. She said she felt that she was going to be "annihilated."

On the morning of the shooting, Ms. Baker asked her husband not to leave and told him that something horrible was about to happen. When he left anyway she locked the doors. She ran frantically around the house holding the gun. She became worried about her children because she was afraid of what they might do to her if they became possessed and of what she might do to them to defend herself. So she made them sit on the sofa and read the Twenty-Third Psalm over and over, feeling that reading the Bible would protect them.

Shortly afterwards, Ms. Baker's aunt suddenly drove into the driveway for an unexpected visit. Ms. Baker told her to go away, but the aunt persisted and went to the back door. Ms. Baker repeatedly urged her aunt to leave. At this time the aunt seemed to Ms. Baker to be sneering at her, along with the dog which she had locked on the porch.

When her aunt suddenly reached through the screening to unlock the door, Ms. Baker said, "I had my aunt over there and this black dog over here, and both of them were bothering me.... And then I had that black dog in front of me and she turned around and I was trying to kick the dog and my aunt was coming in the door and I just—took my hands, I just went like this—right through the screen.... I shot her."

Ms. Baker's aunt fell backward into the mud behind the porch. Although she was bleeding profusely from her chest, she did not die immediately.

The insanity defense, in short, is essential to the moral integrity of the criminal law.

"Why, Joy?" she asked. "Because you're the devil, and you came to hurt me," Joy answered. Her aunt said, "Honey, no. I came to help you." At this point, Ms. Baker said, she saw that her aunt was hurting and became very confused. Then, according to her statement, "I took the gun and shot her again just to relieve the pain she was having because she was hurt." Her aunt died after the second shot.

All the psychiatrists who examined Ms. Baker concluded that she was acutely psychotic and out of touch with reality at the time she shot her aunt. The police who arrested her and others in the small rural community concluded that she must have been crazy because there was no other explanation for her conduct. After Ms. Baker was stabilized on anti-psychotic medication, she was permitted to leave the state to live with relatives in a neighboring state. Eventually the case against her was dismissed by the court, with the consent of the prosecution, after a preliminary hearing at which the examining psychiatrists testified. She was never indicted or brought to trial.

It seems clear, even to a layman, that Ms. Baker was so delusional and regressed at the time of the shooting

Continued

Continued from page 28

that she did not understand or appreciate the wrongfulness of her conduct. It would be morally obtuse to condemn and punish her. Yet, Ms. Baker had the state of mind required for some form of criminal homicide. If there were no insanity defense, she could be acquitted only in defiance of the law.

Let me explain. It is sometimes said that "mens rea," or the "guilty mind" required for criminal liability, refers to a general assessment of personal blameworthiness or evil intentions. But this is not true. The "states of mind" which are required for homicide and other criminal offenses refer only to specific aspects of conscious awareness. They do not have any qualitative dimension. There is good reason for this, of course. The exclusive focus on conscious perceptions and beliefs, often qualified by a requirement of reasonableness, enhances predictability, precision, and equality in the penal law. If the law tried to take into account variations in motivation or more subtle states of mind or psychic aberrations in the definition of offenses, the result would be a debilitating individualization of the standards of criminal liability.

Now let's look at Joy Baker's mens rea at the time of each of the two shots. At the time of the first shot, it could be argued that Ms. Baker lacked the "state of mind" required for murder because she did not intend to shoot a "human being" but rather intended to shoot a person whom she believed to be possessed by the devil. At common law, this claim would probably be characterized as a mistake of fact. Since the mistake was, by definition, an unreasonable one—i.e., one that only a crazy person would make—she would most likely be guilty of some form of homicide (at least manslaughter) if ordinary mens rea principles were applied. Even under the modern criminal codes, such as S. 1630, she would be guilty of negligent homicide since an ordinary person in her situation would have been aware of the risk that her aunt was a human being. And she possibly could be found guilty of reckless homicide, usually graded as manslaughter, since she was probably aware of the risk that her aunt was a human being even though she was so regressed that she disregarded the risk.

Specialized training in forensic evaluation is necessary, and a major aim of such training must be to assure that the expert is sensitive to the limits of his or her knowledge.

It might also be argued that Ms. Baker's first shot would have been justified if her delusional beliefs had been true since she would have been defending herself against imminent annihilation at the hands of the devil. Again, however, the application of ordinary common-law principles of justification, which are carried forward in S. 1630, would indicate that she was unreasonably mistaken as to the existence of justificatory facts (the necessity for killing to protect oneself) and her defense would fail, although the grade of the offense would probably be reduced to manslaughter on the basis of her "imperfect" justification.

At the time of the second shot, Ms. Baker was in somewhat better contact with reality. The psychiatrists explained that she was better able to perceive her aunt as a person when she no longer felt herself in imminent danger of annihilation or disintegration, The first shot removed the threat and, in a sense, took the edge off her frenzy. Now, at a very superficial level, she "knew" that she was shooting her aunt and did so for the nondelusional purpose of relieving her aunt's pain. But euthanasia is no justification for homicide. Thus, if we look only at her legally relevant "state of mind" at the time of the second shot, and we do not take into account her highly regressed and disorganized emotional condition, she is technically guilty of premeditated murder.

I believe that Joy Baker's case convincingly demonstrates why, in theoretical terms, the mens rea approach does not take sufficient account of the morally significant aberrations of mental functioning which can be associated with severe mental disorder.

I readily concede that these technical points may make little practical difference in the courtroom. If the expert testimony in Joy Baker's case and others like it were admitted to disprove the existence of mens rea, juries may behave as many observers believe they do now—they may ignore the technical aspects of the law and decide, very bluntly, whether the defendant was too crazy to be convicted. However, I do not believe that rational criminal law reform is served by designing rules of law in the expectation that they will be ignored or nullified when they appear unjust in individual cases.

Also, another danger of the mens rea approach is that courts will attempt to soften its impact by reinterpreting the concepts of intention, knowledge, and recklessness in order to give them qualitative meanings and thereby achieve exculpatory results in cases where criminal liability seems ethically offensive. This would be a particularly unfortunate response because it would undermine the modern trend toward greater precision and coherence in the definition of mens rea. Again, I believe the cause of criminal law reform, to which this Committee has repeatedly demonstrated its commitment, is best served by retaining the insanity defense as a safety valve for qualitative claims of severe mental impairment rather than by squeezing these claims into the generic states of mind defined in the penal law.

Improving the Quality of Expert Testimony

I have tried to show that perpetuation of the insanity defense is essential to the moral integrity of the criminal law. Yet an abstract commitment to the moral relevance of claims of psychological aberration may have to bend to the need for reliability in the administration of the law.

I fully recognize that the litigation of insanity claims is occasionally imperfect. The defense is sometimes difficult to administer reliably and fairly. In

Continued

Continued from page 29

particular, I recognize that we cannot calibrate the severity of a person's mental disability, and it is sometimes hard to know whether the disability was profound enough to establish irresponsibility. Nor can we be confident that every fabricated claim will be recognized. Yet these concerns are not unlike those presented by traditional defenses such as mistake, duress, and other excuses which no one is seeking to abolish. Indeed, problems in sorting valid from invalid defensive claims are best seen as part of the price of a humane and just penal law. Thus, to the extent that the abolitionists would eradicate the insanity defense in response to imperfections in its administration, I would reply that a decent respect for the moral integrity of the criminal law sometimes requires us to ask questions that can be answered only by approximation. Rather than abolishing the defense, we should focus our attention on ways in which its administration can be improved.

Some of the abolitionist sentiment among lawyers seems to be responsive to doubts about the competence—and, unfortunately, the ethics—of expert witnesses. The cry for abolition is also raised by psychiatrists and psychologists who believe that the law forces experts to "take sides" and to offer opinions on issues outside their sphere of expertise. These are all legitimate concerns and I have no doubt that the current controversy about the insanity defense accurately reflects a rising level of mutual professional irritation about its administration. However, the correct solution is not to abolish the insanity defense but rather to clarify the roles and obligations of expert witnesses in the criminal process. Some assistance in this effort can be expected from the American Bar Association's Criminal Justice-Mental Health Standards now being drafted by interdisciplinary panels of experts in the field.

