Developments in Mental Health Law

The Institute of Law, Psychiatry & Public Policy — The University of Virginia

Volume 21, Number 1 (December 2001)

Mandated Community Treatment: Beyond Outpatient Commitment

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Mandating adherence to mental health treatment in the community through outpatient commitment is among the most contested issues in mental health law. Outpatient commitment refers to a court order that directs a person who has a serious mental disorder to adhere to a prescribed community treatment plan and to be hospitalized for failure to do so if the criteria for involuntary hospitalization are met. Although 39 U.S. jurisdictions have statutes that nominally authorize outpatient commitment, until recently few states made substantial use of these laws. With the 1999 enactment in New York State of "Kendra's Law," nationwide interest in -- and controversy over—outpatient commitment has soared.

Also in this issue:

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In many states a take-no-prisoners battle is under way between advocates of outpatient commitment -- who call this approach assisted outpatient treatment -- and its opponents -- who use the term "leash laws." Much of the strident policy debate on outpatient commitment treats this approach as if it were simply an extension of inpatient commitment, and places outpatient commitment within the same conceptual framework that has historically been used to analyze commitment to a mental hospital. In fact, however, outpatient commitment is only one of a growing array of legal tools that is being used to mandate treatment adherence in the community. Only in relation to these other forms of mandated treatment in the open community, rather than to the body of law and policy developed for confinement in an inpatient facility, can outpatient commitment be adequately understood.

The purpose of this article is to inductively elaborate a new and broader conceptual framework for the various forms of mandated community treatment. First, we review what is known about the variety of influences that are brought to bear on a patient's choice of whether to accept mental health services in the community. Second, we discuss what needs to be known about these various forms of mandated treatment so that their potential role in mental health law and policy can be properly assessed.

People who have severe and chronic mental disorders often interact with the social welfare system and with the judicial system. In both of these contexts, such individuals face loss of liberty, property, or other valued interests if they fail to adhere to prescribed

Developments in Mental Health Law

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

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ISSN 1063-9977

treatment. The "leverage"[1] that is applied by these systems is typically accompanied by assertive community treatment, a mode of service delivery that itself blurs the distinction between voluntary and coerced treatment.[2] Facing such pervasive constraints, patients may attempt to maximize their own control.

MANDATED TREATMENT INVOLVING THE SOCIAL WELFARE SYSTEM

People with mental disabilities may qualify under federal or state laws to receive monetary payments and subsidized housing. It appears that both of these benefits are being used as leverage to ensure that beneficiaries adhere to mental health treatment in the community.

Money as leverage

A recent survey found that 70% of the U.S. population believes that people with diagnoses of schizophrenia are "not very able" or "not able at all" to manage their money[3]. Such beliefs underlie the inclusion of people who have mental disorders in programs that regulate the disbursement of social welfare benefits. For example, recipients of Supplemental Security Income or Social Security Disability Insurance may have a representative payee appointed to receive their checks. Representative payees can ensure that the individual's basic needs are met by directly paying for rent and food. Of the 1.2 million people who receive disability benefits for a mental disorder, 45% have a representative payee.[4]

Representative payees are usually appointed for people who have schizophrenia, people with a co-occurring substance use disorder, those with a history of mishandling money, or homeless persons.[5] The representative payees are usually family members, but organizations often serve this function.[6]

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[1] E. Susser, *"Coercion" and leverage in clinical outreach,* COERCION AND AGGRESSIVE COMMUNITY TREATMENT. Edited by D. Dennis, John Monahan. New York, Plenum. (1996).

[2] M. Neale, and R. Rosenheck, *Therapeutic limit setting in an assertive community treatment program,* PSYCHIATRIC SERVICES, *51:499*–505, (2000).

[3] B. Pescosolido, J. Monahan, B. Link B, *et al., The public's view of the competence, dangerousness, and need for legal coercion among persons with mental illness,* AMERICAN JOURNAL OF PUBLIC HEALTH, *89:1339*–1345 (1999).

[4] Personal communication to L. Kennedy, (2000).

[5] K.J. Conrad, M.D. Matters, P. Hanrahan, et al. ,*Representative payee for individuals with severe mental illness at community counseling centers of Chicago,* ALCOHOLISM TREATMENT QUARTERLY, *17:169*–186 (1999); M.I. Rosen, and R. Rosenheck, *Substance use and assignment of representative payees*, PSYCHIATRIC SERVICES, *50:95*–98 (1999).

[6] S.H. Cogswell, ENTITLEMENTS, PAYEES, AND COERCION, IN COERCION AND AGGRESSIVE COMMUNITY TREATMENT.

Representative payee programs have been found to reduce the number of hospital days,[7] to increase adherence to outpatient treatment,[8] and to decrease homelessness.[9] Patient satisfaction with these programs tends to be high.[10]

A study that surveyed representative payee programs of mental health centers in Illinois found that disbursement was at least "moderately" contingent on avoidance of substance abuse in 71% of the programs — and was "tightly" linked in 31% of programs — whereas receipt of benefits was at least moderately contingent on adherence to mental health treatment in 55% of the programs and tightly linked in 17% of the programs.[11] Similar results were found in Washington State.[12]

Thus disbursement of social welfare benefits to people who have a mental disorder through a representative payee is used frequently and appears to be associated with a variety of positive outcomes. In a majority of representative payee programs, some relationship exists between treatment adherence and receipt of funds; in a substantial minority of programs this relationship approaches a *quid pro quo* status.

Housing as leverage

A recent survey found that a person with a mental disorder who is living solely on disability benefits would not be able to afford the fair market rent for a "modest" efficiency apartment in any area of the United States.[13] To avoid homelessness in this population, the

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Edited by D. Dennis, and J. Monahan. New York, Plenum (1996).

[7] D.J. Luchins, P. Hanrahan, K.J. Conrad KJ, *et al. An agency-based representative payee program and improved community tenure of persons with mental illness,* PSYCHIATRIC SERVICES, *49:1218*–1222 (1998).

[8] R.K. Ries, and K.A. Comtois, *Managing disability benefits as part of treatment for persons with severe mental illness and comorbid drug/alcohol disorders: a comparative study of payee and non-payee participants.* AMERICAN JOURNAL OF ADDICTIONS *6:330*–338 (1997).

[9] R. Rosenheck, J. Lam, and F. Randolph, *Impact of representative payees on substance use by homeless persons with serious mental illness.* PSYCHIATRIC SERVICES, *48:800*–806 (1997).

[10] L. Dixon , J. Turner, N. Krauss, *et al., Case managers' and clients' perspectives on a representative payee program.* PSYCHIATRIC SERVICES *50:781*–786 (1999).

[11] P. Hanrahan, D.J. Luchins, C. Savage, *et al.,* REPRESENTATIVE PAYEE PROGRAMS FOR MENTALLY ILL PERSONS IN ILLINOIS: CENSUS SURVEY. Presented at the Institute on Psychiatric Services, New Orleans, Oct 29 to Nov 2, 1999.

[12] R.K. Ries, and D.G. Dyck. *Representative payee practices of community mental health centers in Washington State.* PSYCHIATRIC SERVICES *48:811*–814 (1997).

[13] E. Edgar, A. O'Hara, B. Smith, *et al.,* PRICED OUT IN 1998: CRISIS FOR PEOPLE WITH DISABILITIES. Boston, Technical Assistance Collaborative (1999).

government provides several housing options in the community for people with mental disorders that are not available to other citizens [implies must be a citizen to receive these benefits]. Some of these programs are tenant based and provide vouchers for the difference between the market rate for housing and what the individual can afford to pay. Other programs are landlord based and offer incentives for landlords to rent to people with mental disorders at below-market rates.

No one questions whether landlords should be able to impose generally applicable requirements—such as not disturbing neighbors—on these tenants. The issue is whether landlords legally can, and whether they in fact do impose additional requirements on tenants who have mental disorders and whether such requirements may pertain to treatment.

Many agencies that manage housing programs for people with mental disorders appear to consider the programs primarily as residential treatment and only incidentally as lodging.[14] It is clear that landlords sometimes try to use housing as leverage. For example, the standard lease used by one provider of supported housing reads, "Refusing to continue with mental health treatment means that I do not believe I need mental health services. . . . I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternative housing. I understand that if I do not, I may face eviction".[15]

Importantly, some statutes may prohibit the use of housing as leverage to ensure treatment adherence, others do not. For example, the federal statute authorizing the Shelter Plus Care program explicitly states, "In addition to standard lease provisions, the occupancy agreement may also include a provision requiring the participant to take part in the supportive services provided through the program as a condition of continued occupancy".[16] The statute defines supportive services as including mental health treatment, alcohol, and other substance abuse services.

Although some patient advocates decry the linking of housing and services,[17] a study of 118 people with mental disorders who were living in public shelters in Boston reported that 92% of these individuals wanted to move out of the shelter and into permanent housing, "even if they were required to continue taking psychotropic medication" as a

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[14] H. Korman, D. Engster, and B. Milstein. HOUSING AS A TOOL OF COERCION, IN COERCION AND AGGRESSIVE COMMUNITY TREATMENT. Edited by D. Dennis, and J. Monahan, New York, Plenum (1996).

[15] M. Allen. *Separate and unequal: the struggle of tenants with mental illness to maintain housing.* CLEARINGHOUSE REVIEW, *30:720*–739, (1996).

[16] 24 C.F.R. 582.315(b).

[17] NATIONAL COUNCIL ON DISABILITIES: FROM PRIVILEGES TO RIGHTS: PEOPLE LABELED WITH PSYCHIATRIC DISABILITIES SPEAK FOR THEMSELVES (2000). Available at http://www.ncd.gov/newsroom/publications/privileges.html.

condition of securing the housing.[18]

Thus, housing is sometimes used formally as leverage to ensure adherence to mental health treatment in the community and, much more often, may be used informally to the same end. Many people who have mental disorders appear to be prepared to accept services if such a trade-off is required in order for them to obtain the housing they want.

MANDATED TREATMENT INVOLVING THE JUDICIAL SYSTEM

People who have severe mental illness are sometimes ordered to comply with treatment by judges or other decision makers in the legal system, such as probation officers. Even in the absence of a judicial order, people may agree to adhere to treatment requirements to avoid an unfavorable judicial order, such as incarceration or civil commitment to an inpatient facility. In these contexts, judicial authority to impose sanctions and curtail freedom provides the leverage for inducing treatment adherence in the community.

Avoidance of jail as leverage

Although informal procedures have long existed for dealing with mentally ill defendants who are charged with minor crimes,[19] the important role that judges play in this area is now acknowledged with much less hesitation than it was in the past. In fact, a new type of criminal court -- called, appropriately, a mental health court -- has been developed that makes explicit the link between sanctioning and treatment in the community.

Adapted from the drug court model and often explicitly premised on notions of "therapeutic jurisprudence",[20] mental health courts give prominence to the role of the judge, who "plays a hands-on, therapeutically oriented, and directive role at the center of the treatment process".[21] In a mental health court, cases are heard on their own calendar, separate from other cases, and are handled by a specialized team of legal and mental health professionals. Emphasis is placed on implementing new working relationships among the criminal justice, mental health, and social welfare systems, particularly in supervising the defendant in the community.

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[18] R.K. Schutt, and S.M. Goldfinger. *Housing preferences and perceptions of health and functioning among homeless mentally ill persons.* PSYCHIATRIC SERVICES, *47:381*–386 (1996).

[19] A. Matthews, MENTAL DISABILITY AND THE CRIMINAL LAW. Chicago, American Bar Foundation (1970).

[20] D.B. Wexler and B.J. Winick. LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE. Durham, NC, Carolina Academic Press (1996); A. Watson, P. Hanrahan, D. Luchins, *et al., Mental health courts and the complex issue of mentally ill offenders.* PSYCHIATRIC SERVICES *52:477*–481, 2001

[21] J. Goldkamp, C. Irons-Guynn. *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernadino, and Anchorage. Philadelphia,* CRIME AND JUSTICE RESEARCH INSTITUTE (2000).

About a dozen courts now refer to themselves as mental health courts.[22] A bill to create 100 demonstration mental health courts across the country by 2004 (S.B. 1865) was signed into federal law in November 2000, although a spending appropriation has not been enacted. There appears to be no lack of demand for these new courts. Of defendants who are given the choice of having their case heard by a mental health court or by a regular criminal court, 95% choose the mental health court.[23]

Goldkamp and Irons-Guynn[24] found many differences among the four pioneering courts that they studied, so much so that it is clear that there is no single model for what constitutes a mental health court.[25] These authors also addressed the extent to which the avoidance of jail is used as leverage:

> Some observers see special courts as vehicles for 'coerced treatment,' a term with favorable and unfavorable connotations. The favorable use of the term suggests that the judicial role and application of sanctions and rewards contribute valuable tools for keeping participants in treatment and increasing the chances for successful outcomes. The unfavorable reference alludes to the problems associated with forcing treatment upon individuals who have not voluntarily consented, from a due process perspective and from the perspective that treatment cannot be effective unless it is wanted.[26]

Mental health courts, in one of several forms, are likely to be established in an increasing number of communities. Where they exist, they seem to attract a large caseload of misdemeanor defendants with mental disorders who, when given the choice, prefer to receive mental health treatment in the community rather than to be incarcerated.

Avoidance of hospitalization as leverage

There are three types of outpatient commitment.[27] The first is a variant of conditional release from a hospital: a patient is discharged on the condition that he or she continues treatment in the

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[22] J. Petrila, N. Poythress, A, McGaha, *et al., Preliminary observations from an evaluation of the Broward County Florida Mental Health Court.* COURT REVIEW, *37(4):*14–22 (2001).

[23] *Id.*

[24] *Id.* at n.21.

[25] H.J. Steadman, S. Davidson, and C. Brown, *Mental health courts: their promise and unanswered questions.* PSYCHIATRIC SERVICES 52:457–458, 2001; A. Watson, D. Luchins, P. Hanrahan, *et al., Mental health courts: promises and limitations.* JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, *28:476–*482 (2000).

[26] *Id.* at 24.

[27] J.D. Gerbasi, R.B. Bonnie, and R.L. Binder, *Resource document on mandatory outpatient treatment.* JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW *28:127–*144 (2000).

community. The second type is an alternative to hospitalization for people who meet the legal criteria for inpatient treatment: they are essentially given the choice between receiving treatment in the community and receiving treatment in the hospital. The third type of outpatient commitment is preventive: people who do not currently meet the legal criteria for inpatient hospitalization but who are believed to be at risk of decompensation to the point that they will qualify for hospitalization if left untreated are ordered to accept treatment in the community.

Two randomized controlled trials of outpatient commitment were recently published. The first -- the Duke mental health study[28] -- followed patients who had been involuntarily hospitalized and given a court order for mandatory community treatment after discharge. Patients who were randomly assigned to the control group were released from the court order. For patients who were randomly assigned to the experimental group, the outpatient commitment order remained in effect for various periods, depending on whether a psychiatrist and the court believed that the patient continued to meet the legal criteria for outpatient commitment.

In bivariate analyses, the control and outpatient commitment groups did not differ significantly in hospital outcomes, although repeated-measures multivariate analyses showed that the likelihood of readmission was lower for the outpatient commitment group.[29] However, when the data from the experimental group were disaggregated according to whether the patients had been subject to outpatient commitment for at least six months or for less than six months, strong differences emerged. The patients who had been under outpatient commitment for a sustained period had significantly fewer hospital readmissions and hospital days than control subjects.

Additional analyses showed that sustained outpatient commitment was associated with fewer hospital readmissions only when it was combined with a higher intensity of outpatient services—averaging approximately seven service events per month. The prevalence of violence toward other persons during the year after discharge was also significantly lower among the patients who had been subject to outpatient commitment for at least six months than among the control subjects and those who had received less than six months of outpatient commitment.[30] Extended outpatient commitment was also associated with a lower rate of criminal victimization and arrest.[31]

The second randomized controlled

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[28] M.S. Swartz, J.W. Swanson, R.R. Wagner, *et al., Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals.* AMERICAN JOURNAL OF PSYCHIATRY *156:1968*–1975 (1999).

[29] *Id.*

[30] J.W. Swanson, M.S. Swartz, R. Borum, *et al., Involuntary outpatient commitment and reduction of violent behavior in persons with severe mental illness.* BRITISH JOURNAL OF PSYCHIATRY *176:324*–331 (2000).

trial -- the Bellevue study[32] -- also followed-up patients who had been hospitalized and given a court order for mandatory community treatment after discharge. A court-ordered outpatient commitment group was compared with a control group over a one-year follow-up period. Both groups received a package of enhanced services that included intensive community treatment.

No significant differences in number of hospitalizations, arrests or in other outcome measures were found between the control and experimental groups. A significantly smaller proportion of each group was hospitalized during the follow-up year than had been hospitalized during the previous year. The researchers concluded that enhanced services made a positive difference in the post-discharge experiences of both groups but that "the court order itself had no discernible added value in producing better outcomes."

Thus it appears that the results of the only two randomized controlled trials of outpatient commitment agree that improving the availability and quality of mental health services leads to positive outcomes, but there is conflict about the value added by legally mandating patients' participation in those services. Both of these studies had methodologic limitations that make it difficult to resolve this conflict.[33]

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[32] *Id.* at 25.

[33] P. Appelbaum. *Thinking carefully about outpatient commitment.* PSYCHIATRIC SERVICES *52:347*–350 (2001); S. Ridgley, R. Borum, and J. Petrila, THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES. Santa Monica, Calif, Rand (2001).

ADVANCE DIRECTIVES

Faced with the possibility of undergoing mandated treatment if their condition deteriorates, patients may choose to specify their treatment preferences before a disabling crisis actually occurs.[34] Some patient advocates see the use of an advance directive as an antidote to mandatory treatment orders. Others have touted the value of an advance directive as a means of binding oneself to future treatment -- "self-mandated treatment" -- by authorizing caretakers to override anticipated objections on the part of the patient. As one commentator stated, "The advent of advance directives for psychiatric care offers an unprecedented opportunity to reconcile, or at least accommodate, the opposing values represented by proponents of involuntary interventions, on the one hand, and by civil libertarians, on the other".[35]

Under the Patient Self-Determination Act of 1991, any hospital that receives federal funds must notify admitted patients of their right to create

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[34] D.S. Srebnik, and J.Q. La Fond, *Advance directives for mental health treatment.* PSYCHIATRIC SERVICES *50:919*–925 (1999).

[35] E. Gallagher, *Advance directives for psychiatric care: a theoretical and practical overview for legal professionals.* PSYCHOLOGY, PUBLIC POLICY, AND LAW *4:746*–787 (1998).

an advance directive. Usually advance directives pertain to medical care at the end of life. However, the 1991 act has given impetus to the creation of advance directives to promote self-determination during periods in which an individual is rendered incapacitated as a result of a mental disorder. Mental health advance directives, first proposed two decades ago as "psychiatric wills",[36] are permitted in all states, and thirteen states have enacted specific statutes that authorize them.[37]

Medical and mental health advance directives differ in an important experiential respect: because end-of-life care typically occurs only once, the individual is likely to have had little direct experience with being unable to make treatment choices. In contrast, because of the episodic nature of mental illness, most individuals who have a severe mental disorder can be expected to accumulate experience on how best to manage the symptoms that impair their decision-making abilities.[38]

Mental health advance directives take two basic forms. An instructional directive tells treatment providers what to do about treatment in the event that the individual becomes incapacitated -- for example, which treatments the individual wants to receive or which facilities the individual wants to avoid.[39] On the other hand, a proxy directive gives treatment providers the name of an individual whom the patient has designated to make treatment decisions in the event that he or she becomes unable to do so. Both types of directive can be combined in the same instrument.[40]

Surveys conducted in the mid-1990s found that only a small percentage of patients with a mental disorder had completed a mental health advance directive.[41] However, with concerted educational efforts, this situation could change radically. One study surveyed people with severe mental disorders who were receiving treatment in public mental health programs and informed them of their right to prepare a mental health

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[36] P. Appelbaum, *Michigan's sensible "living will" [letter].* NEW ENGLAND JOURNAL OF MEDICINE *301:788* (1979).

[37] R. Fleischner, *Advance directives for mental health care: an analysis of state statutes.* PSYCHOLOGY, PUBLIC POLICY, AND LAW *4:788*–804 (1998).

[38] P. Appelbaum, *Advance directives for psychiatric treatment.* HOSPITAL AND COMMUNITY PSYCHIATRY *42:983*–984 (1991); P.F. Stavis, *The Nexum: a modest proposal for self-guardianship by contract.* JOURNAL OF CONTEMPORARY HEALTH LAW AND POLICY *16:1*–95 (1999).

[39] J.W. Swanson, M. Tepper, P. Backlar, *et al., Psychiatric advance directives: an alternative to coercive treatment?* PSYCHIATRY *63:160*–172 (2000).

[40] B.J. Winick, *Advance directive instruments for those with mental illness.* UNIVERSITY OF MIAMI LAW REVIEW *51:57*–95 (1996).

[41] P. Backlar, and B.H. McFarland, *A survey on use of advance directives for mental health treatment in Oregon.* PSYCHIATRIC SERVICES *47:1387*–1389 (1996).

advance directive.[42] Thirty of the forty patients who were surveyed chose to prepare a directive; twenty-two of these chose to designate a proxy decision maker, usually a family member.

None of the patients used the directive to refuse all treatment, although many used the directive to refuse some treatments -- for example, electroconvulsive therapy. Almost all patients were satisfied with their advance directive. As one respondent stated, "It is a document that is my voice when I am not able to be." However, seventeen of twenty-one treatment providers surveyed expressed concern about how the directive would be implemented. They had little confidence that the advance directive would be accessible to clinicians in the event of a crisis.

Mental health advance directives might have a much broader application if they were more aggressively "marketed" to consumers, families, and providers. Technology may play a large role in making advance directives accessible. The recent development of a CD-ROM titled AD-Maker[43] and the online psychiatric advance directives now available from the Bazelon Center for Mental Health Law and from the Advance Directive Training Project may facilitate the use of these instruments. In this regard, New York State has embarked on a one million dollar educational campaign that has distributed 20,000 copies of educational materials on how to complete mental health advance directives.[44]

WHAT WE NEED TO KNOW ABOUT MANDATED COMMUNITY TREATMENT

To evaluate the role that mandated treatment may play in mental health law, we need to know how frequently leverage is used, how the process of applying leverage operates, and the outcomes of leveraged treatment. We also need a sharper understanding of the profound legal, ethical, and political issues that are raised when leverage is used to secure treatment adherence.

Prevalence

Basic descriptive information is lacking for many forms of mandated community treatment. Virtually everything known about a given use of leverage comes from the experience of only one or two states. Part of the reason for this lack of even rudimentary data is that many forms of mandated community treatment have been implemented only recently. However, this state of affairs may also be a reflection of the *sub rosa* quality of many of these arrangements. The use of housing or social welfare benefits as leverage is clearly controversial and subject to legal challenge, and advocates of these practices may consider it

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[42] P. Backlar, B.H. McFarland, J. Swanson, *et al., Opinions about psychiatric advance directives in Oregon. Administration and Policy in Mental Health* (in press).

[43] P. Sherman. *Computer-assisted creation of psychiatric advance directives.* COMMUNITY MENTAL HEALTH JOURNAL *34:351*–362 (1998).

[44] Personal communication from M. Shaw (2001).

imprudent to bring empirical attention to such leverage.

Descriptive information is needed not only about the different types of mandated treatment but also about the joint use of two or more forms of leverage. Data on the overlap among the various forms of mandated community treatment described are essential for determining the prevalence of the use of some form of leverage to induce people to adhere to mental health treatment recommendations. An analogy may be the treatment of alcoholism, for which it has been stated that treatment adherence is governed by at least one of the "four Ls": liver, lover, livelihood, and the law[45].

Alternatively, rather than a single form of leverage being applied to an individual who is reluctant to adhere to treatment, it may be that several forms of leverage are applied. If one form of leverage appears not to be producing treatment adherence, then another is tried, and then another, until adherence is achieved. To the extent that this leverage substitution occurs, eliminating one form of leverage will only increase reliance on other forms.

Process

The central finding from a series of studies of inpatient hospitalization undertaken as part of the MacArthur coercion study was that

> the amount of coercion experienced is strongly related to a patient's belief about the justice of the process by which he or she was admitted. That is, a patient's beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient the chance to tell his or her side of the story, are associated with low levels of experienced coercion.[46]

The authors referred to this process variable as procedural justice. In theory, one might expect that leveraged community treatment would be characterized by much more procedural justice than involuntary inpatient hospitalization, and thus that the people to whom it was applied should experience it as much less "coercive" than hospitalization. For example, financial management by representative payees is designed to be negotiated in order that the patient be involved as much as possible in decisions about how money is to be allocated.

Perhaps the best illustration of active participation by the mentally ill individual is the drafting of a mental health advance directive. Indeed, the very purpose of an advance directive is to memorialize the patient's "voice" while he or she is competent to exercise that

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[45] R. Room, TREATMENT-SEEKING POPULATIONS AND LARGER REALITIES, IN ALCOHOLISM TREATMENT IN TRANSITION. Edited by G. Edwards, and M. Grant. Baltimore, University Park Press (1990).

[46] J. Monahan, C.W. Lidz, S.K. Hoge, *et al., Coercion in the provision of mental health services: the MacArthur studies,* in "Research in Community and Mental Health," vol. 10: COERCION IN MENTAL HEALTH SERVICES: INTERNATIONAL PERSPECTIVES. Edited by J. Morrissey, J. Monahan, Stamford, Conn, JAI (1999).

voice.[47] If the results of the MacArthur coercion study are generalizable to the community, such practices should greatly reduce the individual's experience of coercion. Whether they actually do so is yet to be determined.

OUTCOMES

Outcomes For People Who Have Mental Disorders.

The proponents of mandated treatment believe that without leverage, many individuals would not adhere to mental health treatment[48] and thus would not achieve positive therapeutic outcomes. However, it is not yet clear that services that are effective when received voluntarily produce the same outcomes when they are received under duress.

Even if mandated treatment were shown to be effective, it is still not clear whether other, nonmandated treatment options could be equally effective. What proportion of people with serious mental disorders would, but for the use of leverage, consistently refuse to avail themselves of clinically and culturally appropriate mental health services assertively provided in the community? The answer to this crucially important question is unknown.

The reason often given by family advocates for the claim that, without leverage, many people with serious mental disorders would not adhere to treatment is that mental illness negates the ability to make rational treatment decisions. There is no question that mental disorders can impair the competence of some of the people who suffer from them. In the MacArthur treatment competence study,[49] of the patients who were hospitalized with a diagnosis of schizophrenia, approximately half had a significant impairment in at least one of the abilities necessary for making a competent decision about treatment. However, the number of these individuals who would continually refuse the offer of high-quality mental health treatment is currently unknown.

Patient advocates not only question the positive outcomes claimed for outpatient commitment but also claim that leveraged treatment will have a perverse effect on the use of services: people who might otherwise want to avail themselves of mental health services will avoid such services for fear of being forced to continue with them indefinitely or face inpatient hospitalization.[50]

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[47] E. Howe, *Lessons from advance directives for PADs.* PSYCHIATRY *63:173*–177 (2000).

[48] E.F. Torrey, and M. Zdanowicz, *Outpatient commitment: what, why, and for whom.* PSYCHIATRIC SERVICES *52:337*–341(2001).

[49] T. Grisso, P.S. Appelbaum, *The MacArthur treatment competence study: III. abilities of patients to consent to psychiatric and medical treatment.* LAW AND HUMAN BEHAVIOR *19:149*–174 (1995).

[50] M. Allen, and V.F. Smith, *Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment.* PSYCHIATRIC SERVICES *52:342*–346 (2001).

Campbell and Schraiber[51] reported that 47% of all discharged patients surveyed in California answered yes to the question, "Has the fear of being involuntarily committed ever caused you to avoid treatment for psychological or emotional problems?" However, a disproportionate number of the former patients who were sampled in that study were members of the "survivor" movement. A similar outpatient-commitment survey, administered to a more representative sample of mental health consumers, would be valuable.

One putative outcome of mandated treatment is its effect on reducing violence in the community. Advocates of outpatient commitment have explicitly "sold" the approach largely by playing on public fears of violence committed by people who have mental disorders.[52] As stated by Jaffe,[53] "Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality. . . So if you're changing your laws in your state, you have to understand that. . . . [i]t means that you have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena."

Although playing the violence card may succeed in getting legislation enacted, the actual effect of outpatient commitment on reducing community violence is unclear. Any benefits that accrue as a result of tapping into public fear must be subtracted from the costs of greater stigma toward people with mental disorders that may result from sensationalizing a real -- but modest -- relationship between mental illness and violence.[54]

OUTCOMES FOR THE MENTAL HEALTH SYSTEM

It is also important to determine the outcomes of mandated treatment on the availability of mental health services in the community. It is often said that the use of leverage commits the system to the patient as much as it commits the patient to the system. However, it is not clear how true this bromide is. Are resources merely being shifted from

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[51] J. Campbell, and R. Schraiber, IN PURSUIT OF WELLNESS: THE WELL-BEING PROJECT. Sacramento, California, Department of Mental Health (1989).

[52] K.J. Conrad, M.D. Matters, P. Hanrahan, *et al., Representative payee for individuals with severe mental illness at community counseling centers of Chicago.* ALCOHOLISM TREATMENT QUARTERLY *17:169*–186 (1999).

[53] D.J. Jaffe, *Remarks on assisted outpatient treatment.* Presented at the annual conference of the NATIONAL ALLIANCE FOR THE MENTALLY ILL, Chicago, June 30, 1999.

[54] H. Steadman, E. Mulvey, J. Monahan, *et al., Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods.* ARCHIVES OF GENERAL PSYCHIATRY *55:393*–401 (1998); J. Monahan, H, Steadman, E. Silver, *et al.,* RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE. New York, Oxford University Press (2001).

voluntary cases to leveraged cases? If so, the apparent irony is that people who want services are denied them so that people who do not want services can receive them. Proponents claim that resources are in fact being appropriately prioritized toward patients with the greatest needs.

Alternatively, it may be that leveraged treatment actually leads to an overall increase in the resources allocated to mental health services. The extent to which any augmented funds are earmarked by the legislature for specific types of services -- for example, inpatient beds -- and the relative desirability of such services compared with other treatment needs are additional factors to be considered.

Outside the context of a legislative infusion of new moneys into the public mental health system, there is no apparent reason for a service that was previously unavailable to an individual who needed it to suddenly become available because the name of the service is written on a piece of paper as a mental health advance directive. Nor is "My landlord says I need this" likely to be a winning argument with intake workers in many overburdened treatment agencies. In the era of managed care, "Show me the money" may be the response of service providers.

However, the situation may be different in the case of outpatient commitment and mental health courts. Judges may play a critical role in forcing actors in the mental health, substance abuse, and criminal justice systems to work together in a more effective, less turf-protecting manner. When a judge calls a meeting, people tend to show up -- and on time. Judges' use of their bully pulpit may also get the attention of legislators in a way that traditional lobbying by special-interest mental health activists does not.

Legal, ethical, and political questions

Whatever its outcomes, is leverage legal? There is no shortage of people who assert that some of the forms of mandated treatment described here violate existing statutes. For example, Allen[55] claims that "bundling" housing and services violates the Americans With Disabilities Act, the Fair Housing Act, and the Rehabilitation Act as well as numerous state landlord-tenant laws. Concerns about tort liability are also pervasive. For example, is a mental health professional likely to be sued if he or she provides the type of treatment specified in a patient's advance directive under circumstances in which professional standards indicate that a different treatment is more effective?

Over and above the question of whether any given form of mandated treatment violates a specific statute, it has been claimed that mandated treatment is unconstitutional. The first case that challenged New York's outpatient statute asserted that the statute violated due process and equal protection rights because it permitted treatment to be ordered "without a showing by clear and convincing evidence that the person to whom the order applies lacks the capacity to make a reasoned treatment decision." However,

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[55] M. Allen. *Separate and unequal: the struggle of tenants with mental illness to maintain housing.* CLEARINGHOUSE REVIEW *30:720*–739 (1996).

the court held otherwise: "Clearly, the state has a compelling interest in taking measures to prevent these patients who pose such a high risk from becoming a danger to the community and themselves. Kendra's Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness, and hospitalization continually repeat itself".[56]

Therefore, contrary to the claims of advocates on either side of the debate, it is fair to say that the legal status of many forms of mandated treatment is currently uncertain. It will take a number of years before it is clear from the courts which forms of leverage -- and the manner in which they are operationalized -- violate a state or federal statute or constitution. It is not at all unlikely that some state courts, relying on their statutes and constitution, will approve the same type of mandated treatment that other state courts, relying on their own sources of legal authority, will prohibit. As Berg and Bonnie[57] state, "The law in this area is far from settled. Community treatment providers should be aware of the relevant issues and should begin to shape their own guidelines, rather than wait for litigation and thereby surrender responsibility to the courts." When courts finally do address these issues, empirical research on the prevalence, process, and outcomes of given forms of leveraged treatment may play an important and perhaps decisive role.

Beyond questions of the legality of leverage remains the question of whether using jail, housing, hospitalization, or money to leverage treatment adherence -- or insisting that a treatment decision made by an earlier "competent self" trump a treatment decision made by a later "incompetent self" -- can be morally justified.

From one viewpoint, the operative moral concept in mandated treatment is a threat: "Adhere to mental health treatment in the community, or else you will be jailed or will become homeless." From another point of view, the operative moral concept is an offer: "Before, you were facing the certain prospect of jail, or homelessness. Now, we are offering you a way to avoid that by adhering to mental health treatment in the community. Your choice."

The clearest articulation of the distinction being made here is that of Wertheimer:[58]

> The standard view of coercive proposals is that threats coerce but offers do not. And the crux of the distinction between threats and offers is that A makes a threat when B will be worse off than in some relevant baseline position if B does not accept A's proposal, but that A makes an offer when B will be no worse off than in some

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[56] *Re Urcuyo,* 714 N.Y.S.2d 862 (2000).

[57] J. Berg, and R. Bonnie, WHEN PUSH COMES TO SHOVE: AGGRESSIVE COMMUNITY TREATMENT AND THE LAW, IN COERCION AND AGGRESSIVE COMMUNITY TREATMENT. Edited by D. Dennis, and J. Monahan. New York, Plenum (1996).

[58] A. Wertheimer, *A philosophical examination of coercion for mental health issues.* BEHAVIORAL SCIENCES AND THE LAW *11:239*–258 (1993).

> relevant baseline position if B does not accept A's proposal. On this view . . . the key to understanding what counts as a coercive proposal is to properly fix B's baseline or present situation.

However, with mandated community treatment, fixing the individual's baseline is fraught with contention. The individual may see the funds that are sometimes used by representative payees as leverage for securing adherence to community treatment as "my money"—money that he or she is legally "entitled" to receive. Others may see such funds as "taxpayer's money" to be used as the government chooses to use it.[59] According to this view, if a law currently prohibits the government from using disability benefits as leverage, that law can and should be changed, much as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) -- passed by a Republican Congress and signed by a Democratic President -- ended sixty years of federal benefits to eligible mothers and children in the pursuit of "ending welfare as we know it." What once was an entitlement no longer is.

People who have an expansive view of "welfare rights" or "housing rights" are likely to believe that the baseline against which mandated treatment is to be judged should be much higher than people who believe that the government's obligations in the areas of welfare and housing are more circumscribed. The former group is likely to point out that only for people who are both mentally ill and poor can money or housing effectively function as leverage. The latter group is likely to advocate that the government use limited public resources to promote the public good and that getting treatment to people who need it falls squarely into this category.

Viewed in such a light, the resolution of some -- although hardly all -- of the controversies surrounding mandated community treatment may lie in the trade-offs inherent in the political process. What percentage of people who have mental disorders would adhere to treatment in the community if various forms of leverage were made sufficiently attractive? What percentage of the public would support increases in the resources available for mental health services in the community if they believed that leverage would be applied to ensure that the people most in need of services actually received them? The debate on mandated treatment would be enriched if answers to such questions were available.

CONCLUSIONS

Commitment to treatment in the open community in the early 21st century bears little resemblance to commitment to an inpatient facility in the late 20th century. Commitment can be understood only in the context of a broad movement to apply whatever leverage is available to induce engagement with mental health treatment in the community, a movement that includes the use of representative payees, subsidized housing, mental health courts, outpatient commitment, and mental health advance directives.

Other forms of leverage may exist as well -- for example, continued employment used as leverage under the

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[59] *Id.* at n. 56.

Americans with Disabilities Act.[60] Little hard evidence exists on the pervasiveness of the various forms of mandated treatment for people with mental illness, how leverage is imposed, the actual effects of using leverage for different types of patients with various types and severities of illness, or for various mental health systems.

The many vexing legal, ethical, and political questions surrounding mandated treatment have not been thoroughly aired. Yet there are a number of indications that mandated treatment is expanding at a rapid pace, not just in the United States but throughout the world.[61] If mental health law and policy are to incorporate -- or repudiate -- some or all of these types of leverage, an evidence-based approach must rapidly come to replace the ideologic posturing that currently characterizes the field.

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[60] *Bowers v. Multimedia Television,* WL 856074 (D. Kan. 1998).

[61] A. Halpern, and G. Szmukler, *Psychiatric advance directives: reconciling autonomy and non-consensual treatment.* PSYCHIATRIC BULLETIN *21:323–327* (1997).