A properly trained expert can help the judge or jury to understand aberrations of the human mind. However, training in psychiatry or psychology does not, by itself, qualify a person to be an expert witness in criminal cases. Specialized training in forensic evaluation is necessary, and a major aim of such special training must be to assure that the expert is sensitive to the limits of his or her knowledge.

Whatever the precise terms of the volitional test, the question is unanswerable — or can be answered only by "moral guesses."

The Case for Tightening the Defense

I do not favor abolition of the "cognitive" prong of the insanity defense. However, I do agree with those critics who believe the risks of fabrication and "moral mistakes" in administering the defense are greatest when the experts and the jury are asked to speculate whether the defendant had the capacity to "control" himself or whether he could have "resisted" the criminal impulse. I would therefore narrow the defense by eliminating its so-called volitional prong or control test.

Few would dispute the moral predicate for the control test—that a person who "cannot help" doing what he did is not blameworthy. Unfortunately, however, there is no scientific basis for measuring a person's capacity for self-control or for calibrating the impairment of such capacity. There is, in short, no objective basis for distinguishing between offenders who were undeterrable and those who were merely undeterred, between the impulse that was irresistible and the impulse not resisted, or between substantial impairment of capacity and some lesser impairment. Whatever the precise terms of the volitional test, the question is unanswerable—or can be answered only by "moral guesses." To ask it at all, in my opinion, invites fabricated claims, undermines equal administration of the penal law, and compromises its deterrent effect.

The risks of the volitional inquiry would not be especially great if consideration of the insanity defense were permitted only in cases involving psychotic disorders; in such cases, the law's distinction between cognitive and volitional impairment is clinically artificial anyway. However, when the control test is combined with loose or broad interpretation of the term "mental disease," the inevitable result is unstructured clinical speculation regarding the "causes" of criminal behavior in any case in which a defendant could be said to have a personality disorder, an impulse disorder, or any other diagnosable abnormality.

For example, it is clear enough in theory that the insanity defense is not supposed to be a ground for acquittal of persons with weak behavior controls who misbehave because of anger, jealousy, fear, or some other strong emotion. (Such emotions may account for a large proportion of all homicides and other assaultive crimes.) Many crimes are committed by persons who are not acting "normally" and who are emotionally disturbed at the time; indeed, it is not uncommon to say that they are temporarily "out of their minds." But this is not what the law means, or should mean, by "insanity." To prevent mistaken applications of the defense in such cases, I would define mental disease narrowly and I would abolish the "control" test. Thus:

Defense of [Insanity] [Non-Responsibility Due to Mental Disease]

A. A person charged with a criminal offense shall be found [not guilty by reason of insanity][4] if he proves, by the greater weight of the evidence, that, as a result of mental disease or mental retardation, he was unable to appreciate the wrongfulness of his conduct at the time of the offense.

B. As used in this section, the terms mental disease or mental retardation include only those severely abnormal mental conditions that grossly and demonstrably impair a person's perception or understanding of reality and that are not attributable primarily to the voluntary ingestion of alcohol or other psychoactive substances.

The sole test of legal insanity should be whether the defendant, as a result of severe mental disease, was unable " to appreciate the wrongfulness of his conduct." This language,

Continued

Continued from page 30

drawn from the Model Penal Code, uses clinically meaningful terms to ask the same question posed by the House of Lords in **M'Naghten** 150 years ago. As I indicated earlier, I believe it is a necessary test of criminal responsibility. Now I am arguing that it is a sufficient test as well. During the past ten years, we have evaluated hundreds of cases at our Clinic. Only a handful have involved what I would regard as morally compelling claims of irresponsibility, and all of them would be comprehended by this formulation. Thus, I am convinced that this test is fully compatible with the ethical premises of the penal law, and that results reached by judges and juries in particular cases ordinarily would be congruent with the community's moral sense.

In sum, then, I believe that the insanity defense, as I have defined it, should be narrowed, not abandoned, and that the burden of persuasion may properly be shifted to the defendant. Like the mens rea proposal, this approach adequately responds to public concern about possible misuse of the insanity defense. Unlike the mens rea proposal, however, I believe this approach is compatible with the basic doctrines and principles of Anglo-American penal law. ☐

Notes

[1]See S. 2678, S. 2658.

[2]S. 1558, S. 818, S. 2669 and S. 1106 would all adopt the mens rea approach, although they differ on the label for the verdict. Under S. 1558 and S. 2669, the defendant who lacks mens rea due to mental disease would be found "not guilty only by reason of insanity." Under S. 1106, the defendant who lacks mens rea due to mental disease would be found "guilty but insane"; however, because such an offender is **not** sentenced for the crime and is subject only to therapeutic restraint, the verdict label has only symbolic importance. Finally, S. 818 does not address the verdict form.

[3]Of course, a normal person can escape liability or reduce the grade of his offense by showing that he did not have the intention, awareness, or belief required in the definition of the offense and, under these bills, so could a crazy person. A review of decisional law in the federal judicial circuits indicates that this is now the law: evidence concerning the defendant's abnormal mental condition is admissible whenever it is relevant to prove that the defendant did or did not have the "specific intent" required in the definition of the offense. Cf. § 4.02(1) of the Model Penal Code.

[4]Insert preferred label for verdict. Other possibilities include [not guilty only by reason of insanity] [not responsible due to mental disease] [guilty of a criminal act but not responsible due to mental disease].

New Clinical Training Center for Mental Health and Law at Institute

The Institute of Law, Psychiatry and Public Policy has recently received a grant from the Center for Studies of Crime and Delinquency at the National Institute of Mental Health to develop a Clinical Training Center for Mental Health and Law. Professor John Monahan, Ph.D., Principal Investigator, and Lawrence J. Raifman, J.D., Ph.D., Project Director, are developing a series of curriculum packages or "modules" for use in training public sector psychiatrists, psychologists, and social workers who have professional involvement with criminal courts. The "modules" will guide practicing mental health professionals in conducting evaluations for pretrial incompetence to stand trial and/or insanity. The material will be developed in consultation with an advisory board of judges, lawyers, and mental health practitioners and will be field tested in the training programs run by the Institute. The curriculum packages, along with an appendix applying the legal issues and procedures to the specific situation of mental health professionals in Virginia, will ultimately by published in a comprehensive NIMH monograph for national dissemination.

The goal in developing the curriculum packages, Dr. Raifman said, is to increase the reliability of professional judgments by suggesting model clinical procedures. The availability of this kind of information will increase the expertise of mental health professionals and their willingness to become involved with the criminal courts.

Professor Monahan, Associate Director of the Institute and a member of the faculty of the School of Law, University of Virginia, is considered to be the foremost authority regarding the prediction of dangerousness. Dr. Raifman holds a joint degree in law and clinical psychology from the University of Arizona and has done forensic evaluations in St. Louis, Missouri. Inquiries about the forensic training "modules" can be addressed to Lawrence Raifman at the Institute. ☐

Continued from page 24

Three justices dissented, on the grounds that the application of sovereign immunity here was inconsistent with **James v. Jane** and several subsequent decisions.

The majority's new willingness to find officials immune was based in part on the United States Supreme Court's recent opinion in **Harlow v. Fitzgerald**, 50 U.S.L.W. 4815 (1982), expanding the qualified immunity of public officials to civil rights claims.

The Virginia Supreme Court also noted in **Banks** that despite the doctrine of sovereign immunity, claims arising after July 1, 1982, might still be made against state officials under the newly enacted Virginia Tort Claims Act, Virginia Code §8.01-195.1 et seq. Recovery under the Virginia Tort Claims Act, however, is limited to $25,000 or the limits of any applicable liability insurance, whichever is greater. ☐

Forensic Training

The Forensic Evaluation Training and Research Center continues to offer training designed to acquaint mental health professionals with the Virginia criminal justice system and the types of evaluations requested by the criminal courts. (See the April-June issue of **Developments** for a more detailed description.)

This training is provided under contract with the Department of Mental Health and Mental Retardation. Successful completion of the program and a nationally validated forensic examination are necessary in order to obtain a certificate indicating that the professional has passed the course.

Contact Larry Fitch at (804) 924-5435, Forensic Evaluation Training and Research Center, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901 for more information.