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In the Federal Courts

Parents May Be Reasonably Reimbursed for a Private School Placement if the Local Public School Violates the IDEA

Knable v. Bexley, 238 F.3d 755 (6th Cir. 2001):

The U.S. Court of Appeals for the Sixth Circuit held that a denial of a free appropriate public education occurs if the school's failure to comply with the Individuals with Disabilities Education Act (IDEA) causes substantive harm to the child or his parents. In addition, the Court held that parents can be reasonably reimbursed for a unilateral private school placement if the placement was proper.

After Justin Knable's first year in the Bexley public school system, Bexley officials requested permission from his parents for a special education evaluation. The evaluation team met and determined that Justin was in need of special education services. In early December, the Knables and Bexley officials met to discuss possible placements, but no individualized education plan (IEP) was presented. Justin finished the school year without an IEP although the Knables asked for one several times. During the summer after Justin's first year, the Knables obtained a placement for Justin in a private school for children with behavioral problems. The Knables investigated a possible local placement recommended by Bexley but did not think it was appropriate. By the end of the summer, Bexley had not prepared an IEP for Justin and the Knables sent Justin to the private school at a cost of $51,300 per year. Justin's performed well at his new placement, earning A's and B's, in sharp contrast to his previous failing grades at Bexley.

> Because the parents were denied the opportunity to participate in an IEP conference and their son was denied an appropriate education for his sixth grade year due to a lack of an IEP, the court found substantive harm.

The Knables requested a hearing for reimbursement for the costs of placing Justin in the private school. Their request was denied by an Impartial Hearing Officer, again denied by a State Level Hearing Officer, and denied again by the district court.

In reversing the district court, the Sixth Circuit first applied the two-prong *Rowley* test to determine whether or not Bexley offered the Knables an appropriate placement for their child: (1) did Bexley violate the procedural requirement of the IDEA, and (2) was the Individualized Education Plan (IEP), as developed in compliance with IDEA procedures, reasonably calculated to ensure the child receive education benefits? Based on Bexley's failure to comply with the written requirements for developing an IEP and their failure to convene a timely IEP conference, the Court determined that Bexley violated the procedural requirements of the IDEA. Applying the second prong, the Court

found that even if Bexley's proposed IEP met the procedural requirements of the IDEA, it denied Justin's right to a free and appropriate education because it was too generalized to meet his specific needs and required the Knables' to use their insurance to pay the costs.

Board May Revoke Parole for Refusal to Take Psychotropic Medications

Closs v. Weber, 238 F.3d 1018 (8th Cir. 2001):

The U.S. Court of Appeals for the Eighth Circuit held that a parole board may revoke parole and reduce good-time credits when a parolee refuses to take psychotropic medication, if the parolee agreed to parole terms that included participating in a mental health program approved by the board. Penalizing a parolee for refusing to take psychotropic medications is not a violation of federal law or a prisoner's due process liberty interest in being free from being forcibly administered psychotropic drugs without procedural protections.

> Closs was not forcibly administered psychotropic drugs, since he voluntarily agreed to take them as a condition of parole.

Fourteen years after his conviction, Randy Lee Closs was granted a conditional parole. Closs agreed to maintain psychiatric treatment that was approved by the parole board. Upon release, Closs voluntarily entered into a mental health treatment facility, but initially refused to take his medications. After his parole officer warned him that further refusal could result in a parole violation, Closs took his medication for two days, but then refused again. After being discharged from the mental health facility because of his refusal to take his medications, Closs was brought before the parole board for the parole violation. At the hearing, Closs testified that he could not endure the side effects of the medication.

Notwithstanding his testimony, the board revoked his parole and reduced his good-time credits by two years for failing to follow the terms of his supervision. He appealed to the district court, claiming that he had a right to refuse the medicine, that his due process rights had been violated and that mental health treatment laws had been violated. The district court agreed in part and ordered that Closs' good-time credits be restored. The parole board appealed that decision.

The Eighth Circuit reversed the district court re-instatement of good-time credits, finding the Supreme Court precedents in *Washington v. Harper,* 494 U.S. 210 (1990) and *Riggins v. Nevada,* 504 U.S. 127 (1992) inapplicable. First, Closs was not forcibly administered psychotropic drugs, since he voluntarily agreed to take them as part of his parole agreement. Moreover, Closs was not forced to agree to the terms of his parole supervision. Finally, requiring medication was not an unconstitutional arbitrary parole condition since Closs needed psychotropic medications in order to function safely in society. In addition, the

Court held that according to state law, the parole board has the discretion to reduce good-time credits if the parolee violates probation.

Disclosure of the Defendant's Psychiatrist's Evaluation to the Prosecution Does Not Violate Due Process

Pawlyk v. Wood, 237 F.3d 1054 (9th Cir. 2001):

The U.S. Court of Appeals for the Ninth Circuit held that compelling the disclosure of a psychiatrist's evaluation of a defendant after a mental status defense is raised, does not violate the due process guarantee of access to an independent psychiatrist to assist with the building of an adequate defense.

Following his arraignment on two counts of aggravated first degree murder, William J. Pawlyk's defense counsel retained a psychiatrist for an evaluation. Later, the defense counsel requested and was granted access to a second psychiatrist. When raising his insanity defense, Pawlyk listed only the second psychiatrist as a defense witness.

If the evaluation would have an adverse effect on a mental status defense, then the defense counsel has the choice to refrain from introducing a mental status defense that could result in damaging testimony from the psychiatrist.

After the insanity defense was raised, however, the prosecution was granted access to the first psychiatric evaluation and the right to use the first evaluation in trial only in rebuttal of expert testimony supporting an insanity defense. Following his conviction on two counts of aggravated murder in the first degree, Pawlyk appealed, arguing that by compelling disclosure of an evaluation that was unfavorable to his insanity defense, the state infringed his right to access to psychiatric assistance in preparing a defense. Pawlyk argued that by allowing the prosecution access to a former defense-retained psychiatrist, the defense will be discouraged from seeking opposing psychiatric evaluations, thus violating a defendant's right to an adequate defense as guaranteed by due process and fundamental fairness.

The Court rejected Pawlyk's argument, holding instead that due process guarantees only state-funded access to one competent, independent psychiatrist to assist with the preparation, presentation and evaluation of the defense. It does not guarantee a favorable psychiatric evaluation. If the evaluation would have an adverse effect on a mental status defense, then the defense counsel has the choice to refrain from introducing a mental status defense that could result in damaging testimony from the psychiatrist.

In determining that Pawlyk had access to an adequate defense, the Court distinguished access to an independent psychiatrist and a neutral psychiatrist. Due process is violated when the defendant has access only to a neutral psychiatrist whose duties are determined

by the Court, rather than the defense counsel, so that the defendant is precluded from the assistance of the psychiatrist in evaluating possible defenses. In this case, consistent with his due process guarantee of fundamental fairness, Pawlyk had access to two independent psychiatrists to assist him in evaluating possible defenses.

Guilty Plea Is Voluntary When Defendant's Decision-Making Ability Was Not Compromised Despite His Fear of a Mental Health Defense

U.S. v. Kaczynski, 239 F.3d 1108 (9th Cir. 2000):

The U.S. Court of Appeals for the Ninth Circuit held that a defendant's guilty plea was voluntary if he was properly denied a *Faretta v. California,* 422 U.S. 806 (1975) request for self-representation and if his choice was free of threats or improper promises.

In 1998, Theodore Kaczynski was convicted and sentenced to life imprisonment for the bombing deaths of three persons. Before the trial started, Kaczynski disagreed with his defense counsel's decision to present evidence on his mental status, but eventually agreed to allow his attorneys to use his mental health status in the penalty phase of the trial. On the first day of the trial, Kaczynski again brought up his conflict with counsel about whether to present mental health evidence and requested a change in counsel, which was denied because of the delay a change in counsel would cause. The next day, Kaczynski made a *Faretta* request for self-representation. The district court denied his *Faretta* request because of the delay it would cause. Following the denial, Kaczynski and the government reached a plea agreement: in return for Kaczynski's guilty plea, the government agreed to drop the death penalty. In 1999, Kaczynski filed a motion to vacate his conviction, arguing that his guilty plea was involuntary because the Court denied his *Faretta* request for self-representation and his counsel insisted on presenting mental health evidence over his objections. The district Court denied his motion, and Kaczynski appealed.

> Because Kaczynski's statements showed that he was clearly aware of the consequences of his decision to plead guilty, he was not coerced into pleading guilty simply to avoid a mental health defense.

The Ninth Circuit affirmed the district court's decision. The Court examined the record in order to determine whether or not Kaczynski's plea was voluntary. Because Kaczynski's written and oral statements showed that he was clearly aware of the consequences of his decision to plead guilty, the Court agreed with the lower court's finding that his guilty plea was voluntary. In addition, there was no evidence that Kaczynski was coerced or threatened into pleading guilty.

Stating the rule that an improper

denial of a request of self-representation makes a guilty plea involuntary, the Court next examined the *Faretta* request denial. The Court found that the denial was proper because the request was not timely and was not made in good faith. Specifically, the Court agreed with the district court that Kaczynski's request was a delaying tactic since he knew about his counsel's decision to present evidence about his mental health several months earlier and could have filed a request at that time.

The Court also found that Kaczynski's plea was not involuntary because of his counsel's insistence on presenting evidence of Kaczynski's mental status. Since Kaczynski had already agreed to use his mental status as mitigating evidence against a death penalty sentence before the plea agreement, he was not coerced into pleading guilty simply because he wanted to avoid a mental health defense.

Successive Petition for Habeas Corpus Relief from Forcible Medication Cannot Be Dismissed if it Relies Upon New Rule of Criminal Procedure

Flowers v. Walter, 239 F.3d 1096 (9th Cir. 2001):

The U.S. Court of Appeals for the Ninth Circuit held that the *Riggins'* rule, which requires states to demonstrate overriding necessity and medical appropriateness before forcibly medicating a defendant, is to be applied retroactively. The *Teague* standard allows a rule to be retroactive if it is a new rule that decriminalizes certain private conduct or if it is a new rule of criminal procedure. By holding that § 2244(b)(2)(A) codifies the *Teague* standard, the Ninth Circuit adopts the minority interpretation of § 2244(b)(2)(A) that an express statement by the Supreme Court is not necessary to make a rule retroactive.

Forcible medication without overriding necessity and demonstrated medical appropriateness violates the Sixth and Fourteenth Amendments.

Howard William Flowers petitioned for his first writ of habeas corpus in 1990, eleven years after his conviction for murder. Following the denial of his first writ, Flowers petitioned for his second writ in 1997, alleging violations of his constitutional rights under *Riggins.* Flowers stated in his affidavit that the state forcibly medicated him with psychotropic drugs during his trial in 1979. *Riggins* held that forcible medication without demonstrated overriding necessity and medical appropriateness was a violation of the Sixth and Fourteenth Amendments. The district court denied Flowers' second writ, holding that the *Riggins* rule was not retroactive because there was no express statement of retroactivity by the Supreme Court as required by § 2244(b)(2)(A). Flowers appealed the dismissal.

The Ninth Circuit reversed the district court ruling. Applying the *Teague* standard for retroactivity, the Court first determined that the *Riggins* rule was a new rule of criminal procedure. Under

Teague and § 2244(b)(2)(A), a successive petition survives dismissal if it relies upon a new rule. Since Flowers' second petition relied upon the new rule that forcible medication without justification is a violation of constitutional rights, his petition for a writ of habeas corpus was permissible.

Veterans Not Precluded from Compensation for Substance Abuse Disabilities if Caused by a Service-Connected Disability

Allen v. Principi, 237 F.3d 1368 (C.A. Fed. Cir. 2001):

The U.S. Court of Appeals for the Federal Circuit held that the proper interpretation of 38 U.S.C. § 1110 does not preclude servicemen from being compensated for substance abuse disabilities if the disability is caused by a service-connected (contracted or aggravated in the line of duty) disorder, such as Post Traumatic Stress Disorder (PTSD).

> A disability is service-connected if contracted or aggravated in the line of duty.

William F. Allen, a Marine Corps veteran, sought an increase in compensation for his alcohol abuse disability. The Board of Veterans Appeals denied Allen's appeal of a Veteran's Administration Regional Office's decision to deny an increase in monetary compensation, stating that alcohol abuse is not service-connected and cannot be considered in determining the level of disability compensation. Allen appealed to the Veterans Court, which held that according to *Barela v. West,* 38 U.S.C. § 1110 precludes compensation for any alcohol or drug abuse disabilities. Allen appealed again, arguing that *Barela* was wrongly decided in its interpretation of §1110.

The Court of Appeals agreed with Allen. Based on a close reading of the statute, the legislative history of the statute and its amendments, and Veteran's Administration applications of the statute before the amendments, the Court determined that § 1110 precludes compensation only for alcohol or drug abuse disabilities unrelated to a service-connected disability. If there is a causal connection between the alcohol or drug abuse disability and a service-connected disability, the veteran is not excluded from compensation.

Administering Psychotropic Drugs Without Patient's Consent When the Patient is No Threat to Self or Others Can Be Grounds for Negligence Claim

Threlkeld v. White Castle Systems, 127 F. Supp. 2d 986 (N.D. Ill. 2001):

The District Court for the Northern District of Illinois held that the administration of psychotropic drugs without a patient's consent may give rise to a cause of action for negligence under the states' Mental Health Code.

> The court found that the statute applied to recipients of service, regardless of whether or not they were formally admitted to the hospital. . . Threlkeld's injury was the kind protected under the statute because she was administered a drug without her consent even though she was not a danger to

Deborah Threlkeld was stopped by a security guard at a White Castle restaurant, and then taken by police to Jackson Park Hospital against her will. At the hospital, Threlkeld was locked into a psychiatric emergency room observation room and tied with restraints. The doctor on call then ordered a nurse to give Threlkeld a sedative, without first obtaining Threlkeld's informed consent, for which Threlkeld filed a complaint against the hospital for violating the Illinois Mental Health and Developmental Disabilities Code. The district court denied the hospital's motion to dismiss the suit, finding that Threlkeld met the three-part test for establishing a negligence claim.

First, the Court determined that the Mental Health Code was a public health statute based on the statute's wording that showed a legislative intent to protect both the public and mental health patients from harm.

Next, the Court found that Threlkeld was within the class of people to be protected by the statute. In denying the hospital's argument that the statute did not apply because Threlkeld was never admitted to the hospital, the Court found that the statute applied to recipients of service, regardless of whether or not they were formally admitted to the hospital. Finally, the Court found that Threlkeld's injury was the kind protected under the statute because she was administered a drug without her consent even though she was not a danger to herself or others. The Court also found that Threlkeld's claim of battery was valid because Illinois law treats lack of consent to medical treatment as battery cases.

Cases In the Virginia Courts

Defendant's Mental Retardation Does Not Bar Imposition of the Death Penalty

Atkins v. Virginia, 534 S.E.2d 312 (Va. 2000):

The Virginia Supreme Court held that the death penalty was not an inappropriate sentence for a convicted murderer with an IQ of 59, since he understood the wrongfulness of his acts.

> Execution of the mentally retarded does not constitute cruel and unusual punishment.

Daryl Atkins claimed that his IQ was below that of any person previously

executed by the state. Atkins was tested by two forensic clinical psychologists, one of whom determined that Atkins had mild mental retardation and an antisocial personality disorder. However, the psychologist also stated that Atkins understood that killing the victim was wrong. The other psychologist disputed the diagnosis of mental retardation, citing Atkins' vocabulary and noting that a diagnosis of mental retardation requires the inability to function independently compared to one's age group.

The U.S. Supreme Court has held that the execution of a mentally retarded defendant does not violate the Eighth Amendment's prohibition against cruel and unusual punishment. In Virginia, mental retardation is a mitigating factor to be considered during sentencing. According to the record, the death sentence was not excessive, since Atkins knew his actions were wrong.

Cases In Other State Courts

Employers Not Required to Accommodate Cocaine Addiction Under the ADA

In re Marshall, 762 A.2d 530 (D.C. 2000):

The District of Columbia Court of Appeals held that cocaine abuse is not a mitigating factor in a disbarment case where the attorney's conduct warrants disbarment. The Court further held that disbarment in this case was not a violation of the Americans with Disabilities Act (ADA) since the attorney in question could not show he was otherwise qualified to be a member of the Bar, and the ADA does not require employers to accommodate criminal conduct in its "reasonable accommodation" requirement.

> Allowing addiction to an illegal drug to be a mitigating factor would create incentives for illegal conduct.

The Board on Professional Responsibility recommended that attorney Matthew J. Marshall be disbarred for misappropriating client funds and submitting fabricated documents to bar counsel. Marshall presented a *Kersey* defense, arguing that his cocaine addiction should be considered as a mitigating factor in determining the sanction for his misconduct. In addition, Marshall argued that a refusal to mitigate the sanction violated the ADA.

The Court agreed with the findings of the Board that Marshall's conduct warranted disbarment and that the *Kersey*-type defense (i.e., that alcoholism may be a mitigating factor in determining the sanction) was inapplicable here. This case was distinguished from other addiction cases because cocaine abuse, unlike alcohol and prescription drug abuse, entails violating criminal law. Allowing an addiction to an illegal drug to be a mitigating factor would create incentives for illegal conduct, since an

attorney who violated ethical standards but did not violate criminal law would be more harshly punished than one who violated both ethical standards and criminal law. (The Court did not decide whether or not an addiction to an illegal drug could be considered as a mitigating factor if the attorney sought treatment before being investigated by bar counsel.)

On the ADA issue, the Court found that Marshall failed to meet the "qualified individual" standard necessary for ADA protection because his misconduct renders him unqualified for Bar membership. Moreover, the Court held that the ADA's requirement that employers reasonably accommodate disabilities does not mean that employers must accommodate violations of the law, even if they are caused by a disability such as cocaine addiction.

Defendant Has Statutory Right to Competency Examination Four Years After Sentencing

Commonwealth v. Conaghan, 740 N.E.2d 956 (Mass. 2000):

The Supreme Court of Massachusetts held that a defendant has the statutory right to a competency evaluation on a post-sentence motion to withdraw a guilty plea.

Deborah Conaghan was convicted of manslaughter after she pleaded guilty to killing her son. Four and one-half years later Conaghan filed a motion to withdraw her guilty plea and requested a competency examination. In her affidavit, Conaghan stated that she and her son had been threatened and abused by Paul Haynes, her boyfriend at that time, and that he had told her to cover up for his role in her son's death. The lower Court denied Conaghan's request to withdraw her guilty plea.

The Supreme Court vacated the lower court's denial and remanded the case based on a close reading of the statute and the Court's understanding of the characteristics of Battered Woman Syndrome (BWS). Rejecting the prosecution's argument that Conaghan's claim was not credible because of the four and one-half years that had elapsed between the trial and her new motion, the Court ordered the lower court to evaluate Conaghan's competency with a BWS expert for two reasons: (1) there is no time limit in the statute granting a court the power to order a competency examination, and (2) one of the common characteristics of BWS is the inability to perceive abuse or communicate it to others.