Sixth Annual Symposium To Be Held In Alexandria On December 9 & 10

The University of Virginia
Institute of Law, Psychiatry and Public Policy
Division of Continuing Education (Falls Church Center)
Office of Continuing Medical Education
and
The Virginia Department of Mental Health and Mental Retardation
present the
Sixth Annual Symposium on Mental Health and the Law

This year's symposium will look at the role of mental health and mental retardation experts in the courtroom. The program includes Park Elliott Dietz, M.D., M.P.H., on the insanity defense; Seymour L. Halleck, M.D., on sentencing; Richard P. Lynch, J.D., on the ABA Criminal Justice Mental Health Standards; Andre P. Derdeyn, M.D., Robert E. Emery, J.D., William T. Kerr, J.D., Jack Shapiro, J.D., N. Dickon Reppucci, Ph.D. and Lawrence J. Raifman, J.D., Ph.D., on child custody and divorce mediation; Lois A. Weithorn, Ph.D., on guardianship evaluations; Gary B. Melton, Ph.D. on sterilization; Willis J. Spaulding, J.D., on non-judicial guardianship; and Daryl B. Matthews, M.D., Ph.D., on civil commitments. Five workshops on related topics will be offered on Thursday afternoon.

Time: December 9 and 10, 1982
Place: Ramada Inn, Old Town
Alexandria, Virginia
Fee: $70; $80 if CME or CEU credit is desired.

As an organization accredited for Continuing Medical Education, the University of Virginia School of Medicine designates this continuing medical educational activity as meeting the criteria for up to 12 hours in Category 1 for the Physician's Recognition Award of the American Medical Association. An application for 1.2 CEUs is pending.

For further information, please call or write:
Institute of Law, Psychiatry and Public Policy
Box 100, Blue Ridge Hospital
Charlottesville, Virginia 22901
(804) 924-5435

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
Charlottesville, VA. 22901

Non-Profit Organization
U.S. Postage Paid
Permit No. 160
Charlottesville, Virginia
22901

A Quarterly Publication of the Institute of Law, Psychiatry & Public Policy at the University of Virginia

Developments in
Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 2, No. 4 Oct.-Dec. 1982

A Clinical and Legal Evaluation of the Need for Involuntary Commitment

by Allen S. Gouse, Ph.D., Joseph W. Avellar, Ph.D., and Donald S. Biskin, Ph.D.*

In pursuit of the goal of deinstitutionalization, two distinct objectives emerged for public psychiatric hospitals. The first was, where possible, to discharge patients into less restrictive/more appropriate community-based programs. The second objective was to prevent inappropriate admissions into the psychiatric hospitals. Through these two objectives, the flow in and out of state facilities was to be controlled.

With a decade of deinstitutionalization behind us, it is appropriate to examine the degree to which these objectives have been achieved. As evidenced by the marked decrease in public psychiatric beds during the 1970s and 1980s, it appears that major progress is being made toward the first objective. With regard to the second objective, preventing inappropriate admissions, the picture is less clear. Structures such as community-based pre-admission screening have been set up. For large numbers of individuals seeking inpatient psychiatric care, diversion back into community programs has been achieved. In spite of such efforts, however, it appears that some individuals who do not necessarily need institutional care are still being admitted.

In the case of involuntary commitments, the mechanisms which generally control or prevent inappropriate admissions are (1) the commitment criteria established by state law and (2) commitment hearing evaluations. In an attempt to examine how these two mechanisms are working vis-a-vis preventing inappropriate admissions, the Virginia Department of Mental Health and Mental Retardation conducted the following investigation on public psychiatric admissions. The findings reported herein are part of a larger report available from the authors.

The Study

In this study, Level of Care surveying was carried out for cohorts of newly committed patients from each of Virginia's seven psychiatric facilities which serve adults. With its data on patients' physical and psychological levels of care, the Level of Care Survey has been shown to be a reliable and valid planning/assessment tool. In view of its subscales on ability to care for self, dangerousness, community independence, and psychiatric symptomology, it seemed a most appropriate means of examining this issue empirically.

Developed by the New York State Office of Mental Hygiene, the Level of Care Survey is a 138-item survey which (1) measures 18 different areas of functioning and (2) yields an overall assessment of a client's physical and psychological levels of care through a clinically developed decision-making logarithm. Ten additional items drawing information regarding the commitment hearing evaluation were added to the instrument.

The Level of Care Survey was completed by clinical staff from the hospitals some time between a patient's third and fifth day of hospitalization. The assessment, typically made

Continued

* Dr. Gouse (Ph.D., St. Louis University, 1980), Dr. Avellar (Ph.D., University of California, Riverside, 1975), and Dr. Biskin (Ph.D., Michigan State University, 1971) are employees of the Virginia Department of Mental Health and Mental Retardation.

Also in this issue . . .

35/ Symposium on Mental Health and Law
37/ Insanity Defense Plea Task Force Report
39/ In the Virginia Supreme Court
41/ 1983 Legislative Proposals

Continued from page 33

by a social worker, psychologist, or other professional level staff, was designed to reflect a patient's functional level upon admission or shortly thereafter.

The survey was completed for a two-week cohort of adults involuntarily committed to one of Virginia's seven psychiatric hospitals. Children and geriatric patients were omitted because the low number of such admissions would preclude sufficient sample sizes. From the two week period of study, 171 Level of Care Surveys were completed.

Data were analyzed in two separate ways. The first analysis examined the patients from a predominantly clinical orientation and did not attempt to employ legal perspectives on commitment. Herein, data were analyzed in terms of need for hospital-based vs. community-based care. Building in the legal perspective, the second analysis evaluated the accuracy of commitment hearing assessments in terms of compliance with criteria established in Virginia's involuntary commitment laws.

For the first set of analyses, the basic unit of measurement was the percent of cases whose psychological level of care indicated that their behaviors were not so severe as to contraindicate community-based care. On the Level of Care Survey, this is operationalized as Levels 1-4 (on a scale from 1 to 10). Behaviorally, this would indicate that a person:

1. had not shown any recent violent or dangerous behavior (i.e., dangerous to self, others, or property);
2. had not needed any forms of intensive behavior management (e.g., prn medications, physical restraint, time-out, constant observation, etc.);
3. had shown no recent sexually inappropriate behavior;
4. had shown no recent antisocial behavior;
5. showed little evidence of a thought disorder;
6. showed only a low level of impulse control deficits;
7. rarely engaged in inappropriate or annoying behaviors;
8. might show fairly good social skills;
9. might be alert and well oriented to environment;
10. might show a fair degree of self-initiative.

It should be noted that patients in Levels 1-4 were basically identical in the intensity of their psychological level of care needs. While such patients differed in the specific symptomology they presented, the intensity of psychological need they showed relative to intervention was very much the same.

Almost one-quarter of involuntarily committed patients are presenting behaviors that are not so severe as to contraindicate community-based care.

The Results

Across all types of patients, 24.0% of the 171 patients fell in Levels 1-4. For psychiatric (i.e., non-problem drinker) patients, 24.2% (31 of 128) were from these levels. For problem drinkers, this figure was almost identical, with 23.3% classified into Levels 1-4 [X^2 (1) = 0.016, NS].

These results suggest that, independent of type of patient, there are large numbers of involuntarily committed patients who, based solely on clinical matters (as opposed to any legal matters), could have been considered for diversion from the hospital. Almost one-quarter of involuntarily committed patients are presenting behaviors that are not so severe as to contraindicate community-based care.

The second set of analyses evaluated commitment hearing assessment findings against the three criteria which were explicitly set to indicate the appropriateness of an involuntary commitment in Virginia. These three criteria, set in Code of Virginia Section 37.1-67.3, are "(a) presents an imminent danger to himself or others as a result of mental illness or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable."

The criteria for involuntary commitment are used in a two tiered decision-making system. Only if a criterion in the first tier (criterion (a) or (b) above) is met is the second tier of the decision rules applied. The second tier criterion is whether or not involuntary institutionalization is the least restrictive environment.

For every involuntary admission, criteria for both tiers should have been met. This second analysis therefore examined the validity of the assessments that were made in commitment hearing evaluations. For each of the three commitment criteria, a standard was derived from Level of Care Survey subscales to validate the accuracy of the commitment hearing assessment. Accuracy was measured by concordance between the commitment hearing assessment documentation and the Level of Care Survey validation standard. Liberal validation standards were established in order to insure that only those evaluation reports which were clearly unsubstantiated were identified as such. For example, only those cases where dangerousness was asserted but where the Level of Care Survey revealed no security risks (in terms of violent behavior, need for behavior management, depression, suicide, psychotic behavior, grounds privileges, locked wards, etc.) were noted as unsubstantiated.