The Court ordered that the lower court resolve the following issues based on the expert evaluation: (1) was Conaghan suffering from BWS; (2) if so, was she competent to stand trial at the time of her guilty plea; (3) if suffering from BWS, was she competent to voluntarily plead guilty; and (4) if suffering from BWS, did she plea guilty with a "reasonable degree of rational understanding" and with a "rational as well as factual understanding of the

There is no time limit in the statute granting a court the power to order a competency examination.

proceedings against [her]".

Defense Counsel May Not Raise an Insanity Defense Over a Competent Defendant's Objections

Johnson v. Nevada, 17 P.3d 1008 (Nev. 2001):

The Supreme Court of Nevada held that when a defendant is mentally competent to stand trial, the defendant has the absolute right to prohibit defense counsel from asserting an insanity defense.

The defendant, Richard Christopher Johnson, was convicted of second degree murder with a deadly weapon. Following the defense's psychiatric evaluation, the Court ordered an evaluation of his competency to stand trial. Johnson was found to be competent to stand trial and his new defense counsel entered a plea of not guilty by reason of insanity. Johnson then renewed his request for self-representation because he disagreed with the use of the insanity defense. The district court reviewed his request for self-representation and denied it based on the *Faretta* test: A defendant may waive counsel only if the decision is made with a clear understanding of the consequences of that decision.

> When there is a conflict between counsel and a competent defendant over the assertion of an insanity defense, the defendant's wishes must prevail.

In reversing and remanding the case for further proceedings, the Supreme Court determined that since Johnson had been found mentally competent to stand trial, the defense counsel should not have been allowed to impose the insanity defense over his objections. The Court followed the reasoning of the majority view on this issue: When there is a conflict between counsel and a competent defendant over the assertion of an insanity defense, a competent defendant must consent to any insanity defense because of the serious consequences of choosing between long-term institutionalism and prison, including the social stigma of an insanity defense.

Actuarial Risk Assessment Results Admissible in Sexually Violent Predator Commitment Hearing

In re Commitment of R.S., 773 A.2d 72 (N.J. Super. A.D. 2001):

The Appellate Division of the Superior Court of New Jersey held that the results of actuarially-based risk assessment instruments, used for the purpose of providing a statistical prediction of sex offender recidivism, were admissible in proceedings to determine whether to civilly commit an offender under the state's sexually violent predator act.

R.S. had been convicted of multiple counts of child sexual assault between 1989 and 1993 and served a seven-year prison term. Prior to his release, the New Jersey Attorney General

filed a petition for the involuntary civil commitment of R.S. under the state's sexually violent predator statute. At the commitment hearing, the judge heard testimony from a clinical psychologist who reviewed the criminal and treatment history records of R.S. and conducted a clinical interview and psychological testing. The evaluation included the use of four actuarial risk assessment instruments (Minnesota Sex Offender Screening Tool, California Actuarial Risk Assessment Tables, Registrant Risk Assessment Scale, Rapid Risk Assessment of Sex Offender Recidivism) designed to aid the psychologist in making a prediction about the likelihood that R.S. would recidivate.

"While an actuarial approach to assessment may be distasteful to the judiciary, which displays a preference for focusing on the individual case rather than class membership, this approach is the most accurate approach to psychological assessment."

R.S. objected to the admissibility of the results based on the actuarial assessments, contending that such instruments are insufficiently reliable and not yet widely accepted in the scientific community and that their prejudicial effect outweighs any probative value. The Court rejected these arguments in an opinion notable for its competent and detailed discussion of technical issues concerning actuarial risk assessment. The opinion discusses research and relevant caselaw on the accuracy of predictions of future dangerousness, research showing that actuarially-based prediction is superior to clinical prediction, and research on the predictive accuracy of actuarial instruments.

Quoting approvingly from the seminal work of William Grove and Paul Meehl, the opinion notes that they "conclude that to use clinical judgment in preference to actuarial data when predicting such things as risk of recidivism 'is not only unscientific and irrational, it is unethical'". The opinion also quotes researchers Randy Otto and James Butcher, who argue that "[w]hile an actuarial approach to assessment may be distasteful to the judiciary, which displays a preference for focusing on the individual case rather than class membership, this approach is the most accurate approach to psychological assessment". Importantly, the Court recognized that the psychologist's recommendation was not based on the actuarial results alone, but rather that those results were just one component of the overall clinical and actuarial assessment.

As for the argument that the actuarial assessment results are unduly prejudicial, the Court emphasized that the commitment hearing was not before a jury but a judge. An experienced judge who is well-informed as to the character of the actuarial instruments and who is accustomed to dealing with them is much less likely to be prejudiced by their admission than a one-case, fact-finding jury would be."

Kids Are Different: The Relevance of Development Theory to Decision-making by the Courts

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Presenters

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The Hon. Kimberly O'Donnell, Judge, Richmond Juvenile and Domestic Relations Court
Robert Schwartz, J.D., Juvenile Law Center, Philadelphia
John Mclees, J.D., Virginia Office of the Attorney General
Leena Augimeri, MA, Director, Centre for Children Committing Offences, Toronto, Canada

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Breaking the Cycle: Diverting Persons with Mental Illness out of the Criminal Justice System ***featuring*** **John Petrila, J.D., L.L.M. & Henry Steadman, Ph.D.**

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Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law.

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Informed Consent and Substitute Decision-making

March 19, 2002
Eastern State Hospital, Williamsburg, VA

❧

Civil Commitment

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❧

Breaking the Cycle: Diverting Persons with Mental Illness out of the Criminal Justice System

Mental Health and the Law Symposium
Friday, May 3, 2002

Virginia Museum of Fine Arts,
Richmond, VA

Featuring

John Petrila, J.D., L.L.M

Professor and Chair, Department of Mental Health Law & Policy, Florida Mental Health Institute, and Professor, College of Public Health, University of South Florida

Henry Steadman, Ph.D.

President, Policy Research Associates, Inc.
National Resource Center on Homelessness and Mental Illness,
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DEVELOPMENTS IN MENTAL HEALTH LAW

The Institute of Law, Psychiatry & Public Policy — The University of Virginia

Volume 21, Number 2 (March 2002)

2002 Legislation Impacting the Delivery of Mental Health, Mental Retardation, and Substance Abuse Services

By Dana Martin Johnson, J.D., Jane D. Hickey, J.D., and Allyson K. Tysinger, J.D.*

The Virginia General Assembly passed three pieces of legislation during its 2002 Session that will have a significant impact upon the delivery of mental health, mental retardation, and substance abuse services in the Commonwealth in the years to come. The first, House Bill 9,[1] abolishes the Department for the Rights of Virginians with Disabilities (DRVD) and replaces it with an independent agency, the Virginia Office of Protection and Advocacy (VOPA). The second, House Bill 995,[2] establishes the framework for restructuring the facility service delivery system. The third, Senate Bill 482,[3] limits forensic hospitalization to no more than twelve months for individuals found not guilty by reason of insanity (NGRI) of misdemeanor offenses. The following is a summary of these important legislative initiatives.

Also in this issue:

* Dana Martin Johnson, Jane D. Hickey, and Allyson K. Tysinger are at the Office of the Attorney General, Commonwealth of Virginia.

[1] 2002 VA Acts ch. 572.
[2] 2002 VA Acts ch. 803.
[3] 2002 VA Acts ch. 750.

Virginia Office for Protection and Advocacy

With the passage of House Bill 9, the Virginia General Assembly created an independent state agency to serve as the Protection and Advocacy Agency (P & A Agency) for the Commonwealth.[4] It will become effective upon completion of a required federal re-designation process[5] and once complete, the newly-created Virginia Office for Protection and Advocacy (VOPA) will replace the Department for Rights of Virginians with Disabilities (DRVD) as the agency designated to protect and advocate for the rights of persons with disabilities. VOPA will also become the mechanism by which Virginia receives federal funds to implement a number of federal programs, including those established by the Protection and Advocacy for Individuals with Mental Illness Act,[6] the Developmental Disabilities Assistance and Bill of Rights Act,[7] and section 509 of the Rehabilitation Act.[8]

Each state or federal territory determines the best way to provide

[4] House Bill 9 will create a new Chapter 8.1 within Title 51.5 and will be codified as VA Code § 51.5-39.1.

[5] A federal re-designation process is required with a public notice and comment period before changing the designation from DRVD to VOPA.

[6] 42 U.S.C. §§ 10801-10807.

[7] 42 U.S.C. §§ 6041-6043.

[8] 29 U.S.C. § 794e.

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

Developments in Mental Health Law is distributed free of charge to Virginia residents twice annually and to out-of-state subscribers at an annual rate of $30 or a two year rate of $55. If you are not on our mailing list but would like to receive this publication, please send your full name and address with your subscription request to P.O. Box 800660, University of Virginia Health System, Charlottesville, VA 22908. Changes of address should include both old and new addresses. Please also include a telephone number and e-mail address with your correspondence.

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ISSN 1063-9977

protection and advocacy services.[9] Some P & A agencies are private, non-profit agencies; others are entities of state government. Of those that are part of state government, some are executive branch agencies and others are independent of gubernatorial oversight. In more than forty states, however, the P & A agency is either an independent state agency or is not a part of state government at all.[10] Concerned Virginians have been advocating for an independent P & A agency for many years. These advocates for an independent P & A agency argued that having the Department for Rights of Virginians with Disabilities (DRVD) accountable to the same person that oversees the agencies providing services to persons with disabilities was a conflict of interest and led to poor human rights protections for Virginia's citizens with disabilities.

In 1999, the Virginia General Assembly passed legislation creating VOPA, but that bill was never signed into law.[11] Instead, DRVD oversight was transferred from the Secretary of Health and Human Resources to the Secretary of Administration. Prior to 1999, DRVD was under the supervision of the Health and Human Resources Secretariat, which also houses the DMHMRSAS, the Department of Rehabilitative Services, and the Department of Health, among others. Although DRVD was still an executive branch agency, the transfer removed DRVD from the same secretarial oversight as these other service providers.[12]

The scope of VOPA's authority will extend to all actions that adversely affect the "health, safety, welfare or civil or human rights of any person with mental, cognitive, sensory or physical disabilities."[13] Two significant additions to the duties and responsibilities of the new P & A Agency are (1) the creation of an ombudsman program and (2) a protection and advocacy fund. The provisions involving the ombudsman program[14] will not become effective until July 1, 2004. The ombudsman program will create a new section within VOPA

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[9] The Commonwealth of Virginia has two protection and advocacy systems: an external system, discussed in this article, and an internal system. The internal system for the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is governed by the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation, and Substance Abuse Services*, 12 VA Admin. Code §§ 35-115-10 to -250, and is operated by DMHMRSAS' Office of Human Rights.

[10] According to the National Association of Protection and Advocacy Systems, Virginia will become the 43rd state to have an independent P & A agency.

[11] *See* H.B. 1214, 1999 Gen. Assem., Reg. Sess. (Va. 1999).

[12] In addition to being independent of the Governor, VOPA will be independent of the Virginia Attorney General's Office. The new law provides that VOPA will have the authority to "employ and contract with legal counsel" to carry out its duties, initiate legal actions, and provide legal representation to the agency. 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.2).

[13] *Id.*

[14] 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.7, effective July 1, 2004).

that will be responsible for receiving complaints and conducting investigations regarding any activity, practice, policy, or procedure of a program providing mental health, mental retardation, substance abuse services, rehabilitative services, and social services.[15]

In addition to creating VOPA, the new legislation establishes its governing board, consisting of eleven members who are to be appointed by the Governor and the General Assembly.[16] The Board must include at least two members with experience in the fields of developmental disabilities and mental health.[17] In appointing the membership of the Board, consideration must be given to those persons nominated by statewide advocacy groups for the disabled, but those who appoint the members are not bound by these nominations.[18] The Board will have the power to hire and supervise the agency director, who must be an attorney licensed to practice in Virginia.

The Protection and Advocacy Fund (Fund) is a non-reverting fund, administered by VOPA's Board, and will be effective with the re-designation of the new P & A agency.[19] The Board, on behalf of the agency, will be able to apply for and accept gifts, donations, grants, and bequests from the federal government and any other source. Any monies received will be deposited into the Fund.[20] The creation of this Fund prevents money allotted to and collected on behalf of VOPA from reverting to the Commonwealth's general fund and prevents any such funds from being used for any other purposes except those determined by the Board.

Most of the powers and duties previously granted to DRVD have been transferred to VOPA. For example, the

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[15] Particularly, those providers covered are any hospitals, facilities, or programs operated, funded, or licensed by the DMHMRSAS, the Department of Social Services, or any other state or local agency. 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.7(A), effective July 1, 2004).

[16] The Governor will appoint three members of the board who shall be confirmed by a majority vote of each house of the General Assembly. The Speaker of the House of Delegates will appoint five members, and the Senate Committee on Privileges and Elections will appoint three members. The initial membership terms will be staggered as follows: two one-year terms (both legislative appointees); three two-year terms (one gubernatorial and two legislative appointments); three three-year terms (one gubernatorial and two legislative appointments); and three four-year terms (one gubernatorial and two legislative appointments). Thereafter, all membership terms will be for four years. 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.2(C) and (D)).

[17] No current employee of the Departments of Mental Health, Mental Retardation and Substance Abuse Services, Health, Rehabilitative Services or the Blind, and Vision Impaired or a community services board, behavioral health authority, or local government department with a policy-advisory community services board shall serve as a member of the Board.

[18] 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.2(B)).

[19] 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.5(B)).

[20] *Id.*

authority to receive reports of critical incidents or deaths of consumers in state facilities has been incorporated into the new legislation. The DMHMRSAS Commissioner must also continue to provide the VOPA Director with written follow-up reports setting forth the known facts within fifteen working days of any such incident.[21] The federal statutes that establish P & A Agencies - the Protection and Advocacy for Individuals with Mental Illness Act,[22] the Developmental Disabilities Act,[23] and section 509 of the Rehabilitation Act[24] - remain unchanged.

Mental Health System Restructuring

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) currently operates eight mental health facilities throughout the Commonwealth for the care and treatment of persons with mental illness and one facility specifically for the treatment of children and adolescents. With improvements in medications and psychosocial rehabilitation techniques, more and more individuals with mental illness can be effectively served in the community, closer to their homes and support systems. As a result, significant restructuring of the mental health system was proposed by the Anderson Commission on Community Services and Inpatient Care in December 1999.[25]

This year, the General Assembly took the first step in bringing this recommendation to fruition by enacting a new Virginia Code section 37.1-48.2, which establishes a framework for bringing this about.[26]

Prior to considering the restructuring of the system of mental health services that would impact an existing state mental health facility, the DMHMRSAS Commissioner (Commissioner) must establish a state and community consensus and planning team. The team consists of DMHMRSAS staff, as well as representatives of the jurisdictions served by the facility, including local government officials, consumers, family members of consumers, advocates, state facility employees, community services boards, public and private service providers, licensed hospitals, state-operated medical hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested citizens. Moreover, members of the House of Delegates and the Senate representing the jurisdictions serviced by the affected facility may also serve on the team.[27]

Every state and community consensus and planning team, in collaboration with the Commissioner, must develop a plan that addresses the following:

1. The types, amounts, and locations of new and expanded community services that will be needed to successfully implement the closure or conversion of a facility to any use

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[21] *See* 2002 VA Acts ch. 572 (to be codified at VA Code § 51.5-39.12, formerly VA Code § 51.5-37.1(2000)).
[22] 42 U.S.C. §§ 10801-10807.
[23] 42 U.S.C. §§ 6041-6043.
[24] 29 U.S.C. § 794e.
[25] Final Report to Governor James S. Gilmore, III, December 15, 1999.

[26] *See* 2002 VA Acts ch. 803 (to be codified at VA Code § 37.1-48.2(A)).
[27] *Id.*

other than the provision of mental health services, including a six-year projection of the need for inpatient psychiatric beds and related community mental health services;
2. The development of a detailed implementation plan designed to build a community mental health infrastructure for current and future capacity needs;
3. The creation of new and enhanced community services prior to the closure of the facility or its conversion to any use other than the provision of mental health services;
4. The transition of state facility patients to community services in the locality of their residence prior to institutionalization or in the locality of their choice;
5. The resolution of issues relating to the restructuring implementation process, including employment issues involving state facility employee transition planning and appropriate transitional benefits; and
6. A six-year projection comparing the cost of the current structure and the proposed structure.[28]

The Commissioner must further insure that each plan includes the following components:

1. A plan for community education;
2. A plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas;
3. A plan for assuring the availability of adequate staff in the affected communities, including specific strategies for transferring qualified state facility employees to community services;
4. A plan for assuring the development, funding, and implementation of individualized discharge plans for individuals discharged as a result of the closure or conversion of the facility; and
5. A provision for suspending implementation of the plan if the total general funds appropriated to the Department for state facility and community services decrease in any year of plan implementation by more than ten percent from the year in which the plan was approved by the General Assembly.[29]

In addition to meeting the collaboration and planning requirements, any plan to close or convert the use of a facility must be approved by the General Assembly. The state and community consensus and planning team must submit the plan to the Joint Commission on Health Care and the Governor for their review and recommendation at least nine months prior to any proposed closing or conversion.[30] The Joint Commission on Health Care must then make a recommendation to the General Assembly no later than six months prior to the date of the proposed closure or conversion.[31] Upon approval by the General Assembly and the Governor,

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[28] *Id.*

[29] *Id.* (to be codified at VA Code § 37.1-48.2(B)).

[30] *Id.* (to be codified at VA Code § 37.1-48.2(C)).

[31] *Id.* (to be codified at VA Code § 37.1-48.2(D)).

the Commissioner may implement the plan.[32]

Most importantly, any funds saved by the closure or conversion of the facility not allocated to individualized services plans for patients being transferred or discharged as a result, must be invested in the Mental Health, Mental Retardation and Substance Abuse Services Trust Fund.[33] Its purpose is to insure that the proceeds from the sale of any buildings and land as a result of any facility closing or conversion would first be used to provide mental health, mental retardation, and substance abuse services within the same service areas where the buildings and land are located and to provide benefits to employees who are no longer employed or are otherwise negatively affected by such sale or conversion.[34] These provisions thus insure that any savings or proceeds realized from the closing or conversion of a facility will be reinvested in the mental health, mental retardation, and substance abuse service delivery system.

The new legislation also requires that concurrently with the development of any plan involving Eastern State Hospital, the Commissioner must assess the impact and feasibility of using a portion of the real property for the placement of a new campus of Thomas Nelson Community College and for the development of a Center for Excellence in Aging and Geriatric Health. Such assessment must be done in consultation with the Chancellor of the Community College System, the President of Thomas Nelson Community College, and the President of the College of William and Mary, and with the advice of the state and community consensus and planning team. Any transfer of property shall be subject to the condition that Thomas Nelson Community College use the property for its general education mission, which includes the operation of a School of Allied Health Professions to offer health care degrees, including Licensed Practical Nurse programs, and for the training of mental health care providers. Prior to transfer of property, the Department of General Services must obtain an independent assessment of the property's value, including the value of mental health training services to be provided by Thomas Nelson Community College. Funds equal to the assessed value of the property must be deposited in the Trust Fund.[35]

Finally, through the enactment clauses, the General Assembly directs the Secretary of Health and Human Resources to work with the Department of Housing and Community Development, the Housing Authority, and the federal Department of Housing and Urban Development to ensure adequate housing options for individuals transitioning to community services. The Secretary must also coordinate the efforts of the Department of Medical Assistance Services and DMHMRSAS in seeking maximum Medicaid service options and potential Medicaid waivers from the Centers for Medicare &

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[32] *Id.* (to be codified at VA Code § 37.1-48.2(E)).