Data from Table 1 suggest that across types of patients and criteria large numbers of assessments were unsubstantiated. For patients assessed as dangerous, 17.5% of these assertions at the first tier were unsubstantiated by the Level of Care Survey validaton standard. While figures for psychiatric patients and problem drinkers differed slightly (19.2% vs. 13.3% respectively), this difference was not statistically significant [X^2 (1) = 0.504, NS].

Continued on page 42

Sixth Annual Symposium Rescheduled To March 14-15

The Sixth Annual Symposium on Mental Health and the Law has been rescheduled to March 14-15, 1983, in Charlottesville, Virginia. Sponsored by the Virginia Department of Mental Health and Mental Retardation, the Sixth Symposium will consist of addresses on the insanity defense, divorce and child custody disputes, and guardianship, as well as several small workshops. Please see the reverse side for program details.

The Symposium will be held in Caplin Auditorium, University of Virginia School of Law. The cost of registration is $40.00. Interested persons may register by calling (804) 924-5435, or writing to Elaine Hadden at Box 100, Blue Ridge Hospital, Charlottesville, Virginia, 22901.

This year's Symposium is co-sponsored by the University of Virginia's Division of Continuing Education which tentatively has approved the program for 1.2 CEUs. There is an additional charge of $10.00 for registrants desiring CEU credit.

The program is also co-sponsored by the University of Virginia School of Medicine (Office of Continuing Medical Education). As an organization accredited for Continuing Medical Education, the School of Medicine has designated this continuing medical education activity as meeting the criteria for up to 12 hours in Category 1 for the Physician's Recognition Award of the American Medical Association. There is an additional charge of $10.00 for all physicians to cover CME administrative costs.

Keynote Address

Park Elliott Dietz, M.D., M.P.H.
Associate Professor of Law and of Behavioral Medicine & Psychiatry, and Medical Director,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Speakers

Roger M. Adelman, L.L.B.
Assistant United States Attorney and Adjunct Professor of Law
Georgetown University Law Center

Joseph J. Bevilacqua, Ph.D.
Commissioner of Mental Health and Mental Retardation
Commonwealth of Virginia

Richard J. Bonnie, LL.B.
Professor of Law and Director,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Gloria DeCuir, ACSW
State Human Rights Coordinator
Virginia Department of Mental Health and Mental Retardation

Andre P. Derdeyn, M.D.
Professor of Behavioral Medicine & Psychiatry
University of Virginia

Robert E. Emery, Ph.D.
Professor of Psychology
University of Virginia

W. Lawrence Fitch, J.D.
Assistant Professor of Law, General Faculty, and Director Forensic Evaluation Training and Research Center
Institute of Law, Psychiatry & Public Policy
University of Virginia

C. Cooper Geraty, J.D.
Mental Health Law Fellow
University of Virginia

Jane Hickey, J.D.
Assistant Attorney General
Commonwealth of Virginia

Richard P. Lynch, J.D.
Director, American Bar Association
Criminal Justice Mental Health Standards Project
Washington, D.C.

Gary B. Melton, Ph.D.
Associate Professor of Psychology
University of Nebraska at Lincoln

John Monahan, Ph.D.
Professor of Law and Associate Director,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Roberta A. Morris, J.D.
Instructor of Psychology
University of Nebraska at Lincoln

Lawrence J. Raifman, J.D., Ph.D.
Assistant Professor of Law and Legal Medicine,
General Faculty, and Project Director,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Elizabeth S. Scott, J.D.
Assistant Professor of Law and Legal-Administrative Director of the Forensic Psychiatry Clinic,
Institute of Law, Psychiatry & Public Policy
University of Virginia

C. Robert Showalter, M.D.
Associate Medical Director,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Michael A. Solomon, M.D.
Forensic Psychiatry Fellow
University of Virginia

Willis J. Spaulding, J.D.
Director, Mental Health Law Training and Research Center
Institute of Law, Psychiatry & Public Policy
University of Virginia

Janet I. Warren, D.S.W.
Psychiatric Social Worker
Instructor, Division of Social Work
Institute of Law, Psychiatry & Public Policy
University of Virginia

Lois A. Weithorn, Ph.D.
Assistant Professor of Law and Psychology,
General Faculty, and Director of Research,
Institute of Law, Psychiatry & Public Policy
University of Virginia

Registration Form

Name ______________________________ Telephone ______________
last first

Employer ______________________________

Mailing Address ______________________________

____

Fees (check one): ______ $40 regular registration ______ $50 with CEUs ______ $50 with CMEs (all physicians)

Please make checks payable to the Institute of Law, Psychiatry and Public Policy.

Send check with this form to: *Elaine M. Hadden*
Institute of Law, Psychiatry and Public Policy
Box 100, Blue Ridge Hospital
Charlottesville, Virginia 22901

Sixth Annual Symposium on Mental Health and the Law

March 14-15, 1983

Caplin Auditorium, School of Law, University of Virginia

PROGRAM

Monday, March 14, 1983

8:00 a.m. Registration and coffee at Caplin Auditorium

9:00 a.m. Opening Remarks
Richard J. Bonnie, LL.B.

9:15 a.m. Keynote Address:
"The Forensic Evaluation of the President's Assailant"
Park Elliott Dietz, M.D., M.P.H.

10:15 a.m. **"The American Bar Association's Criminal Justice Mental Health Standards Project"**
Richard P. Lynch, J.D.

11:15 a.m. Panel Discussion:
"Should the Insanity Defense Be Abolished?"
Richard J. Bonnie, LL.B., Moderator
Roger M. Adelman, LL.B.
John Monahan, Ph.D.
C. Robert Showalter, M.D.

12:00 noon Lunch Break

2:00 p.m. Workshop 1
"Current Issues in Jail Psychiatry"
Michael A. Solomon, M.D.

Workshop 2
"Expert and Lay Opinion Testimony on Testamentary Capacity"
Roberta A. Morris, J.D.
Willis J. Spaulding, J.D.

Workshop 3
"Recent Changes in the Virginia Insanity Defense"
W. Lawrence Fitch, J.D.

Workshop 4
"Human Rights Regulations in Virginia Mental Health and Mental Retardation Facilities: 1983 Revisions"
Gloria DeCuir, ACSW
Jane Hickey, J.D.

3:30 p.m. Workshop 5
"The Social Worker as an Expert Witness"
Janet I. Warren, D.S.W.

Workshop 6
"Expanded Responsibilities for the Community Mental Health Professional in Civil Commitment"
C. Cooper Geraty, J.D.

Workshop 7
"Evaluating the Effect of Advocacy on Social Security Benefits Based on Mental Disability"
Roberta A. Morris, J.D.

Workshop 8
"Withdrawing or Withholding Life Support Procedures from Incompetent, Terminally Ill Patients"
Willis J. Spaulding, J.D.

5:00 p.m. Recess

Tuesday, March 15, 1983

9:00 a.m. Commissioner's Address
"Serving Justice and Serving the Client: New Problems for Mental Health and Mental Retardation Professionals"
Joseph J. Bevilacqua, Ph.D.

10:00 a.m. **Substitute Decision-Making for Incompetent Persons**
Roberta A. Morris, J.D., Moderator
"Evaluations of Mentally Retarded Persons for Sterilization: Contributions and Limits of Psychological Consultation"
Gary B. Melton, Ph.D.
Elizabeth S. Scott, J.D.
"Legal Criteria and Clinical Assessment in Guardianship Cases"
Lois A. Weithorn, Ph.D.
"Non-Judicial Designations of Substitute Decision-Makers: New Alternatives to Guardianship"
Willis J. Spaulding, J.D.

11:30 a.m. **"Virginia Commitment Law Reform-1983"**
C. Cooper Geraty, J.D.

12:30 p.m. Lunch Break

2:30 p.m. **New Directions in Divorce and Child Custody Resolution**
Elizabeth S. Scott, J.D., Moderator
"Joint Custody: A Perspective"
Andre P. Derdeyn, M.D.
"Family Mediation"
Robert E. Emery, Ph.D.
"Mediational vs. Adversarial Approaches in Divorce and Child Custody Disputes: The Lawyer's Response"
Lawrence J. Raifman, J.D., Ph.D.