[33] *Id.* (to be codified at VA Code § 37.1-48.2(F)), established during the 2000 Session of the General Assembly; see also VA Code §§ 37.1-258 to 260 (1996) (establishing the trust fund).

[34] *See* VA Code § 37.1-260 (1996).

[35] *See* VA Acts ch. 803 (to be codified at VA Code § 37.1-48.2(H)).

Medicaid Services. The Secretaries of Commerce and Trade, Administration, Education, Transportation, and Public Safety must also assist the Secretary of Health and Human Resources in developing strategies to provide transition services and benefits to any affected state facility employees and to assist any affected local communities with economic development and transportation needs.

Hospitalization of NGRI Misdemeanants

When a person charged with a crime is found not guilty by reason of insanity (NGRI) and meets the commitment criteria identified in Virginia Code section 19.2-182.3,[36] the person is committed to the custody of the DMHMRSAS and continued confinement is governed by Virginia Code section 19.2-182.5. Under this latter statute, a hearing to assess the NGRI acquittee's need for continued hospitalization is conducted at yearly intervals for five years and at biennial intervals thereafter. The law does not impose any limitation on the total length of time that an NGRI acquittee can be confined in the custody of the DMHMRSAS as long as the commitment criteria are met.

Currently, DMHMRSAS has 252 NGRI acquittees in custody. Of those, 218 were acquitted of felonies and thirty-four of misdemeanors. The average length of stay of the current misdemeanant acquittees in the custody of DMHMRSAS is 7.2 years.[37] Had these same misdemeanant acquittees been convicted, however, they likely would have been confined in jail for no more than twelve months.[38] To address this disparity in length of confinement between those found NGRI of a misdemeanor and those convicted, the General Assembly enacted Senate Bill 482.[39]

Senate Bill 482 creates a distinction between misdemeanant NGRI acquittees and felony NGRI acquittees. The law remains unchanged as it pertains to felony NGRI acquittees. However, a different path is created for misdemeanant acquittees. Most significantly, the bill establishes a fixed limit on the forensic confinement of a misdemeanant NGRI acquittee.

The bill amends VA Code section 19.2-182.5 by providing that a misdemeanant NGRI acquittee is to remain in the custody of DMHMRSAS pursuant to Chapter 11.1 of Title 19.2 of the Code of Virginia for a period not to exceed one year from the date of acquittal. Thus, the forensic confinement of a misdemeanant NGRI acquittee in the custody of DMHMRSAS is limited to a one-year period. This one-year period mirrors the maximum length of confinement in jail that could be imposed as punishment for a misdemeanor conviction under Virginia Code section 18.2-11.

The bill adds a new subsection that is applicable to all misdemeanant NGRI acquittees beginning on July 1, 2002. The DMHMRSAS has until

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[36] The criteria for commitment are: (i) the acquittee is mentally ill or mentally retarded and (ii) in need of inpatient hospitalization. *See* VA Code § 19.2-182.3 (2000).

[37] Figures obtained in April 2002 from the Office of Forensic Services of the DMHMRSAS.

[38] *See* VA Code § 18.2-11 (1996).

[39] 2002 VA Acts ch. 750.

October 1, 2002, to apply this subsection to all misdemeanant NGRI acquittees currently in its custody.

In addition to setting the length of forensic confinement, the bill provides direction to the DMHMRSAS Commissioner in cases where the misdemeanant acquittee no longer requires inpatient treatment. The bill specifies that prior to, or at the conclusion of, the one-year period, if the Commissioner determines that the acquittee meets the criteria for conditional release[40] or release without conditions,[41] the Commissioner shall petition the committing court for such. Therefore, it is possible for a misdemeanant acquittee to be released with court approval prior to the expiration of the one-year period. In addition, the conditional release provisions of Virginia Code sections 19.2-182.7-182.11 are clearly applicable to these acquittees. Should a misdemeanant NGRI acquittee be released, either with or without conditions, the Commissioner must provide written notice to the Commonwealth's Attorney of the committing jurisdiction not less than thirty days prior to the scheduled release date.

The bill further states that prior to or at the end of the one-year period, the DMHMRSAS Commissioner shall petition the committing court for emergency custody pursuant to Virginia Code section 37.1-67.01, temporary detention pursuant to Virginia Code section 37.1-67.1, or involuntary commitment pursuant to Virginia Code section 37.1-67.3, if the Commissioner believes that the misdemeanant acquittee meets such criteria.[42] Thus, if at the end of the one-year period the Commissioner believes that the misdemeanant NGRI acquittee continues to need inpatient hospitalization, the Commissioner must file a petition with the committing court. The statute also provides that the Commissioner's duty to file such a petition does not preclude any other person meeting the requirements of

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[40] The criteria for conditional release are: (i) the acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization; (ii) appropriate out-patient treatment and supervision are reasonably available; (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and (iv) conditional release will not present an undue risk to public safety. *See* VA Code § 19.2-182.7 (2000).

[41] The criteria for release without conditions are: (i) the acquittee does not need inpatient hospitalization and (ii) does not meet the criteria for conditional release. *See* VA Code § 19.2-182.6 (2000).

[42] The criteria for involuntary civil commitment are: (i) that the person presents an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (ii) that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to institutional confinement. *See* VA Code § 37.1-67.3 (1996).

Virginia Code section 37.1-67.01[43] from filing a petition for emergency custody or temporary detention. If the misdemeanant NGRI acquittee is civilly committed based on such a petition, filed by either the Commissioner or any other person, the acquittee's status would change from forensic to civil and further inpatient hospitalization or release would be governed by the civil commitment laws contained in Title 37.1 of the Code of Virginia.

Because the DMHMRSAS has custody of only thirty-four misdemeanant NGRI acquittees at this time, it is not anticipated that Senate Bill 482 will have a great impact on the number of available forensic beds. It will be interesting to note, however, if the number of misdemeanant NGRI acquittees increases after the bill's effective date. For attorneys that steer their clients away from the insanity defense based on a history of lengthy and indefinite forensic confinements in the DMHMRSAS after acquittal, Senate Bill 482 makes the outcome of such a verdict a little less uncertain.

Conclusion

The Virginia General Assembly, through the enactment of these key pieces of legislation, addressed three primary concerns in the field of mental health law. At the forefront of the many issues facing lawmakers in the mental health arena are community integration, forensic mental health, and consumer protection from abuse and neglect. Virginia lawmakers have made significant strides in the past several years toward improving the statutes affecting persons with mental disabilities in the Commonwealth and the 2002 General Assembly Session is no exception.

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[43] Virginia Code § 37.1-67.01 states that a magistrate may issue an emergency custody order upon the sworn petition of "any responsible person."

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Civil Commitment of Sexual Offenders Cannot Stand Without Lack-of-Control Determination

Kansas v. Crane, 534 U.S. 407 (2002):

The Supreme Court of the United States held that *Kansas v. Hendricks,* 521 U.S. 346 (1997), does not require that the state prove that an offender had total or complete lack of control over his dangerous behavior in order to commit him under the Kansas Sexually Violent Predator Act. However, the Court also held that it would be unconstitutional to permit the commitment of a dangerous sexual offender without *any* determination of whether the sexual offender lacked control over his dangerous behavior.

> Insistence upon absolute lack of control would risk barring the civil commitment of highly dangerous persons suffering severe mental abnormalities.

The State of Kansas sought the civil commitment of Michael Crane, a previously convicted sexual offender who suffers from both exhibitionism and antisocial personality disorder. Kansas argued that the Kansas Supreme Court, in reversing the commitment of the lower court, wrongly read *Hendricks* as requiring the State to *always* prove complete inability of the offender to control his behavior. Kansas asserted instead that *Hendricks* did not require *any* lack-of-control determination before committing a dangerous sexual offender.

The Court agreed in part with the state's claim. Specifically, it agreed that *Hendricks* did not require a finding of total or complete lack of control to commit a sexual offender. The Court reasoned that "[i]nsistence upon absolute lack of control would risk barring the civil commitment of highly dangerous persons suffering severe mental abnormalities" and therefore found this approach "unworkable." It did not, however, agree with the State's assertion that civil commitment was allowed in instances where there is *no* determination of any kind of an offender's lack of control. The Court held that while the inability to control behavior need not be determined with "mathematical precision," the State must be able to prove "serious difficulty" in controlling behavior. The Court, in explaining its decision, stressed the need to determine an offender's lack of control in order to distinguish dangerous sexual offenders from the typical criminal offender. Its main concern was that civil commitment would then become a mechanism for retribution or general deterrence, instead of leaving that function to the criminal system.

Cases in Other Federal Courts

Appointed Counsel Must Investigate Defendant's Competency Prior to Court's Acceptance of Waiver of Counsel

Appel v. Horn, 250 F.3d 203 (3d Cir. 2001):

The Third Circuit Court of Appeals held that when appointed counsel failed to conduct any investigation into the defendant's competency prior to the court's acceptance of the defendant proceeding *pro se,* the defendant was constructively denied counsel and was thus deserving of a new trial.

In June of 1986, Martin Daniel Appel shot and killed three bank employees during a robbery. Appel informed the two public defenders assigned to his case that he wished to represent himself. The court ordered a psychiatric examination to determine whether Appel was competent to waive counsel. The psychiatrist's report, based solely on an hour-long interview with the defendant, found Appel to be competent. Although Appel's appointed counsel were present at the competency hearing, they did not challenge the psychiatrist's conclusion and added nothing to the record at that time. The judge accepted Appel's waiver of counsel and appointed the public defenders as standby counsel. Appel subsequently pled guilty to three counts of criminal homicide and, at his request, the court imposed three sentences of death on Appel. Appel subsequently argued that he was mentally ill and incompetent when he waived counsel and the appointed counsel failed to investigate this issue prior to the court's acceptance of waiver of counsel.

They had an obligation to "act as counsel at Appel's competency hearing by subjecting the state's evidence of competency to meaningful adversarial testing."

The Court agreed with Appel's characterization of the events. It found that for the ten days between the assignment of the case to them and the court's acceptance of the waiver of counsel, they had an obligation to "act as counsel at Appel's competency hearing by subjecting the state's evidence of competency to meaningful adversarial testing." The Court noted that a failure to investigate Appel's background, to speak with his family and friends, and to obtain health and employment records, constructively denied Appel a right to counsel. Although appointed counsel testified that they did not consider themselves to be Appel's counsel during that time period, the Court nonetheless found for the defendant, citing Pennsylvania Rules of Criminal Procedure, which state that "counsel for a defendant may not withdraw his or her appearance except by leave of the court." Because the unconstitutional deprivation of counsel at the competency hearing affected all later stages of his prosecution, the Court vacated Appel's conviction and ordered a new trial.

Social Security Act Denies Disabled Status to Alcoholic Individuals Seeking Benefits

Ball v. Massanari, 254 F.3d 817 (9th Cir. 2001):

The Ninth Circuit Court of Appeals rejected a Constitutional challenge to an amendment to Title II of the Social Security Act, which provides that where drug addiction or alcoholism is a material contributing factor, an individual cannot be found disabled. The Court also found that the Administrative Law Judge (ALJ) properly analyzed the claimant's case when it did not explicitly consider whether his condition, standing alone, would be disabling, since the claimant's non-substance abuse related impairments were not found to be "severe."

> By removing alcoholism from its analysis, the ALJ was "in effect" addressing whether Ball would still be found disabled if he stopped using alcohol.

James Ball, a logger injured on the job in 1986, was denied Social Security benefits on the basis that he could not establish disability. The ALJ determined that Ball had osteopenia, a severe impairment that precluded his ability to perform past relevant work, and dysthymia. Additional medical information also revealed that Ball had a diagnosis of late stage, chronic alcohol dependence. Ball argued that the ALJ erred when he failed to consider what impairments would remain once Ball stopped drinking and whether these impairments would be disabling.

The Court disagreed. It concluded that by removing alcoholism from its analysis, the ALJ was "in effect" addressing whether Ball would still be found disabled if he stopped using alcohol. In addition, it held that only "severe" conditions warranted this analysis. Since Ball's injury was mild, the Court felt that there was no need for the ALJ to explicitly consider whether the condition, standing alone, would be disabling. The Court was not persuaded by Ball's Constitutional challenge. The Court found that alcoholics are not a suspect or quasi-suspect class, and thus the state's goal of "discouraging drug and alcohol abuse" satisfies a rational-basis scrutiny.

The Professional Judgment Standard Is the Appropriate Standard When Reviewing Medical Care Claims of Involuntarily Committed Patients

Patten v. Nichols, 274 F.3d 829 (4th Cir. 2001):

The Fourth Circuit Court of Appeals held that medical care claims asserted by involuntarily committed patients must be measured under the professional judgment standard and not the more stringent "deliberate indifference" standard used for pre-trial detainees.

> Liability will be imposed upon finding a substantial departure from accepted professional judgment.

Patten died of "coronary insufficiency" while involuntarily committed to Virginia's Western State Hospital (WSH). Patten called family members earlier that week, informing

them that her breathing was getting worse and that she felt that she was dying. The family called WSH and requested a full physical exam of Patten. Two doctors from WSH then spoke with Patten for 10-20 minutes but never examined her. Patten died the next morning. Patten's estate sued on the grounds that WSH failed to provide Patten with proper medical care. Defendants contended that the deliberate indifference standard, used to measure pre-trial detainees' claims, was the appropriate standard by which to measure claims by involuntarily committed patients.

The Court disagreed and held that under *Youngberg v. Romeo,* 457 U.S. 307 (1982), the exercise of professional judgment is the standard to be used for patients involuntarily committed to a state psychiatric facility. The Court reasoned that applying the deliberate indifference standard would be "giving involuntarily committed patients the *same* treatment as that afforded to convicted prisoners, a result the *Youngberg* Court specifically condemned." It noted that the difference in the purposes for which the groups are confined and the nature of the confinement itself are more than enough to warrant treating their denial of medical care claims under different standards. Thus, liability will be imposed upon finding a substantial departure from accepted professional judgment.

Eleventh Amendment Does Not Preclude Recovery for Title II ADA Violations by a State

Project Life, Inc. v. Glendening, 139 F. Supp. 2d 703 (D. Md. 2001):

The United States District Court of Maryland held that the Eleventh Amendment did not preclude recovery of monetary judgments against the state for violations of Title II of ADA, despite a recent Supreme Court decision that the Eleventh Amendment barred suit by private citizens against a state under Title I.

> Project Life was discriminated against on the basis of a disability in violation of the ADA.

Project Life, Inc. (Project Life) was denied a permanent berth for a decommissioned U.S. Navy ship that was to be used as a residential education facility for women recovering from substance abuse. Project Life brought a claim against the port authority under Title II of the ADA, which prohibits discrimination in furnishing public services. The port authority argued that the recent decision in *Board of Trustees of the University of Alabama v. Garrett*, 531 U.S. 356 (2001), which held that Congress's abrogation of the States' Eleventh Amendment immunity was invalid for suits by private citizens against a state in federal court for damages under Title I of the ADA, should equally apply to Title II.

The Court decided not to extend *Garrett* to include Title II, since other decisions seemed to have validated the abrogation of sovereign immunity in Title II claims. The Court went on to find that Project Life was discriminated against on the basis of a disability, in violation of the ADA, and issued an injunction to compel the port authority to enter into a long-term lease with Project Life.

Cases in State Courts

Violation of ADA Is Not a Defense in Parental Termination Proceedings

Adoption of Gregory, 747 N.E.2d 120 (Mass. 2001):

The Supreme Judicial Court of Massachusetts held that a violation of the Americans with Disabilities Act (ADA) is not a defense to a termination of parental rights proceeding because termination proceedings do not constitute "services" under the ADA.

When Gregory was born, hospital staff reported that he was at risk for neglect. His parents failed to take prenatal or parenting classes, had poor impulse control, and showed lack of personal hygiene. When proceedings began for the termination of parental rights, Gregory's father, who suffers from a cognitive disorder and attention deficit hyperactivity disorder (ADHD), argued that the Department of Social Services failed to reasonably accommodate his disorders, in violation of Title II of the ADA.

> Allowing the provisions of the ADA to constitute a defense to termination proceedings would "improperly elevate the rights of the parent above those of the child."

The Court held that proceedings to terminate parental rights do not constitute "services, programs, or activities" for the purposes of 42 U.S.C. section 12132 and therefore violations of the ADA were not a defense to such proceedings. The court felt that allowing the provisions of the ADA to constitute a defense to termination proceedings would "improperly elevate the rights of the parent above those of the child." The Court also found that the father's disabilities were reasonably accommodated when the Department of Social Services scheduled visitations, retained a social worker experienced in working with cognitively limited individuals, and provided him with one-on-one parenting classes. It held that it was the father who failed to make use of these numerous accommodations.

Actuarial Scores Not Appropriate in SVPA Commitments When Offenses Are Committed by a Minor

In re J.P., 772 A.2d 54 (N.J. Super. Ct. App. Div. 2001):

The Appellate Division of the Superior Court of New Jersey held that testimony regarding a sex offender's actuarial scores is not admissible to predict his future dangerousness when offenses were committed while he was under the age of eighteen. The Court also held that expert testimony regarding future dangerousness is insufficient to meet the clear and convincing standard when the expert relies solely on a record review and does not conduct a personal interview.

> Actuarial scores were not valid because they reflected adolescent behaviors that did not necessarily continue into adulthood.

J.P. was fifteen years old when he committed three sexual assaults against women. After serving seventeen years in prison for these crimes, the state attempted to involuntarily commit

J.P. using actuarial tools that assessed his risk of dangerousness based on previous crimes committed as a juvenile. Experts for the state found that, based on his prior actions as a juvenile, J.P. was "high risk" and likely to engage in acts of sexual violence in the future. J.P. argued that his actuarial scores were not valid because they reflected adolescent behaviors that did not continue with him into adulthood. He also argued that the state could not meet its burden by relying on experts who made recommendations to commit him without having conducted a clinical interview.

The Court found in favor of J.P. First, it reasoned that "when an individual's last sex offense was committed while he was age fifteen, and he has been incarcerated since, the static nature of the instruments effectively freezes that person in his adolescence, making no allowance for the process of maturity." Thus, the Court found that J.P.'s actuarial scores were "ambiguous and incomplete" and remanded the matter for an evidentiary hearing concerning the admissibility of such instruments under these circumstances.