5:00 p.m. Adjourn

Insanity Defense Plea Task Force Report

A fifteen member interdisciplinary Task Force appointed by Secretary of Human Resources Joseph Fisher has proposed a comprehensive agenda for re-defining and codifying Virginia's laws relating to the defense of insanity and the disposition of persons acquitted by reason of insanity. The recommendations of the Insanity Defense Plea Task Force were submitted to the Governor in early December and will be presented to the General Assembly for its consideration in 1983.

Although agreeing unanimously to recommend neither the abolition of the defense of insanity nor the creation of a guilty but mentally ill verdict, the Task Force expressed concern about cases in Virginia in which the insanity defense has been improperly invoked in the past and, accordingly, focused its attention on refinements in the defense that might reduce its potential for abuse. Two major weaknesses in the current insanity defense law were identified: the limited utility and questionable validity of the irresistible impulse test and the absence of any clear guidance as to the sorts of mental disorders that may qualify as mental disease within the meaning of insanity.

The majority of the Task Force concluded the irresistible impulse instruction opens the door to moral mistakes in the administration of the defense in cases involving "temporary berserkness" or "loss of control" by otherwise normal individuals—conditions that most observers agree rarely rise to the level of legal insanity. Furthermore, the observation was made that because of the elusiveness of the concept of volitional impairment, experts are invited to testify on issues beyond their expertise, such as whether an "impulse" was "irresistible" or was merely "unresisted." For these reasons, the Task Force recommended the elimination of the irresistible impulse test.

The Cognitive Test

An essential corollary to the Task Force's proposal to eliminate the irresistible impulse defense, however, is its proposed redefinition of the cognitive test for insanity in Virginia. Some severely disordered, psychotic defendants may "know" right from wrong in a superficial, intellectual sense but may not have a meaningful understanding of the significance of their conduct, the Task Force observed. In order to make it clear that the defense is meant to be available to such defendants, the Task Force proposed that the language "was unable to appreciate the wrongfulness of his conduct..." be used to define the level of cognitive impairment required for insanity. This language has been incorporated into the insanity laws of most jurisdictions in recent years and is universally supported by legal scholars and mental health experts.

The Task Force recommended the elimination of the irresistible impulse test.

The Task Force also recommended that that part of the existing cognitive test requiring that the defendant not "understand the nature, quality, and consequences of his act" be eliminated because it is superfluous. The significance of a defendant's failure of perception (not knowing what he was doing or understanding its consequences) lies in the fact that such misperceptions render him unable to appreciate the wrongfulness of his conduct, the Task Force reasoned. Moreover, it observed, cases in which a defendant truly did not know what he was doing at the time (for example, a defendant who strangles someone thinking he is squeezing a lemon) simply do not arise.

Mental Disease

With regard to the question of what should constitute mental disease for the purposes of the insanity defense, there was a clear consensus among the Task Force members that only major mental disorders involving a significant impairment of the defendant's understanding of reality should suffice. Personality disorders should not be permitted to serve as the predicate for an insanity defense, the Task Force concluded. The Task Force also concluded that mental disturbances caused primarily by self-induced intoxication should never be permitted to establish the "mental disease" required for the insanity defense. The Task Force recognized that cases occasionally arise in which an intoxicating substance voluntarily ingested will activate a latent mental disorder which may then form the basis for an insanity defense, but it pointed out that such cases should not be affected by its proposed provision because the relevant mental impairment in these cases is primarily attributable to the underlying mental disorder, not the intoxicating substance.

In a further effort to prevent insanity acquittals based on mental disorders legally insufficient to satisfy the mental disease or mental retardation requirement, the Task Force proposed a procedure that would provide for a pretrial judicial screening of the evidence proffered by the defense in support of the insanity plea to determine whether such evidence would be legally sufficient, if not controverted, to establish that the defendant had a mental disease or was mentally retarded at the time of the offense. If the court determined that the evidence proffered, even if true, was not legally sufficient to establish the predicate for insanity, the defense would be precluded from presenting such evidence to the jury.

Jury Instructions

Another matter addressed by the Task Force relating to the administration of the insanity defense was whether the defendant should be entitled to an instruction to the jury concerning the consequences of an acquittal by reason of insanity. After much debate, the Task Force concluded that, because the verdict of insanity speaks in terms of "acquittal," some jurors might believe that such a

Continued

The Task Force proposed that the language "was unable to appreciate the wrongfulness of his conduct . . ." be used to define the level of cognitive impairment required for insanity.

Continued from page 37
verdict would result in the defendant's automatic release and, therefore, might be inhibited from giving full consideration to the defense of insanity. Accordingly, the Task Force proposed that the defendant be entitled, upon request, to an instruction to the jury concerning the consequences of an insanity acquittal.

There is a constitutional requirement that commitment of an insanity acquittee under special procedures less libertarian than ordinary civil commitment procedures be predicated on a finding that the acquittee committed the otherwise criminal act (and, therefore, poses a special threat of danger to others). In recognition of this, the Task Force proposed that, before considering a defendant's plea of insanity, the jury be required to find beyond a reasonable doubt that the defendant engaged in an act that would have constituted a particular criminal offense had the defendant not been insane.

Expert Opinion

With regard to the question of who should be permitted to offer expert opinion concerning a defendant's mental state at the time of the offense, the Task Force concluded that more should be taken into account than simply whether the professional's training satisfies the educational requirements established by the statute. Given the special difficulties presented by the use of mental health opinion in criminal cases—including, perhaps most significantly, the fact that very few mental health professionals receive any meaningful training in forensic evaluation as part of their regular professional education—the Task Force was of the opinion that the General Assembly should establish a set of guidelines for judges to follow in qualifying mental health professionals to testify as experts in criminal proceedings. The guidelines recommended would permit testimony only by a qualified psychiatrist, neurologist, or psychologist who has received specialized training concerning the performance of forensic evaluations and who has performed a direct examination of the defendant.

A related issue addressed by the Task Force was the appropriate scope of the expert's testimony on the question of mental state at the time of the offense. The Task Force noted that the trend seems to be toward a recognition that the mental health professional who is qualified by education, training, and experience and who has conducted an appropriate evaluation may possess specialized knowledge beyond the ken of the lay person sufficient to permit him to respond to the particular factual components of the psycho-legal question presented. This is the position of the Federal Rules of Evidence (Rule 704) and is the position taken by the Task Force in its recommendations to the Secretary of Human Resources. While the Task Force would permit the expert to provide testimony that "embraces an ultimate issue of fact to be decided by the trier of fact," it would preclude the expert from stating a "legal conclusion, including but not limited to an opinion stating whether the defendant was or was not insane at the time of the offense."

Related Laws

In recommending codification of the insanity defense, the Task Force was sensitive to the existence of related laws that should be considered for codification as well. It concluded that if the insanity defense were codified, the other major, traditionally recognized defense relating to the defendant's mental state at the time of the offense—the so-called automatism, or unconsciousness, defense—also should be codified. The Task Force felt that codification of this defense was particularly appropriate in light of the proposed elimination of the irresistible impulse defense, because autômatism and irresistible impulse sometimes are confused and it should be clear that the elimination of one does not signal a rejection of the other.

The automatism defense focuses on the actus reus element of the crime and essentially stands for the proposition that if the defendant did not have conscious physical control of his otherwise criminal act at the time that he committed it, he should not be held criminally responsible for the act. The most common examples of "automatic" or unconscious acts are those committed during an epileptic seizure or during an episode of sleepwalking. Although the automatism defense is very rarely invoked, it is well established in the common law in Virginia and throughout the Anglo-American world. The provision proposed by the Task Force employs the language of the Model Penal Code, which has been adopted in approximately two-thirds of the states.

Disposition of Acquittees

Faced with an assortment of constitutional, political, and practical concerns relating to the disposition of insanity acquittees, the Task Force carefully reviewed Virginia's present

Continued on page 40

Developments in Mental Health Law

is distributed as a public service by the Institute of Law, Psychiatry and Public Policy, with the support of funds from the Virginia Department of Mental Health and Mental Retardation. The opinions expressed do not necessarily reflct the official position of either the Institute or the Department.