Second, the Court held that the testimony of experts who base their recommendations solely on a record review of an offender is insufficient in a commitment hearing. The Court found that the Legislature clearly intended that a Sexually Violent Predator Act commitment hearing include "testimony from a mental health professional who has personally interviewed the person subject to commitment." There was also concern for the trustworthiness of the sources of information used by experts conducting a record review. Based on these two broad concerns, the Court concluded that J.P.'s commitment was not supported by clear and convincing evidence.

Courts Have Affirmative Duty to Further Investigate Defendant's Competency During Trial

State v. Sanders, 549 S.E.2d 40 (W. Va. 2001):

The Supreme Court of Appeals of West Virginia held that a defendant was entitled to a retrospective competency hearing when the trial court abused its discretion by failing to conduct further investigation into the defendant's competency after new evidence cast serious doubt on the validity of an earlier competency finding.

Lewis Sanders was arrested for robbing a woman at gunpoint in a parking lot. From 1994 to 1997, Sanders was found incompetent to stand trial due to a psychotic disorder.

> The court failed to recognize that his bizarre behavior...raised sufficient doubt as to his continued mental fitness and warranted additional inquiry into his competency to stand trial.

In August of 1998, a psychiatrist found Sanders competent but noted that if the trial was not conducted immediately, Sanders' condition would likely "disintegrate to the point of incompetency." The trial did not commence until December. Although the defendant became uncooperative with his attorneys, engaged in lengthy incoherent monologues on the stand, and refused his psychiatric medication during this time, the trial court refused to

grant a mistrial on the grounds that the defendant had become incompetent. Sanders argued on appeal that the trial court failed to recognize that his bizarre behavior at trial raised sufficient doubt as to his continued mental fitness and warranted additional inquiry into his competency to stand trial.

The Supreme Court of Appeals agreed. Recognizing that it is a fundamental right of due process not to be tried or convicted while incompetent, it imposed on the trial court an affirmative duty to "remain vigilant and watchful" to the possibility that the defendant may lapse into incompetency. The trial court need only suspend proceedings and conduct a second competency hearing, however, when it is presented with a substantial change of circumstances or with new evidence casting serious doubt on the validity of the finding of competency. Rather than grant a mistrial, the Court ordered a retroactive assessment of Sanders' mental competency at the time of his trial. The Court considered the passage of time, the availability of medical evidence, statements by the defendant, and the availability of witnesses who interacted with the defendant before and during the trial, in reaching its decision.

Virginia Legislation

Medical Treatment of Incapacitated Persons.
SB 483

Summary as passed:

This bill expands the current medical treatment statute that applies to incapacitated patients and residents of state facilities to include incapacitated community services board consumers and to cover dental treatment. This bill provides that neither a licensed health professional nor a licensed hospital will be subject to liability arising from a claim based on lack of informed consent or be prohibited from providing services when a delay in treatment might adversely affect the recovery of an individual who has no guardian or committee and who is receiving community mental health services from a community services board or behavioral health authority if two physicians (or dentists in the case of dental treatment) document this in writing.

Discharge of Patients and Residents from State Facilities.
HB 1228 and SB 661

Summary as passed:

Directors of training centers for persons with mental retardation are required to prepare a predischarge plan for residents in conjunction with the community services board that serves the political subdivision where the resident resided prior to admission, or by the board that serves the political subdivision where the resident (or legally authorized representative) chooses to reside if the resident (or his representative) chooses to be discharged. No resident of a training center who is enrolled in Medicaid will be discharged if the resident (or the legally authorized representative on his behalf) chooses to continue in the training center. Legally authorized

representatives will make this decision if the resident lacks the mental capacity to do so.

All predischarge plans for all individuals discharged to an assisted living facility from state hospitals or training centers must (1) identify the facility, (2) document its appropriateness for housing and capacity to care for the individual, (3) contain evidence of the facility's agreement to admit and care for the individual, and (4) describe how the community services board will monitor the individual's care in the facility.

Investigation of Deaths in Mental Health Facilities.
HB 396

Summary as passed:

This bill adds patients or residents of state mental health or mental retardation facilities who have died to the list of deaths that must be reported to the medical examiner of the locality in which the facility is located. The Commissioner of and Inspector General for Mental Health, Mental Retardation and Substance Abuse Services must be provided with a copy of the autopsy report. The Department will pay the fee for such services.

MHMRSAS; Board Membership.
SB 400

Summary as passed:

The State Board of Mental Health, Mental Retardation and Substance Abuse Services must now include a practicing psychiatrist.

Criminal Background Check; Substance Abuse Treatment Professionals.
HB 658

Summary as passed:

Community services boards, behavioral health authorities, and agencies licensed by the DMHMRSAS are now permitted to hire persons for adult substance abuse treatment programs who were convicted of a broader list of crimes, i.e., a misdemeanor violation relating to (i) unlawful hazing as set out in section 18.2-56; or (ii) reckless handling of a firearm as set out in section 18.2-56.1; or (iii) any misdemeanor or felony violation related to (a) reckless endangerment of others by throwing objects as set out in section 18.2-51.3; (b) threat as set out in section 18.2-60; (c) breaking and entering a dwelling house with intent to commit other misdemeanor as set out in section 18.2-92; or (d) possession of burglarious tools as set out in section 18.2-94; or (iv) any felony violation relating to the distribution of drugs as set out in Article 1 (section 18.2-247 et seq.) of Chapter 7 of Title 18.2, except an offense pursuant to subsection H.1. or H.2. of section 18.2-248 (drug lord offenses); or (v) an equivalent offense in another state. The hiring provider must determine, based upon a screening assessment, that the criminal behavior was related to the applicant's use of substances and that the person has been successfully rehabilitated and is not a risk to consumers.

Mental Health and Substance Abuse Treatment Services; Licensing of Providers.
SB 504

Summary as passed:

The Commissioner of the DMHMRSAS now has the authority to issue licenses to providers of day support, in-home support, or crisis stabilization services funded through the Individual and Families Developmental Disabilities Support Waiver. The Department of Rehabilitative Services shall collaborate with the DMHMRSAS in activities related to licensing providers of services under such waiver. These activities include involving advocacy and consumer groups who represent persons with developmental disabilities in the regulatory process; training the DMHMRSAS, local human rights committees, and the State Human Rights Committee, on the unique needs and preferences of individuals with developmental disabilities; assisting in the development of regulatory requirements for such providers; and providing technical assistance in the regulatory process and in performing annual inspections and complaint investigations.

Minors' Consent to Treatment for Substance Abuse.
HB 127

Summary as passed:

When a minor is not receiving care, treatment, or rehabilitation for substance abuse, a parent, legal guardian, or person standing *in loco parentis* will not be prevented from obtaining the results of the minor's nondiagnostic drug test.

Policies Regarding Medication Recommendations by School Personnel.
HB 90

Summary as passed:

The Board of Education must develop and implement policies prohibiting school personnel from recommending the use of psychotropic medications for any student. The policies will not prohibit school health staff from recommending that a student be evaluated by an appropriate medical practitioner or prohibit school personnel from consulting with such practitioner with the written consent of the student's parent. "Psychotropic medications" is defined as those medications the prescribed intention of which is to alter mental activity or state, including, but not limited to, antipsychotic, anti-depressant, and anxiolytic medication and behavior-altering medication. Medications such as Ritalin (methylphenidate), Prozac (fluoxetine), and Paxil (paroxetine) would be included in this classification. HB 754 was incorporated in this bill.

Child Custody Proceedings.
HB 1224

Summary as passed:

The juvenile and domestic relations district court has the authority to order psychological or custody evaluations and drug tests of a parent,

guardian, legal custodian, or person standing *in loco parentis* to the child.

Custody and Visitation; Use of Mental Health Records of Parent.
HB 1001

Summary as enacted with Governor's Recommendation:

In any case in which custody or visitation of a child is at issue, any information obtained during therapy and the records kept by any licensed mental health care provider concerning a parent shall be privileged and confidential. Additionally, a mental health care provider may not be required to testify on behalf of or against a parent or adult relative of the parent except that the court may order the provider to testify on child abuse matters. The privilege and confidentiality provisions do not apply to providers who have conducted or are conducting an independent mental health evaluation pursuant to a court order. The bill is effective July 1, 2003.

Persons Acquitted of Misdemeanors by Reason of Insanity.
SB 482

Summary as passed:

A person found not guilty of a misdemeanor by reason of insanity shall remain in the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services for a period not to exceed one year from the date of acquittal. Prior to or at the conclusion of one year, if the Commissioner determines that the acquittee meets the criteria for release, emergency custody, temporary detention, or involuntary commitment, the Commissioner shall file a petition to accomplish the same. The Commissioner must notify the committing attorney for the Commonwealth prior to release.

Witnesses; Treatment Plan of Practitioner Admissible.
HB 37

Summary as passed:

This bill provides that a diagnosis or treatment plan of the practitioner, as documented in the patient's medical record, during the time of the practitioner's treatment, may be disclosed in discovery or in testimony. To be admissible at trial, the diagnosis must be offered at a reasonable degree of medical probability.

Discovery of Medical Evidence at Trial.
HB 923

Summary as passed:

When the physical or mental condition of the patient is at issue in a civil action, facts communicated to, or otherwise learned by, a practitioner of any branch of the healing arts in connection with the patient's examination or treatment shall be disclosed only by discovery or testimony, or when a court orders disclosure because it deems disclosure necessary to the proper administration of justice. However, no order shall be entered compelling a party to sign a release for medical records from a

health care provider unless the health care provider is located outside the Commonwealth or is a federal facility. In addition, orders must be restricted to medical records relating to the physical or mental conditions at issue in the case.

Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law.

The typical article is ten to fifteen pages long, without substantial footnoting. The reading audience is multi-disciplinary, typically with legal or mental health training, but not necessarily both. Therefore, *Developments* seeks articles that are useful to a general audience interested in mental health law.

How to contact Developments in Mental Health Law:

1) The preferred method of submitting articles is to submit a short query by e-mail, describing the topic and general thesis. Send e-mail to: th4n@virginia.edu, with a subject line of "*Article Query,*"

or

2) Query letters can be mailed to the attention of the Editor: *Developments in Mental Health Law,* P.O. Box 800660, Charlottesville VA 22908-0660. The street address is: 1107 Main St.

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

INSTITUTE OF LAW, PSYCHIATRY, AND PUBLIC POLICY
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Institute faculty and associates have particular expertise in issues relating to the mental health needs of juvenile offenders, adjudicating and sentencing juveniles as adults, and the forensic evaluation of juveniles. Institute faculty have active and extensive research programs and frequently provide consultation in these areas:

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Developments in Mental Health Law
Institute of Law, Psychiatry & Public Policy
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DEVELOPMENTS IN MENTAL HEALTH LAW

The Institute of Law, Psychiatry & Public Policy — The University of Virginia

Volume 21, Number 3 (June 2002)

An Eleven Year Retrospective Study of Community-Based Forensic Evaluations: Service Delivery, Quality Assurance, and Evaluation Outcomes*

By Janet I. Warren, D.S.W.,** William J. Stejskal, Ph.D.,*** and Preeti Chauhan, B.S., B.A.****

During the past decade there has been a growing interest in forensic pretrial evaluations and the various systems that have been developed to provide these evaluations to the courts and to defendants in an equitable and fair manner. Concerns about these evaluations have focused on the provision of services that are cost effective while still adequately protecting the constitutional rights and liberty interests of defendants. Much of the research in this field examines the forensic service delivery systems from both a categorical and a dimensional perspective (Poythress, Otto, & Heilbrun, 1991; Grisso, Coccoza, Steadman, Fisher, & Greer, 1994;

Also in this Issue:

* This research was funded under contract by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services and the Office of the Attorney General. The points of view expressed in this document reflect those of the authors and do not necessarily represent the official position of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services or the Office of the Attorney General.

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Roesch & Ogloff,1996). Earlier studies sought to identify basic forensic delivery structures across states while later studies developed dimensional models that could be used to more accurately describe divergent models or systems. A smaller number of studies examines the impact of these approaches on the evaluative process itself and the outcomes reached by clinicians (Warren, Rosenfield, Fitch, & Hawk, 1997). The current study seeks to add to this research base by summarizing detailed evaluation and outcome data from Virginia's decentralized, community-based forensic system over an eleven-year period.

Service Delivery Models

In one of the first publications in this area, Poythress, Otto, and Heilbrun (1991) offered paradigmatic descriptions of contemporary and emerging models for providing pretrial evaluations for criminal courts and discussed the various training and quality assurance issues intrinsic to these models. Their five model paradigms included the institution-based inpatient model; the institution-based outpatient model; the community-based outpatient model; the community-based private practitioner model; and a mixed model. They sought to analyze these different models in terms of cost, geographical and population distribution, and the number of evaluations conducted each year. Based upon these analyses they concluded that the move towards decentralized and mixed models was likely to continue due to their ability to provide more evaluations at less cost in more geographically distinct locales.

Grisso, Coccoza, Steadman, Fisher, & Greer (1994) sought to further refine this paradigm by delineating underlying dimensions that could be used to describe the variation within models. These dimensions included agency types (inpatient versus outpatient and use of a statewide, regional, or local catchment area); agency descriptors (professional training of the evaluators, by whom evaluators are employed, funding, security issues, range of services provided, and location

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

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ISSN 1063-9977

of evaluation sites); system descriptors (annual number of pretrial evaluations, time required to complete the evaluations, quality control mechanisms, and respondent satisfaction); and state descriptors (population, geographic size, and geographic location). Using these dimensions as conceptual markers for classification, the authors generated a similar but different typology that included traditional, mixed, private practitioner, community-based, and modified-traditional service delivery systems.

In classifying the various states according to their primary designation, Grisso et al. (1994) determined that ten states fell within the traditional model, nine within the private practitioner model, eleven within the community-based model, five within the modified-traditional model, and five within the mixed model. Eight states were unclassifiable. Four of the five service delivery models, i.e., the private practitioner, community-based, modified-traditional, and mixed models, contained varying proportions of outpatient evaluations conducted by examiners with different types and degrees of professional and forensic training. Based on this assessment, Grisso et al. conclude that "the traditional use of centrally located, inpatient facilities for obtaining pretrial evaluations survives in only a minority of states, having been replaced by other models that employ various types of outpatient approaches" (p. 388). They observe that most states, in addition to the dominant outpatient approach, also rely on a secondary or back-up approach for obtaining pretrial forensic evaluations, adding complexity and variation to the primary approaches. Given this variability, Grisso et al. highlight the importance across systems of quality assurance, continuing education, review of forensic evaluations, and examiner certification procedures.

Warren, Rosenfield, Fitch, and Hawk (1997) used a multi-state study design to examine the effects that the various service delivery systems might have on referral dynamics for pretrial evaluations and evaluation outcomes. They argued that the older, more traditional, centralized type of forensic service delivery system may have camouflaged potential differences across states, allowing the debate regarding evaluation variability in outcomes to be attributed solely to differences in the legal standards underlying the evaluations. To further explore this hypothesis, they studied evaluation outcomes from three states with comparable legal standards but divergent forensic delivery systems. Using data from Virginia, Michigan, and Ohio, they found significant differences between the states in the types of defendants referred for evaluation as well as in the opinions offered by the evaluating clinicians. They also found significant differences in the diagnostic and offense categories of defendants referred for evaluation. Based upon these findings, Warren et al. conclude that "the structure of a system for providing forensic evaluation services may significantly affect both the group of individuals referred for evaluation as well as the evaluation outcome" (p. 377).

Quality Assurance Within a Community-Based System

Shortly after the implementation of a decentralized, community-based forensic evaluation system in Virginia, Melton, Weithorn, and Slobogin (1985) undertook a systematic review of the performance of the newly trained community-based forensic evaluators. Based on a review by a panel of national forensic experts of all of the forensic reports submitted, combined with feedback from Commonwealth's attorneys, defense attorneys, and

attorneys, defense attorneys, and judges regarding evaluator performance, they concluded that the reports and testimony of the community-based evaluators were equal to and, in many regards, of better quality than those being conducted in an inpatient setting. Further, the Commonwealth's attorneys, defense attorneys, and judges who were evaluating the new examiners reported that it was their impression that the work of the examiners was less biased and more thorough than the evaluative work being produced, at that time, in state facilities.

In 1988, Fitch and Warren further explored outcome measures associated with this implementation effort. They found that community-based clinicians who underwent an initial seven-day training program concluded that forensic evaluations represented a needed addition to the services offered by their clinics. These clinicians also reported that providing this type of service and working as part of a forensic team was personally rewarding. The judges, Commonwealth's attorneys, and defense attorneys that were the recipients of this work positively rated the reports provided, citing their timeliness, clarity, and quality. Positive ratings were also given to the performance of the evaluators, including their knowledge of legal issues, knowledge of clinical issues, courtroom testimony, objectivity, accessibility, and willingness to assist in case presentation.

Current Study

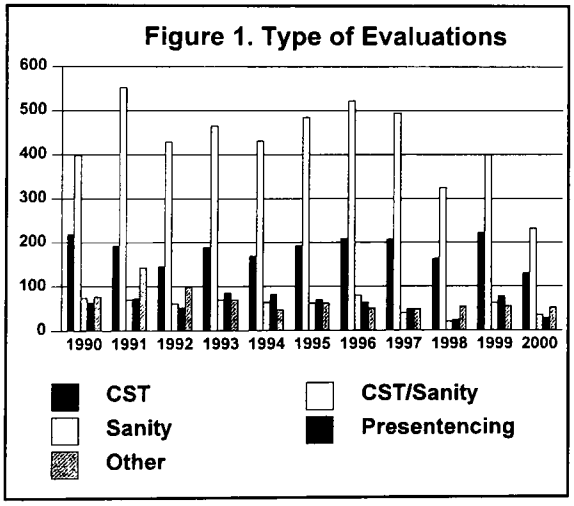
The current study is designed to apply forensic evaluation data from Virginia, a community-based, public/private practitioner model, to these paradigmatic and systemic delivery considerations. Following the initial research that was conducted by Melton et al. (1985), a Forensic Evaluation Information System (FEIS) was implemented to track systemic changes in the new decentralized system over time; to provide quality assurance feedback to the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Virginia Supreme Court; and to provide a research avenue for examining the impact of pretrial evaluations on case outcome. The FEIS is a voluntary system that asks evaluators trained by the Institute of Law, Psychiatry and Public Policy to submit a two-page forensic checklist to the Supreme Court along with their requests for payment. These forms are then returned to the Institute for analysis.

The original FEIS form contained information concerning the defendant being evaluated; the training and affiliation of the evaluator; the evaluation procedures, i.e., the testing, interview, and record review used in conducting the evaluation; and the psycho-legal conclusions offered by the evaluator regarding the defendant's adjudicative competence and sanity. Since its inception, the form has undergone a significant number of revisions to include further information concerning the defendant's prior criminal and psychiatric history; the defendant's compliance at the time of the offense with prescribed psychotropic medication; the use of alcohol or other non-prescribed substances at the time of the offense; and the inclusion of psychological, neuropsychological, or neurological tests as part of the evaluation process. The section on psycho-legal conclusions was expanded to reflect the psychiatric symptomatology that contributed to the evaluator's opinion about whether the defendant's ability to understand the nature, character, and consequences or wrongfulness of his or her act was significantly impaired (i.e., impairments that may support the defense of insanity). A previous review suggests that the FEIS system contains information regarding 50% to 80% of the court-ordered forensic evaluations

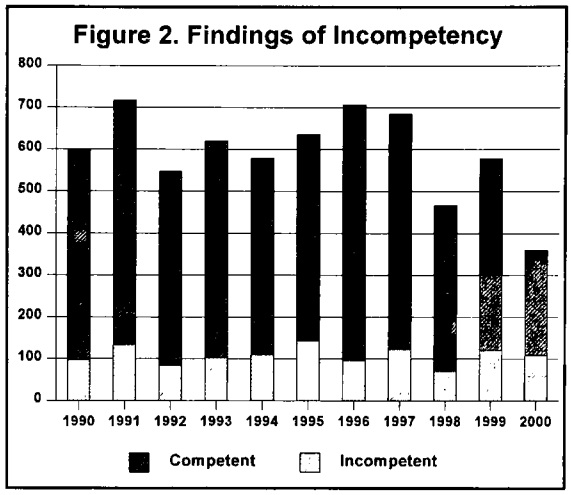
conducted in Virginia each year (Warren, 1992).

RESULTS

Figure 1 provides a description of the number and types of evaluations requested by attorneys and the courts each year over a ten-year period. As summarized, the most common referral question involves a combined Competency to Stand Trial (CST)/Sanity evaluation. A CST-only evaluation was the next most frequent referral request. It is our impression that the combined CST/Sanity evaluation is frequently used as a "fishing expedition" by the defense to obtain clinical information that might be relevant to plea negotiations or sentencing. This observation derives from reports that more than 90% of all criminal charges are resolved



through a process of plea bargaining. Prior research has further indicated that the clinical information contained in these evaluations is not only relevant to plea negotiations and sentencing but may also prompt community treatment and the dismissal of relatively minor charges (Warren, Rosenfield, & Fitch, 1994). The decrease in the total number of evaluations conducted in 1998-2000 does not reflect a decrease in the number of evaluations requested and conducted each year but rather systemic problems that derived from the move of the Institute of Law, Psychiatry and Public Policy to a new location and the decision of one state facility to stop

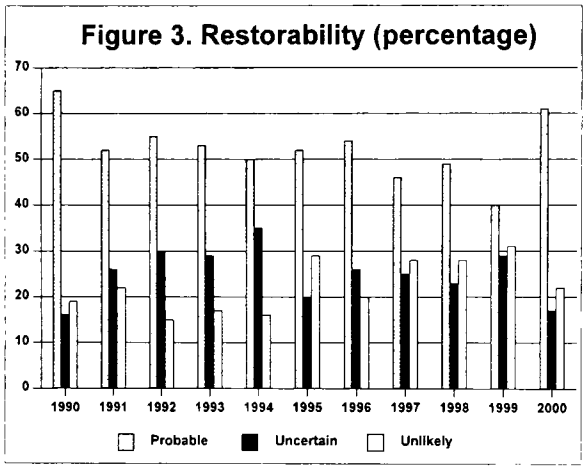


submitting forms to the FEIS system. These problems are currently being addressed.

Figure 2 illustrates the proportion of defendants ordered for evaluation who are opined by the evaluator to be competent or incompetent to stand trial. This proportion has remained relatively consistent across years, ranging from 14% in 1996 found incompetent to 30% in 2000, with an eleven-year mean of 20%. This appears to represent random variability that may be due to the nature of the referred cases. The data do not reflect a particular trend that suggests a steady increase or decrease in the number of defendants opined to be incompetent by the evaluating clinicians. These proportions are in line with previous research concerning the adjudicative competence of criminal defendants (Melton, Petrila, Poythress, & Slobogin, 1997).

Figure 3 illustrates the opinions of the evaluating clinicians regarding the restorability to competency of the defendants (probable, uncertain, and

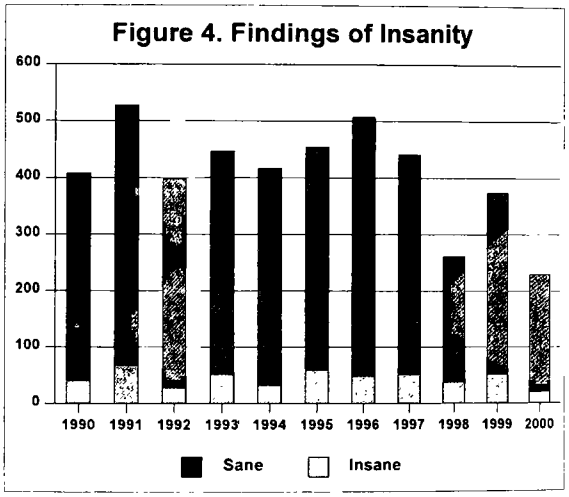
unlikely). There is considerable variability in this type of opinion across time, ranging from a low of 15% in 1992 to a high of 31% in 1999 being considered unlikely to be restored to competency, with a mean proportion of 25% of defendants being considered unlikely to be restored to competency across the



eleven-year period. This variation again appears to be relatively random and does not reflect any consistent or sustained change across time in the proportion of defendants thought to be unrestorably incompetent by the forensic evaluators. Furthermore, any apparent effects may be more a reflection of the relatively small number of cases involved. It is interesting to observe that the advent of more sophisticated medications for psychotic and major affective disorders over the past eleven years has not apparently affected opinions regarding the unrestorability of incompetent defendants in general.

Figure 4 indicates the relative proportion of defendants opined to be legally sane or insane by the evaluating clinicians. There is some degree of variability in the percentage of defendants thought to be insane, ranging from 7% in 1992 to 15% in 1998, with a mean of 12%, but with no obvious trend across the eleven-year period. The proportions of defendants thought to be incompetent is consistently larger than those thought to be insane by the forensic evaluators.

This pattern clearly reflects the referral practice of defense attorneys (and, as a responsive matter, of courts



and prosecutors). A defense attorney is unlikely to seek a competence assessment unless there is a genuine doubt about the defendant's capacities. However, the threshold for referral for an insanity evaluation (or a combined evaluation) is likely much lower (as noted earlier) because of the potential usefulness of offense-related mental health information in plea bargaining and sentencing. Of course, the standards for findings of incompetence and insanity are both very high.

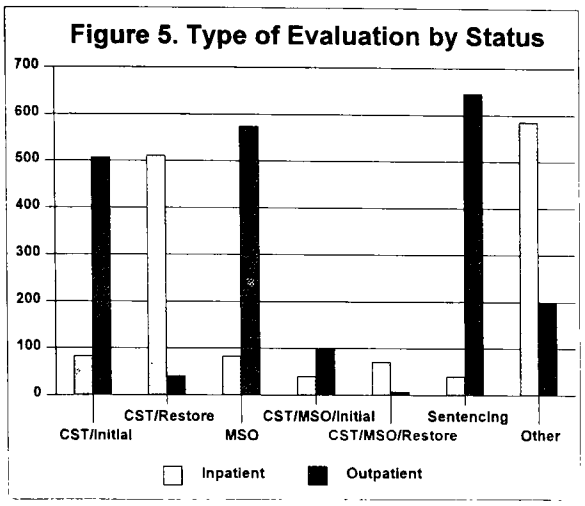
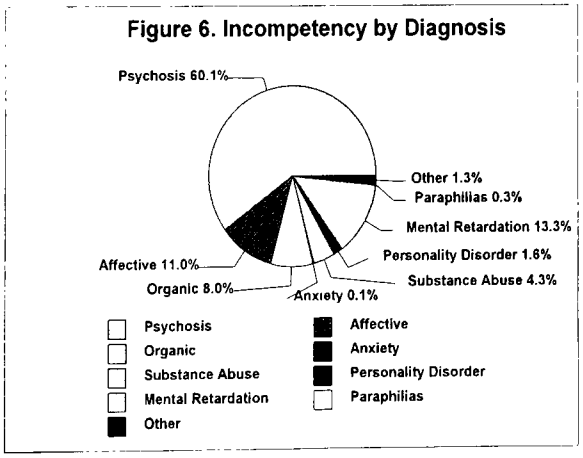
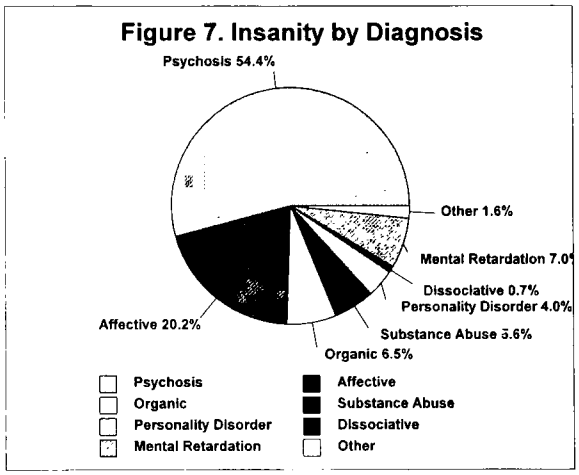


Figure 5 summarizes the types of evaluation being conducted on an inpatient or outpatient basis over the eleven-year period. Initial evaluations of competence and sanity and sentencing evaluations are clearly more likely to take place in the community. However, evaluations to determine if the defendant has been restored to competence occur more frequently in the hospital where the defendant has been placed for restoration services. These findings basically confirm the integrity of the community evaluation system implemented in 1981.



Figures 6 and 7 summarize the primary diagnosis received by the defendants found incompetent to stand trial or insane at the time of the offense. Both diagrams clearly demonstrate that a psychotic disorder is the most prevalent diagnosis with over 50% of the individuals being attributed this severe diagnosis. Psychosis is followed by affective disorders for defendants found insane and mental retardation for defendants found incompetent. Anxiety disorders and dissociative disorders were the least likely diagnoses. These findings again are supportive of the integrity of the community system with those defendants thought to be incompetent or insane by the evaluating clinicians suffering from the most severe forms of psychiatric and cognitive disturbances.



Figures 8 illustrates the psychiatric and criminal history of the defendants found incompetent to stand trial. Over half (52%) of these defendants had prior criminal convictions. Roughly two-thirds (67%) also had past psychiatric hospitalizations. Almost half (44%) had been prescribed psychotropic medication although approximately only a third (30%) were taking their medications at the time of the offenses. Less than a quarter (22%) of these defendants were under the influence of either alcohol or drugs at the time of the alleged offense. These findings are congruent with an emergent picture of a chronically mentally ill in-

competent defendant who due to his/her illness has repeat contact with the criminal justice system. This kind of criminological and psychiatric profile lies at the core of the debate regarding the development of mental health courts for the chronically mentally ill, non-violent offender.

Figure 8. History by Incompetence

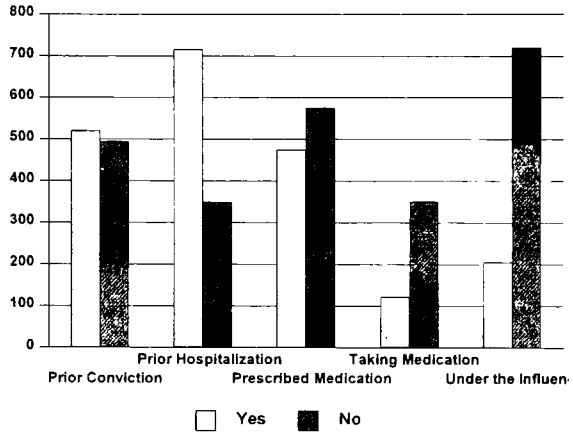
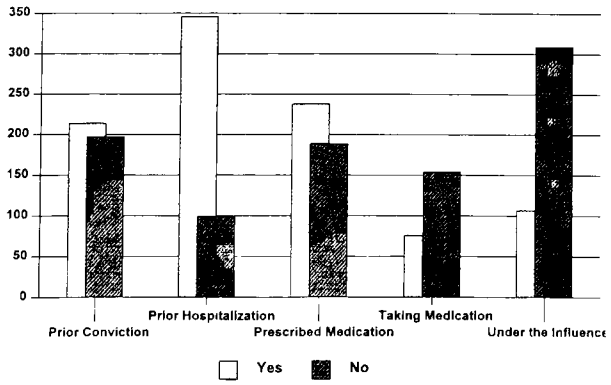


Figure 9 summarizes these same historical factors for defendants opined to be insane at the time of the offense by the evaluating clinician. Over three-quarters (78%) of these defendants had prior psychiatric hospitalizations and more than half (56%) had been prescribed medication. However, only approximately a third (35%) of these defendants were taking their prescribed medications at the time of the offense.

Figure 9. History by Insanity



Roughly the same proportion (26%) of these individuals were under the influence of either alcohol or illegal drugs at the time of the offense as had been the case for defendants considered to be incompetent to stand trial. These findings highlight the importance of medication compliance in the reduction of criminal behavior among chronically mentally ill individuals.

DISCUSSION

These findings support two of the pivotal requirements for a high-quality, sustainable, community-based system of forensic evaluation, namely, that forensic evaluations can be conducted in a consistent (i.e., reliable) and accurate (i.e., valid) manner on an outpatient basis by forensically trained, community-based evaluators. Although the current data reveal some variability across years in opinions regarding both competence and sanity, variations appear to be random and outcomes have remained remarkably stable across the state. This finding is impressive given that it reflects more than 8,932 evaluations conducted over an eleven-year period by several hundred evaluators throughout the Commonwealth of Virginia.

In addition, these findings suggest that trained community clinicians offer opinions that are clinically consistent across evaluators in line with previous research regarding the rates of adjudicative incompetence and legal insanity. These opinions also appear congruent with general forensic understanding regarding the clinical profile of incompetent and insane defendants.

For example, defendants opined to be incompetent to stand trial are primarily psychotic or mentally retarded, likely to have both a criminal and psychiatric history, and are largely medication noncompliant. The clear majority are considered to be restorable, arguably primarily through the use

of medication combined with educational efforts regarding the importance of medication maintenance.

The profile of the defendants thought to be insane by the evaluating clinicians is similar in many regards but with even a greater proportion of these defendants having a psychiatric history -- a factor indicative of the threshold condition of a "major disease or defect" required by the insanity standard in Virginia. Further, the majority of these individuals had been prescribed psychotropic medication although many were not taking it at the time of the offense.

The consistency of these findings across evaluators and the congruence of these findings with prior research suggest that forensic evaluations in Virginia reflect an appropriate standard of practice.

Taken as a whole, these data suggest that the Commonwealth of Virginia has succeeded in implementing a comprehensive, reliable, and valid community-based system of forensic evaluation that is cost-effective and that supplies a high quality pretrial evaluation to the criminal courts throughout the state. The success of this system seems to derive from three intertwined and related factors. The first of these involves the long-term contractual collaboration among the University of Virginia; the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services; and the Office of the Attorney General. This contractual arrangement has created a cross-fertilization of ideas and perspectives that has been instrumental in developing and maintaining the training, research, and policy initiatives that lie at the core of this endeavor.

The second factor involves the training that is statutorily required for those professionals conducting forensic evaluations in the Commonwealth of Virginia and that is offered by the University of Virginia through a series of on-going training programs, symposia, mentoring opportunities, and newsletters. This series of programs not only keeps community-based forensic evaluators informed of advances in clinical forensic practice and state-of-the-art research, but also creates a collegial sense of support that is of value given the high stakes and multiple stresses of this type of clinical undertaking.

Third, the development of the Forensic Evaluation Information System (FEIS) has facilitated the process of quality assurance review and made possible research that monitors and verifies the integrity of the evaluation work that is being conducted by evaluators throughout the Commonwealth of Virginia. Not only has this information system provided data relevant to the process utilized and the basis of the psychological opinions offered to the courts, but it has also allowed the state and the university to monitor diverse systemic changes in the community such as the movement of a significant number of evaluators from the public into the private sector and the related need for an increase in the standard fees (set in 1986) paid by the Virginia Supreme Court for pretrial evaluations. The success of this multidimensional initiative demonstrates the viability of university-state agency collaboration and the integration of practice, policy, and research.

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Announcing Plans for *e-Developments in Mental Health Law*

Developments in Mental Health Law is pleased to announce plans to provide an e-mail supplement for its readers—*e-Developments in Mental Health Law.* Anticipated to be available initially on a bi-monthly basis, *e-Developments* will supply a succinct and timely update on legal developments of relevance to mental health providers. Ultimately, recipients of *Developments* who have provided their e-mail addresses to the Institute of Law, Psychiatry and Public Policy in the past will automatically receive an e-mail invitation to receive these updates. However, because this list is incomplete and in some cases dated, recipients are encouraged to send their current e-mail addresses to Amanda French at amandafrench@virginia.edu if interested in receiving this service.

Cases in the Federal Courts

Maximum Security Confinement of Mentally Ill Inmates Is Cruel and Unusual Punishment

Jones 'El v. Berge, 164 F. Supp. 2d 1096 (W.D. Wis. 2001):

The District Court of Wisconsin granted a preliminary injunction to mentally ill inmates housed in a maximum security prison. The injunction ordered inmates transferred out of that facility and into an inpatient psychiatric facility due to the conditions of extreme isolation and sensory deprivation in the prison.

The plaintiffs are mentally ill inmates that challenged their living situation at Supermax. Supermax is a maximum security prison facility where cells are illuminated twenty-four hours a day, inmates spend only four hours a week outside their cell, and no clocks, radios, watches, or televisions are allowed. The inmates argued that the decision to place a seriously mentally ill inmate in this prison constituted cruel and unusual punishment under the Eighth Amendment because the conditions could be devastating to the health of individuals with a mental illness.

> The conditions at Supermax, which serve no legitimate penological purpose, are so severe and restrictive that they create and exacerbate symptoms in the mentally ill.

The court agreed. It found that the conditions at Supermax served no legitimate penological purpose and were so severe and restrictive that they created and exacerbated psychiatric symptoms in mentally ill inmates. The court held that Supermax was designed to house disruptive prisoners, but not mentally ill ones. The defense tried to demonstrate that the prison's screening process for identifying mentally ill inmates was a "reasonable step" taken to keep the mentally ill out of the facility, but the court was not persuaded. It felt the screening process was ineffective and not a reasonable step to prevent the risk of harm in sending seriously mentally ill inmates to Supermax. The court found that the defendants were aware of the risks associated with housing the mentally ill at Supermax and thus met the "deliberate indifference" standard. The court also balanced the inmates' interests against those of the public. It concluded that the minimal harm that could result from moving the mentally ill inmates to another facility, coupled with the public's interest in keeping prisons a humane place, supported the grant of a preliminary injunction.