Developments in Mental Health Law is distributed free of charge on a quarterly basis. If you are not currently on our mailing list but would like to receive the newsletter, please send full name and address with your subscription request to: Box 100 - Blue Ridge Hospital, Charlottesville, Virginia 22901. We also welcome your suggestions and comments.

Editor
Willis J. Spaulding
Managing Editor
Elaine M. Hadden
Assistant Managing Editor
Linda P. Seaborn

In the Virginia Supreme Court

Among the decisions handed down on December 3, 1982, by the Virginia Supreme Court were three of particular interest.

Guardianship

• In **Schmidt** v. **Goddin**, No. 811750, ___Va. ___ (1982), the Court heard the appeal of a Richmond man who had been adjudicated incompetent and involuntarily committed to a private psychiatric facility in 1953. In 1981, with the assistance of his children, he unsuccessfully petitioned the lower court for removal of his guardian and release from the hospital.

While the lower court's opinion implied that the guardian, Goddin, appointed in 1953 only for the purpose of managing Schmidt's estate, had the authority to "volunteer" Schmidt into the hospital and authorize his continued detention there, the Supreme Court refused to consider the legality of Schmidt's detention beyond concluding that his admission was governed by Va. Code §37.1-67.2.

Much confusion in this case was attributable to the language in 1974 Va. Laws ch. 351 which provided that patients like Schmidt committed under the pre-1974 commitment law became "voluntary" under §37.1-65 on November 1, 1974, unless re-committed under the new libertarian procedure. Around this time the hospital apparently converted Schmidt's status to "voluntary," although the parties seem never to have understood why this happened.

The case may have been further complicated by language in §37.1-65 which until 1976 authorized guardians to volunteer their wards into hospitals. This language was deleted by 1976 Va. Laws ch. 671, although such admissions have not yet been prohibited expressly. The question of whether an "incompetent" patient, whose status became voluntary in 1974 by statute, can obtain his discharge seems not to have been addressed squarely by the Court. The Court's decision to view, however incorrectly, his admission as governed by §37.1-67.2 and to declare his petition for habeas corpus moot suggests strongly that Schmidt did have the right since 1974 to leave the hospital, despite the desire of his guardian that he remain there.

The Court turned away Schmidt's attempt to have his competency restored and in doing so provided some interpretation of the guardianship law.

Current law in §37.1-134.1 which sets forth a procedure for the restoration of competency and removal of a guardian contains neither an explicit standard of proof nor allocation of the burden of proof. Nor does it require the consideration of the "least restrictive alternative" as the statutes, such as §37.1-128.01, now require for initial determination of guardianship.

The Court was satisfied that despite conflicting testimony the trial judge's finding that Schmidt was still incompetent was "supported by the evidence." The Court declined to consider what standard of proof ought to be employed at the trial. But it did make clear that the elaborate procedural safeguards now provided in the initial determination of competency had no place in restoration proceedings under §37.1-134.1, despite the fact that in 1953 when Schmidt's guardian was appointed, he was accorded little in the way of due process.

The Court approved the trial judge's exclusion of Schmidt from the courtroom. It distinguished **Vitek** v. **Jones** 445 U.S. 480 (1980) and **Evans** v. **Paderick**, 143 F. Supp. 583 (E.D. Va. 1977), by finding that the presence in the courtroom of the committee, guardian ad litem, his children, and their attorney, and the possibility that Schmidt's hearing the hospital staff's testimony would injure his therapeutic relationship with the staff permitted the exclusion. The Court's reasoning is susceptible to being extended to other proceedings in Virginia such as civil commitment.

Reimbursement

• In **Commonwealth** v. **Jenkins**, No. 801980, ___Va. ___ (1982), the Court found a forensic patient committed under former Va. Code §19.2-169 liable for the costs of his hospitalization. The former patient had argued and the lower court had agreed that he was really an "inmate" awaiting trial and, as such, not liable for the costs of his detention in the state hosptial.

The Court reasoned that after Jenkins' evaluation for competency to stand trial (for which the State did not seek reimbursement), he was civilly committed and treated like any other civilly committed patient. Therefore he was liable to the same extent under §37.1-105, for the costs of his hospitalization.

The poorly developed facts of this case apparently precluded the Court's consideration of Jenkins' claim that his hospitalization after being found incompetent to stand trial was unconstitutional.

Defendants like Jenkins currently are committed specifically for the purposes of "restoring" their competency to stand trial under §19.2-169.2. Only if, after treatment, they are found "unrestorable" are they likely to face commitment under §37.1-67.1. Thus the Court's decision in **Jenkins**, insofar as it rests on the fact that Jenkins was "civilly" committed, pending trial, under §37.1-67.1, would not impose liability on defendants "criminally" committed under the new forensic evaluation law's §19.2-169. (or §19.2-169.6).

Criminal Intent

• A defendant claiming self-defense in the shooting of his father was entitled to introduce the testimony of a social worker on the defendant's good character. The trial judge's refusal to allow the testimony of a social worker led the Supreme Court to reverse the conviction and order a new trial in **Barlow** v. **Virginia**, No. 811623, ___Va. ___ (1982).

Barlow had attempted to introduce the testimony of a social worker with York County Social Services to the effect that Barlow had no reputation in the community for violence. The Court held that evidence of the defendant's reputation for being peaceable is admissible insofar as it tends to negate the mens rea required for a murder conviction. □

Continued from page 38
statute governing the commitment of insanity acquittees and set for itself three objectives: (1) to put the statute on a sound constitutional footing; (2) to enable the supervision of acquittees who are released from inpatient care (and establish procedures for the rehospitalization of conditionally released acquittees whose conditions deteriorate); and (3) to otherwise improve and clarify the provisions of the statute. The members of the Task Force unanimously agreed that so long as the insanity acquittee has been proven beyond a reasonable doubt to have committed an otherwise criminal act, society is justified in treating him somewhat differently for the purposes of commitment than it treats persons subject to ordinary civil commitment (in order to account for the increased likelihood of the acquittee's dangerousness). However, it recognized that there are limits to the extent of differential treatment that is acceptable, and it fashioned a set of procedures that reflects this.

The Task Force debated at length the appropriate criteria for the commitment of insanity acquittees and concluded that commitment should be based on a finding that the acquittee is "mentally disordered or otherwise mentally disabled" and sufficiently likely to engage in "criminal conduct presenting a danger of bodily injury to other persons or serious damage to property in the foreseeable future." The Task Force selected the terminology "mentally disordered or otherwise mentally disabled" to enable a broader criterion for commitment than would be possible if "mental disease or mental retardation" (the insanity language) were used. This was done to assure a basis for the commitment of disordered persons whose insanity acquittals were based on borderline mental disease or retardation. The recommendation to require that both a mental disability and dangerousness to others be established was unanimous. Commitment on the basis of mental disability alone, or mental disability plus dangerousness to self or inability to care for self, was specifically rejected because it was felt that commitment under these special procedures was constitutionally acceptable only if predicated on the dangerousness to others implied by the finding that the acquittee committed an otherwise criminal act. The Task Force was of the opinion that commitment on the basis of dangerousness alone amounted to nothing more than preventive detention, and it concluded that, constitutional considerations aside, commitment on such a basis would permit an inappropriate and intolerable use of hospital beds sorely needed for the treatment of mentally disabled persons.

The guidelines recommended would permit testimony only by a qualified psychiatrist, neurologist, or psychologist who has received specialized training concerning the performance of forensic evaluations and who has performed a direct examination of the defendant.

An important feature of the proposed provision is its specific recognition that an acquittee whose mental disability is in remisson may still be considered mentally disabled for the purpose of commitment under these procedures if there is reason to believe that the acquittee's condition will deteriorate in the foreseeable future if treatment is not continued. This provision is designed to guard against the premature release of the acquittee whose disorder responds rapidly to treatment but who is subject to relapse if treatment is discontinued.

Under the proposed provisions, an insanity acquittee would qualify for conditional release so long as (1) he meets the criteria for commitment, (2) there is no significant reason to believe that he could not be supervised and treated on an outpatient basis, (3) outpatient services are available, and (4) there is no significant reason to believe that the acquittee, if released, would fail to comply with the conditions of release. The provision explicitly requires the designation of an agency, facility, or person to supervise the conditionally released acquittee and monitor his compliance with the terms of conditional release. Furthermore, the provisions require this supervisor to submit written reports concerning the acquittee's progress no less frequently than every six months.