Government May Forcibly Medicate Pretrial Detainees to Restore Competency

United States v. Weston, 255 F.3d 873 (D.C. 2001):

The United States Court of Appeals, District of Columbia Circuit, held that the forcible administration of antipsychotic drugs to pretrial detainees to render detainees competent to stand trial is proper upon a finding that the involuntary treatment (1) was medically appropriate, (2) satisfied an essential state policy, and (3) was necessary to restore competency.

Russell Eugene Weston, who suffers from paranoid schizophrenia, allegedly shot and killed two police officers at the United States Capitol and seriously injured a third officer.

> "[A]ntipsychotic medication is the only therapeutic intervention available that could possibly . . . make him competent to stand trial."

The government wished to try Weston for these crimes. The severity of Weston's symptoms, however, rendered him incompetent to understand the proceedings against him and to assist in his own defense. The government sought to administer antipsychotic drugs to Weston against his will to render him competent to stand trial. The government claimed a fundamental interest in finding, convicting, and punishing criminals, especially when dealing with the murder of federal police officers in a government building. In response, Weston asserted a Fifth Amendment due process liberty interest in avoiding unwanted bodily intrusion.

The court found that under *Riggins v. Nevada*, 504 U.S. 127 (1992), the government may, under certain circumstances, forcibly administer medication, provided that it is "medically appropriate." With regard to Weston, the court weighed the benefits the drugs would have in alleviating Weston's symptoms against their capacity to produce side effects. The court concluded that the medication was medically appropriate. The court also found that Weston's liberty interests were outweighed by a finding that the medication was essential for the safety of Weston and others. Finally, the court determined that the government could not adjudicate Weston's guilt or innocence by using less intrusive means: "antipsychotic medication is the only therapeutic intervention available that could possibly . . . make him competent to stand trial." Based on these findings, the court affirmed a lower court order permitting the government to forcibly medicate Weston.

The Cost of Community-Based Placements Is an Adequate Defense to an ADA Claim by Developmentally Disabled Residents of State Psychiatric Institutions

Williams v. Wasserman, 164 F. Supp. 2d 591 (D. Md. 2001):

The United States District Court of Maryland held that the Americans with Disabilities Act (ADA) did not require fundamental alteration of a state psychiatric institution's program when the requested modifications would be inequitable. The court found that it would have been inequitable for the plaintiffs to receive the requested relief given the large number of services the state must provide for all those individuals with mental disabilities.

> "The immediate shift of resources sought by plaintiffs would have resulted in a fundamental alteration of the State's provision of services."

Plaintiffs were a group of developmentally disabled residents of Maryland state psychiatric institutions. The disabilities of the patients rendered them very difficult to care for and caused symptoms such as proneness to irritability, confusion, memory loss, and aggressive behavior. Doctors and hospital staff had informed the plaintiffs that residential hospitals were not appropriate settings for them and recommended that they be placed in the community. However, community placement was never provided. These residents brought suit, alleging that the State's failure to provide them with community treatment, rather than institutional care, violated Title II of the ADA. The state raised the "fundamental alteration" defense, claiming that it would be unmanageably expensive to find or create community placements for

the plaintiffs beyond efforts already being made.

The court found that under *L.C. v. Olmstead*, "unjustified isolation" is properly regarded as discrimination based on disability. It also found that "lack of funding" is a justifiable defense to this alleged discrimination. Thus, the court found that it was under an obligation to "consider the totality of the expenses and programs undertaken by the State when evaluating the fundamental alteration defense." The court considered the amount of time it takes to place a resident, the cost of maintaining a number of hospital beds and funding the placements of other residents, and the efforts of the state in general. The record also showed that Maryland has a long policy of supporting community-based treatment and reducing inpatient psychiatric hospital beds. The court found that "[t]he immediate shift of resources sought by plaintiffs would have resulted in a fundamental alteration of the State's provision of services." The state was not, therefore, required under the ADA to do more towards the care of these individuals.

Cases in the Virginia Supreme Court

Actions of State Psychiatric Staff Taken in Execution of Involuntary Commitment Order Are Protected by Commonwealth's Sovereign Immunity

Patten v. Commonwealth, 262 Va. 654, 553 S.E.2d 517 (2001):

The Virginia Supreme Court upheld a trial court's judgment that the Commonwealth of Virginia had sovereign immunity in a wrongful death suit arising from the death of an involuntarily committed patient at Western State Hospital. The plaintiff asserted that the decedent, Maura K. Patten, died as a result of negligence on the part of the hospital staff. However, the court determined that employees of Western State were acting pursuant to the execution of a lawful court order for the hospitalization and treatment of Patten when they made decisions concerning the decedent's medical care and thus their actions are protected by the Commonwealth's sovereign immunity.

> [T]he term "court order" necessarily encompassed both mandatory *and* discretionary acts by the authorized agents . . . the hospital staff.

Patten was committed to Western State Hospital pursuant to an April 1997 "Certification and Order for Involuntary Admission to a Public or Licensed Private Facility." Patten suffered from chronic undifferentiated schizophrenia and had been involuntarily committed to Western State continuously from 1991 until her death. Patten also suffered from obesity and chronic obstructive pulmonary disease. A change in her anti-psychotic medicine in 1996 caused a large increase in weight that adversely affected her cardiovascular system. Even after the dosage was reduced, Patten complained to hospital medical staff that she was not feeling well and complained to her sister that she "felt like" she was dying. Although an employee of the hospital promised Patten's sister that a full medical evaluation would be ordered, no such evaluation occurred and Patten was found dead three days later (it was determined through an autopsy that Patten died of "coronary insufficiency due to coronary atherosclerosis and cardiomegaly due to hypertension").

The Commonwealth pleaded sovereign immunity, asserting that the alleged negligent acts by the hospital

employees were taken in execution of the court order issued in April of 1997 and were thus covered by Code § 8.01-195.3(4). That Code section provides an exception to the Commonwealth's limited waiver of immunity for tort claims "based on an act or omission of an officer, agent or employee of any agency of government in the execution of a lawful order of any court." The Court agreed with the Commonwealth that the term "court order" necessarily encompassed both mandatory *and* discretionary acts by the authorized agents, in this case, the hospital staff. In other words, discretionary hospital actions or omissions affecting Patten's health could not give rise to tort claims because these actions were mandated by a lawful court order and, as such, fall within the exception to the Commonwealth's limited waiver of immunity.

Cases in Other State Courts

Validity of Miranda Waiver by a Mentally Retarded Defendant Must Be Analyzed Under the Totality of the Circumstances

People v. Kaiser, 32 P.3d 480 (Colo. 2001):

The Supreme Court of Colorado held that a defendant's waiver of *Miranda* rights was knowing and intelligent, despite her mild mental retardation, because under the totality of the circumstances it was clear that she understood both the nature of her rights and the consequences of waiving them.

Angela Kaiser was charged with sexual exploitation and sexual assault of a child. The police, aware that the defendant was considered developmentally delayed, advised her of her *Miranda* rights prior to questioning her. Kaiser made a number of incriminating statements, all of which she sought to suppress at trial on the grounds that her mental capacity made it impossible for her to make a knowing and intelligent waiver.

> The defendant's mental capacity is certainly relevant in determining whether the defendant is capable of making a knowing and intelligent waiver; however, it is not determinative.

The court found that while a defendant's mental capacity is relevant to determining whether she is capable of making a knowing and intelligent waiver of *Miranda* rights, it is not determinative. It held that the validity of a waiver must be based on the totality of the circumstances surrounding the custodial interrogation. The court listed factors such as the defendant's age, experience, education, background, and intelligence that should be considered when analyzing the totality of the circumstances. Here, the court considered the police action of tailoring the advisement to the defendant's level of understanding, the defendant's cogent and responsive answers to questioning, and the defendant's ability to live independently and raise children in determining that the defendant understood her *Miranda* rights and the consequences of relinquishing them. Thus, while the Court acknowledged Kaiser's diminished mental capacity, it held that it was nonetheless adequate for her to make a knowing and intelligent waiver of her *Miranda* rights.

Right to Raise Ineffective Assistance of Counsel Claims Extended to Involuntary Commitment Hearings

In re Mental Health of K.G.F., 29 P.3d 485 (Mont. 2001):

The Supreme Court of Montana held that a statutory right to counsel provides an individual subject to an involuntary commitment proceeding the right to raise an allegation of ineffective assistance of counsel in challenging a commitment order. The court further held that the scope of this right includes the appointment of competent counsel with specialized training, the right to make informed decisions on whether to accept counsel, the right to a thorough investigation of one's case by counsel, the right to an initial client interview with counsel, and the right to have counsel present during the patient's court-ordered mental health examination.

> [T]he role of counsel is all the more critical where a patient may be involuntarily committed.

K.G.F., voluntarily hospitalized for mental health treatment, was diagnosed with bipolar disorder. When K.G.F. began refusing medication and expressing suicidal ideation, an involuntary commitment hearing was ordered and K.G.F. was appointed counsel. Following her hearing, the court ordered that K.G.F. be committed for ninety days for mental health treatment. K.G.F. appealed, arguing that she received ineffective assistance of counsel at her commitment hearing.

The court held that persons facing involuntary civil commitment have a statutory right to raise an ineffective assistance of counsel claim pertaining to related hearings. It reasoned that when an individual subject to involuntary commitment is afforded a right to counsel, "the legislature could not have intended that counsel be prejudicially ineffective." The fundamental question, then, was to determine just how effective this counsel must be. The court rejected the standard set forth in *Strickland v. Washington,* 466 U.S. 668 (1984), which afforded counsel a presumption of reasonable professional assistance. It reasoned that the *Strickland* standard was insufficient, given that involuntary commitment proceedings routinely accept "an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation." The court responded by providing a list of "critical areas" that effective counsel must address in involuntary commitment proceedings, including an initial investigation and a client interview.

Police Violated Defendant's Right by Failing to Inform Him of Attorney's Advice

State v. Joslin, 29 P.3d 1112 (Ore. 2001):

The Supreme Court of Oregon held that a defendant did not knowingly waive his protection from compelled self-incrimination during his custodial interrogation when the defendant was not informed that his sister had hired him a lawyer and that the lawyer had advised the defendant to remain silent until he was present.

> [A] suspect must be "fully apprised of the situation that actually existed."

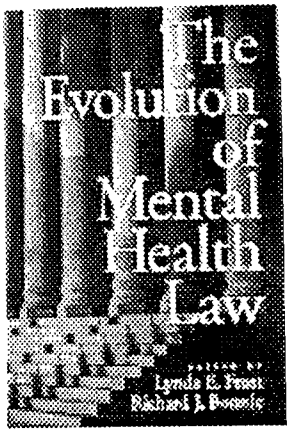
Charles Joslin was a suspect for the murder of a woman. While Joslin was voluntarily answering questions at the police station, his sister contacted the police department and told the lieutenant that she had hired a lawyer named Lipton for Joslin and that Lipton

requested that Joslin be told that his lawyer did not want him to speak to the police until he was present. The lieutenant, upon the advice of a deputy district attorney, told Joslin that Lipton had been hired, but did not relay the message that he requested Joslin not to speak. Joslin then signed a waiver of his *Miranda* rights and continued to be interrogated by two detectives and a psychiatrist assisting the police. The defendant moved to suppress the statements made at the police station on the grounds that they were obtained in violation of his state and federal rights against compelled self-incrimination. Specifically, he argued that in withholding information about the lawyer's advice, the police prevented him from making an informed or knowing waiver of this right.

The state argued that the police were under no obligation to convey a message to the defendant and that his waiver was nonetheless voluntary because the defendant was aware of the existence of the right against self-incrimination. The court did not agree. It found that a suspect "'must be informed when counsel actually seeks to consult with him and must voluntarily and intelligently have rejected that opportunity.'" Thus the defendant could not knowingly waive his rights until he has been "'fully apprised of the situation that actually existed.'" Because Joslin was unaware that his lawyer requested that he not speak to police, the court found that his waiver was not "knowing" and thus was invalid.

The court also did not consider it significant that it was Joslin's sister, and not his lawyer, who made the call. The court held that the police are bound to convey legal advice from a third party, here the defendant's sister, absent a reasonable basis that she should be disbelieved. Because the police had no reason to disbelieve the sister, they were under an obligation to convey her message to Joslin or to refrain from questioning him altogether. Because they failed to do either, the court held that Joslin's statements should have been suppressed.

The court also held that this error by the police was not harmless but affected a "substantial right" of the defendant. The court noted that the defendant did not dispute that he had shot and killed the victim, but rather raised an insanity defense. The court found that the testimony of the psychiatrist who interviewed the defendant at the police station was pivotal to the state's efforts to refute the insanity defense and a failure to suppress this testimony was grounds for reversing the defendant's conviction.



The Evolution of Mental Health Law

Edited by Lynda E. Frost, JD, PhD, and Richard J. Bonnie, LLB

June 2001

Hardcover

344 Pages

The *Evolution of Mental Health Law* chronicles a relatively new field that has developed around the goals of protecting the rights and needs of people with disabilities, defining the proper sphere of individualization in criminal justice, and drawing boundaries between science and morality in decision making. The editors have brought together leading specialists from the field's many domains, including lawyers, health policy specialists, forensic psychologists, law professors, psychiatrists, and sociologists, who share their theoretical insights and empirical research of significant developments in mental health law and policy in the past twenty-five years.

Particularly notable are chapters that examine shifts in attitudes toward the use of human participants in research; whether the statutory and regulatory framework of the increasingly privatized public mental health services system adequately protects patients' rights; how notions of therapeutic jurisprudence influence the behavior of judges and lawyers; and the means by which judges, lawyers, and clinicians can work from a more therapeutic frame of reference in the context of civil commitment proceedings. This volume fills an important gap in the field and will be useful to specialists in law, psychology, and psychiatry involved in mental health law and policy.

Published by the American Psychological Association (www.apa.org/books)
APA Members/Affiliates: $39.95
List: $49.95
Item # 431654A
ISBN: 1-55798-746-7

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New Civil Training for 2002-2003

Legal Issues Involved in Working with Minors - September 18, 2002*

This full-day program will address issues unique to working with the juvenile mental health, mental retardation, and substance abuse populations. Topics to be covered include consent to treatment, confidentiality of minors' medical records, the Psychiatric Inpatient Treatment of Minors Act, clinical assessment of minors, and tips on working with Guardians Ad Litem, Court Appointed Special Advocates, and the Department of Social Services.

* ***Note:*** In the training Calendars, the date for this training was listed as September 16. The date has been changed to September 18.

Legal Issues Involved in Working with the Substance Abuse Population October 17, 2002

This half-day program will address issues unique to working with those seeking treatment for substance abuse or dual diagnoses. Topics to be covered include the Federal Substance Abuse Confidentiality Laws (42 C.F.R. Part 2), Virginia laws related to HIV and AIDS, and other topics developed in conjunction with the DMHMRSAS's Office of Substance Abuse Services.

Special Justice Training November 14, 2002

This program, developed in conjunction with the Virginia Supreme Court, is devoted to the legal issues encountered by those serving as Special Justices. Topics to be covered include emergency custody and temporary detention orders, civil commitment hearings, a review of "capacity to consent" to treatment, judicial authorization of treatment under §37.1-134.21, and the use of pre-admission medical screenings.

HIPAA Implementation for Administrators, Managers, and Medical Record Staff December 12, 2002

This program will focus on the requirements of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and will help prepare those in leadership positions within their organizations for HIPAA's implementation. In addition to a basic review of the HIPAA Privacy Rule, topics to be covered will include drafting policies and procedures, contract provisions, and notice requirements. This program will also discuss elements of Virginia's confidentiality laws, such as the Patient Health Records Privacy Act and the confidentiality and reporting provisions of the Human Rights Regulations, that will continue to be applicable under HIPAA.

Note: *This training is limited to DMHMRSAS facility and Community Services Boards staff.*

The Emergency Medical Treatment and Labor Act ("EMTALA") - January 15, 2003

This half-day program will focus on the requirements of EMTALA, the patient "anti-dumping" statute. Topics to be covered include the definition of coming to the emergency department, pre-admission screenings, what constitutes a sufficient screening and an appropriate transfer, and applying EMTALA to a mental health population.

Training Center Admissions February 13, 2003

This two-hour program will review recent regulations covering judicial certification for training center admissions and will discuss issues unique to working with persons with mental retardation.

HIPAA Training March 13, March 27, April 3, 2003

This full-day "nuts and bolts" program will focus on the requirements of the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as well as elements of Virginia confidentiality laws that are not preempted by HIPAA. Topics to be discussed include HIPAA regulations, the Virginia Patient Health Records Privacy Act, and the confidentiality and reporting requirements of Virginia's Human Rights regulations.

Note: *This training is limited to DMHMRSAS facility and Community Services Boards staff.*

Risk Management - June 19, 2003

This half-day program will focus on the legal issues surrounding risk management in a facility and community services board setting. Topics to be covered include peer review and practitioner-patient privileges, a discussion of what constitutes "quality improvement," and tips on reporting to the Virginia Office of Protection and Advocacy and the Inspector General. We are hopeful that this will be a forum for participants to share risk management plans and strategies with each other.

New Forensic Training for 2002-2003

Adult Advanced Evaluation for Forensic Coordinators - December 16, 2002
This program targets the experienced forensic evaluator with an emphasis on emergent topics including assessing the mentally retarded defendant, risk management techniques, personality disorders, and institutional violence.

Risk Assessment for Sex Offenders - January 13, 2003
This one-day program will summarize the various risk assessment instruments currently used in assessing the level of risk posed by sex offenders both for violent recidivism and involvement in other types of violent crime. Instruments will include the Static 99, MnSORT-R, SVR:20, and SONAR and they will be examined for their demonstrated validity and reliability and generalizability to various groups of offenders. Controversies involving the use of these instruments and the actuarial versus clinical debate will be explored using case materials.

Forensic Mock Trial - April 10, 2003
The forensic mock trial is a simulated court room learning experience that is conducted at the University of Virginia Law School using experienced litigators and class participants as expert witnesses. All participants are provided case information prior to the program to encourage involvement in pretrial preparation and the development of testimony for both the defense and prosecution. Legal strategies for direct and cross-examination and an assessment of the performance of the "expert witnesses" will be discussed during this program.

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Developments in Mental Health Law encourages the submission of articles on timely and interesting topics in the area of mental health law.

The typical article is ten to fifteen pages long, without substantial footnoting. The reading audience is multi-disciplinary, typically with legal or mental health training, but not necessarily both. Therefore, *Developments* seeks articles that are useful to a general audience interested in mental health law.

How to contact Developments in Mental Health Law:

1) The preferred method of submitting articles is to submit a short query by e-mail, describing the topic and general thesis. Send e-mail to: th4n@virginia.edu, with a subject line of "Article Query,"

or

2) Query letters can be mailed to the attention of the Editor: *Developments in Mental Health Law,* P.O. Box 800660, Charlottesville VA 22908-0660. The street address is: 1107 Main St.

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