The provisions set out procedures for the periodic review of every acquittee's case and for the consideration of conditional release for hospitalized acquittees who apply for such release or for whom the hospital director so requests. They also set out procedures for the modification of conditions of release (to accommodate changed conditions) and the revocation of conditional release (should inpatient care become necessary).

The members of the Task Force were closely divided on the question of who should be responsible for making decisions regarding conditional release and discharge of insanity acquittees (after the initial commitment by the court). Some felt that this responsibility should remain, as it now is, with the committing court. Others felt that this authority should be conferred on an interdisciplinary, quasi-judicial board similar to a parole board. Although it was generally agreed that such a board likely would result in improved decision-making at the post-commitment stage, a number of Task Force members felt that, given the small number of insanity acquittals each year in Virginia, the creation of such a specialized bureaucracy could not be justified. The Task Force acknowledged the praise that has been accorded Oregon's Psychiatric Security Review Board, on which Virginia's board would be modeled, but it also took note of the fact that many more defendants are acquitted by reason of insanity in Oregon than in Virginia. Ultimately, the Task Force resolved to propose alternative statutes reflecting each of these two approaches.

With regard to the duration of commitment, the Task Force concluded that, because of the necessary relationship between the acquittee's having committed an otherwise crimi-

Continued on page 44

1983 Legislative Proposals

Natural Death Act

Established by the 1982 General Assembly's House Joint Resolution No. 115, the Joint Subcommittee Studying the Rights of the Terminally Ill is expected to produce a bill this year which would establish a Natural Death Act. In the words of the draft of the Act (December 1982), its purpose is to protect the "dignity, privacy, and sanctity of terminally ill persons" by permitting them to give oral or written instructions for the removal of "life-prolonging procedures." The application of the Act to mentally incapacitated persons is left quite uncertain in the draft. The Act declares it does not "prevent" certain kinds of surrogate decisionmaking for patients incapable of "communication." But even with respect to this class of patients, the Act does not authorize any procedure and, as drafted, leaves the matter to existing guardianship statutes and the common law, the confused state of which led to the creation of the Joint Subcommittee.

Because of the complexity of the decision to be allowed to die and the likelihood that the patient's decisionmaking will be impaired, the process of determining competency, appointing a surrogate decisionmaker, and guiding the decisionmaker are essential factors to any "Natural Death Act" but seem to have been overlooked by the Subcommittee.

Also overlooked by the Subcommittee are the good possibilities for making relatively minor changes to existing statutes to permit patients to choose a "natural death."

For example, competent persons might authorize others to consent to the withdrawal of medical procedures under a durable power of attorney. An amendment to Va. Code § 11-9.1, which authorizes powers of attorney which survive incompetency (i.e., "durable" powers of attorney), could provide specifically for their use in medical decisionmaking and permit, in the case of incompetent, terminally ill patients, the attorney-in-fact to consent to withholding or withdrawal of medical services where it is in the patient's best interests.

Va. Code § 37.1-134.2 easily could be amended to permit judicial authorization of "DNR," "no code," or "slow code" orders or the withdrawal of medical services to which the patient is unable to consent, where the physician testifies that the patient is terminally ill and such a decision is in his best interests. Also, features of § 37.1-134.2 which permit the court in effect to adjudge the patient to be conclusively capable of giving informed consent are well suited for reviewing the decisions of patients whose decisionmaking capacity is in doubt. § 37.1-134.2's defect is that it does not employ a surrogate decisionmaker independent of the physician and the court. But on the other hand, its procedures are neither so expensive nor so time-consuming as judicial guardianship procedures, and unlike an "administrative" guardianship procedure (where the physician or a hospital review panel appoints a surrogate when the patient is felt to be incompetent), legal representation and judicial review are assured under §37.1-134.2. Cases like **Superintendent of Belchertown State School v. Saikewicz**, 370 N.E. 2d 417 (Mass. 1977), have required judicial review of a decision to withhold life-prolonging procedures even where a judicially appointed guardian has been appointed and is willing to consent to the withholding.

Civil Commitment

Since 1974 when the Virginia civil commitment laws were reshaped along libertarian lines, there have been complaints that judges and court-appointed defense lawyers were ignoring procedural safeguards of the law and permitting the commitment of persons who did not meet the statutory criteria of commitment. There were in addition reports (such as that based on a level of care survey summarized elsewhere in this issue) that most of the patients committed under the parens patriae criterion of "so seriously mentally ill as to be substantially unable to care for himself" did not meet that criterion and did not otherwise need hospitalization. Finally, concern has been expressed over the rising costs of pre-trial hospitalization, often in private facilities. As a consequence, the 1982 General Assembly, in House Joint Resolution No. 73, charged its Joint Subcommittee on Mental Health and Mental Retardation with conducting public hearings on civil commitment and preparing corrective legislation for the 1983 Session.

The most recent draft to emerge from the subcommittee, prepared by Delegate Warren G. Stambaugh of Arlington, suggests that the General Assembly will be presented with a good opportunity this year to undertake a complex and thoroughgoing overhaul of the civil commitment statutes. Highlights of the bill likely to be introduced by members of the Subcommittee follow.

- **Tougher standards for the issuance of temporary detention orders.** The present law allows for the temporary detention of anyone "mentally ill and in need of hospitalization," but requires an additional finding (e.g., "dangerousness") for commitment. The proposal may employ the commitment criteria as standards for temporary detention.
- **More precision in both the police power and parens patriae standards of commitment.** The police power criterion would require proof of a "recent overt act or threat" as evidence of dangerousness. The parens patriae criterion would require a showing of a substantial inability to "provide for himself or secure from others his minimally adequate nutritional, clothing, shelter, or safety needs."
- **Introduction of a new criterion of commitment.** In contrast to increased restrictiveness of the traditional criteria of commitment, the bill may contain a third alternative grounds of commitment based on a likelihood that the defendant will "suffer substantial mental or emotional deterioration" if not

Continued on page 43

Table 1
Percent of Unsubstantiated Assessments for First Tier Criteria

Criteria	Psychiatric Patients	Problem Drinkers	Total
Unsubstantiated Dangerousness Assessment[1]	19.2% (14/73)	13.3% (4/30)	17.5% (18/103)
Unsubstantiated Selfcare Problem Assessment[2]	32.0% (31/97)	14.8% (4/27)	28.2% (35/124)

1 - Dangerousness asserted, but unsubstantiated by Level of Care data.
2 - Substantial inability to care for self asserted, but unsubstantiated by Level of Care data.

Table 2
Percent of Unsubstantiated Admissions by Criteria

Criteria		Psychiatric Patients	Problem Drinkers	Total
First Tier Only	Unsubstantiated Dangerousness Assessments	0.0% (0.0%)	0.0% (0.0%)	0.0% (0.0%)
	Unsubstantiated Selfcare Problem Assessment	10.8% (32.4%)	2.8% (8.4%)	8.8% (26.6%)
	Unsubstantiated Dangerousness and Selfcare Problem Assessments	1.8% (5.4%)	2.8% (8.4%)	2.0% (6.0%)
First and Second Tier	Unsubstantiated Dangerousness and LRE Assessments	0.9% (2.7%)	0.0% (0.0%)	0.6% (1.8%)
	Unsubstantiated Selfcare Problem and LRE Assessments	5.4% (16.2%)	0.0% (0.0%)	4.1% (12.4%)
	Unsubstantiated Dangerousness, Selfcare Problem, and LRE Assessments	0.9% (2.7%)	0.0% (0.0%)	0.6% (1.8%)
Second Tier Only	Unsubstantiated LRE Assessment	13.5% (40.5%)	27.8% (83.2%)	17.0% (51.4%)
Overall	Percent of Total Commitments That Are Unsubstantiated	33.3%	33.4%	33.1%

For each cell, the top percentile figure refers to the percent of the total admissions (for a given type of patient) that were unsubstantiated. The second percentile figure, set off in parentheses, refers to the percent of unsubstantiated admissions that fall into that class.

Continued from page 34

Approximately 28.2% of assessments where inability to care for self was cited were unsubstantiated by the Level of Care Survey validation standard. Inability to care for self was stipulated for 27 of 43 problem drinkers (62.8%) and was unsubstantiated for only 4 of those 27 (14.8%). Inability to care for self was attributed to 75.8% of the psychiatric patients and, of those, 32.0% were unsubstantiated. Again, the difference between these two groups in terms of unsubstantiated assessments was nonsignificant [$X^2(1) = 3.064$, NS].

Table 2 presents the accuracy of assessments for the two tiers simultaneously. Each row presents the frequency with which a combination of criteria were unsubstantiated. Before discussing the findings of Table 2, however, a key feature of this data should be noted. Cases where both first tier criteria were asserted, but where only one of the two was actually substatiated, are treated herein as substantiated at the first tier. This, in combination with some missing data, makes comparison with percentages from Table 1 inappropriate.

For psychiatric patients, 33.3% of all commitments were unsubstantiated at one or both tiers. The largest class of unsupported findings was from the second tier, i.e., the least restrictive environment (LRE) assessments. Approximately 14% of the psychiatric commitments were unsubstantiated at the second tier. Of just the unsubstantiated assessments, 40.5% were not supported for the LRE criterion. Though one of the primary criteria might have been met, these cases still had unsubstantiated LRE assessments. The next largest class of unsubstantiated assessments for psychiatric patients was self-care assessments, with 10.8% of the psychiatric commitments falling into this first tier only category (32.4% of the unsubstantiated assessments). For another 5.4% of the psychiatric commitments, both a self-care assessment and the LRE assessment were unsupported (16.2% of the unsubstantiated assessments).

The remaining 10.8% of the unsubstantiated psychiatric commitments involved unsupported dangerousness

Continued

Continued from page 42
assessments. In combination with an unsupported self-care assessment, unsubstantiated dangerousness was found in 5.4% of the unsubstantiated psychiatric assessments (1.8% of the psychiatric commitments). Both dangerousness and LRE assessments were unsupported in 2.7% of the unsubstantiated assessments (0.9% of the psychiatric commitments). Finally, an equally small percentage of cases (2.7% of the unsubstantiated psychiatric assessments; 0.9% of the psychiatric commitments) had unsupported assessments in dangerousness, self-care, and LRE.

For problem drinkers, the picture was quite different. While the percent of commitments that were unsubstantiated was almost identical to that of the psychiatric patients (33.4% vs. 33.3%), the majority of these unsubstantiated assessments were at the second tier only (i.e., LRE). For 83.2% of the unsubstantiated assessments for problem drinkers, the only problem was an unsubstantiated LRE assessment.

These results show that large numbers of admissions are unsupported with respect to the involuntary commitment criteria which have been established. This problem is particularly acute with regard to LRE and inability to care for self. These findings suggest that (1) the criteria by which commitment decisions are made are unclear and/or (2) the existing structures of commitment hearing evaluations are insufficient for assuring a thorough and valid assessment of the need for involuntary commitment.

If the commitment hearing evaluation is to be an effective means of preventing inappropriate admissons, it will be necessary to operationalize more precisely the criteria for commitment, especially for ability to care for oneself and for the least restrictive treatment environment. Failure to specify exactly what is meant by inability to care for self or to identify the appropriate dimensions for determining what is the least restrictive treatment environment will result in (1) evaluations becoming perfunctory and/or (2) the labels becoming legally meaningless grab bags.

Beyond specification of commitment criteria, provisions and procedures for commitment hearing evaluations may need to be modified. Such evaluations must go beyond the traditional mental status examination. Input from informants such as the family, the petitioner, and/or community program staff is needed for an examiner to make a determination of ability to care for self. Similarly, a determination of what is the least restrictive treatment environment cannot properly be made without talking to staff from programs in the patient's community of residence. □

Note

[1]Furman, W., and D. Lund. "The Assessment of Patient Needs: Description of the Level of Care Survey." New York Office of Mental Health (1977); and Rosen, B., and M. Cohen. "Computer Derived Levels of Care (Care 10) and the Clinical Course of Acute Psychiatric Patients: A Validation Study" Ripple, No. 11, pp. 8-11 (1978).

Forensic Training

The Forensic Evaluation Training and Research Center continues to offer training designed to acquaint mental health professionals with the Virginia criminal justice system and the types of evaluations requested by the criminal courts. (See the April-June, 1982, issue of **Developments** for a more detailed description.)

The training is provided under contract with the Department of Mental Health and Mental Retardation. The Department encourages the participation of psychiatrists, psychologists, and social workers affiliated with community mental health centers. CMHC professionals need pay only a minimal fee to cover the cost of printed materials.

The training program consists of six days of instruction at the Institute's facility in Charlottesville and a seventh day of supervised evaluations at Central State Hospital in Petersburg. The program is offered every two months. For more information, please contact Larry Fitch at (804) 924-5435, Forensic Evaluation Training and Research Center, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901.

Continued from page 41
treated. This criterion permits commitment of persons who will benefit from treatment but who are not necessarily dangerous or unable to care for themselves.

- **Brief, non-judicial pre-trial detention by medical certification.** The bill will probably propose to authorize physicians and psychologists to order detention for up to four hours while a formal petition for commitment is filed.

- **Earlier judicial review and appointment of counsel.** Under present practice, the first hearing is often the commitment hearing, with defense counsel appointed only minutes before. The proposal would call for a preliminary hearing within twenty-four hours of detention where probable cause for commitment and for detention pending the commitment hearing would be considered, and counsel would be appointed.

- **A longer maximum period of temporary detention.** After the preliminary hearing the defendant might be detained and treated for an additional seventy-two hours. Since he may have been in custody as long as twenty-four hours before the preliminary hearing, and under the proposal may be entitled to one continuance of twenty-four hours, the pre-trial detention might be as long as six days, roughly twice as long as the present maximum period of pre-trial detention (forty-eight hours, or seventy-two hours, if that period ends on a weekend or holiday). Stricter standards for detention and earlier judicial review, however, may reduce the number of persons who are actually detained this long. Better pre-trial preparation by defense counsel permitted by this longer period of pre-trial detention may also reduce the commitment rate.

- **Consolidation of pre-admission screening and court-appointed evaluation.** The bill may give community mental health clinics and community services boards complete responsibility for conducting an evaluation of the patient which includes a survey of available placements less restrictive than the hospital. The services boards would also have the responsibility for designating the facilities to which the patient could be taken for evaluation or treatment prior to trial. □

Continued from page 40

nal act and his commitment under these special procedures, the maximum period of commitment under these special procedures should not exceed the maximum term to which the acquittee might have been sentenced had he been convicted of the act which he was found to have committed. (A number of courts have held that such a limitation is constitutionally required.) Furthermore, the Task Force reasoned, because few criminals are sentenced to or actually serve the maximum terms for their offenses, limiting the period of commitment on this basis alone is insufficient. Rejecting "formula" proposals (such as limiting the commitment period to the time that the acquittee would have had to serve before becoming eligible for parole if he had been sentenced to the maximum term for the applicable offense), the Task Force selected fifteen years as the outer limit on commitments under these special procedures. (Of course, anyone released from such a commitment may become the subject of commitment proceedings under §37.1-67.3 or certification proceedings under §37.1-65.1.)

Pretrial Forensic Services

In addition to proposing new procedures for the administration of the insanity defense and the commitment of insanity acquittees, the Task Force addressed a number of issues relating to the provision of pretrial forensic services. The most significant of its recommendations in this regard concern the performance of evaluations in connection with capital sentencing proceedings and procedures for the therapeutic hospitalization of pretrial jail detainees.

The proposed capital sentencing evaluation provision would authorize the court to order an evaluation of a capital defendant to assess (1) whether the defendant acted under extreme mental or emotional disturbance at the time of the offense, (2) whether the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law was significantly impaired, and (3) whether there are any other factors in mitigation relating to the history or character of the defendant or the defendant's mental condition at the time of the offense. The provision also explicitly sets out the procedures and protections applicable during the capital sentencing evaluation.

The proposed hospitalization provision would permit the voluntary admission of jail detainees who were determined by the court to be mentally ill and in need of treatment in a hospital rather than the jail. Involuntary admissions would be possible only pursuant to procedures similar to ordinary civil commitment procedures.

— **W. Lawrence Fitch**

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
Charlottesville, VA. 22901

Non-Profit Organization
U.S. Postage Paid
Permit No. 160
Charlottesville, Virginia
22901