DEVELOPMENTS IN MENTAL HEALTH LAW

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Reforming Civil Commitment in Virginia*

By Leroy Rountree Hassell, Sr., Chief Justice of the Supreme Court of Virginia

I am truly honored to welcome you today to this conference that is sponsored by the Supreme Court of Virginia and the Virginia State Bar.

When I began my tenure as Chief Justice, one of my most important priorities was to reform Virginia's mental health laws and judicial processes that relate to the mental health laws. Many have raised the questions: Why does the Chief Justice care about this issue? Why is this issue important to Virginia's judiciary? Why does the Supreme Court of Virginia care about this issue? I care. The courts care. You care, and we care because we are committed to improving the quality of mental health services provided to those Virginians who are least able to care for and help themselves.

We are also committed to an outstanding judicial process that is fair and impartial and that respects the rights of people who are subject to Virginia's involuntary civil commitment process. I believe that all persons and all institutions that are involved in Virginia's mental health system – mental health practitioners, law enforcement personnel, including sheriffs (who are extremely important in this process), judges, attorneys, magistrates, special justices, patients, patients' families and friends – must always exhibit attitudes of care. We must care that we provide the appropriate mental health services to those in need; care that we have the available resources to help mental health patients, including sufficient patient beds; care that persons are afforded mental

Also in this issue:

* Edited introductory remarks presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

health treatment as opposed to unwarranted imprisonment; care for society's public safety needs; care for each individual who has mental health issues; and care that we always exhibit dignity and respect for those persons who have mental illnesses.

As we all know, the solutions to the problems that confront Virginia's mental health system and legal processes are complex and subject to great debate. Today's conference is the beginning of a journey that I am confident will culminate in reforms to Virginia's mental health laws and reforms to Virginia's civil commitment process.

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Reforming Civil Commitment: Serving Consumers' Needs While Protecting Their Rights[1]

By Richard J. Bonnie[2]

Preface

I am pleased to be here and to share the podium with the Chief Justice. For many years I have studied the laws that affect people with mental illness and have many thoughts about what these laws should look like. But I have been asked to be here for a specific reason—to sound the keynote and to set the tone for today's conference on "Reforming the Involuntary Commitment Process" in the Commonwealth of Virginia.

So it is best to begin with the unvarnished truth—the involuntary commitment process in Virginia does need to be reformed. Many of you were among the 300 participants in this process who completed questionnaires recently sent out by the Chief Justice seeking your opinions on the current practice of civil commitment in the Commonwealth. These responses reveal a great deal of dissatisfaction with this practice across a broad range of issues.[3]

What is most striking are the responses to a question that asked what you would do if you could "fix just one thing." Many of you refused to play by the rules, saying that there are so many things that need to be fixed that you could not pick out only one thing. Moreover, the scope of the challenge we face is shown by the fact that you picked many different things. But to sum up your responses in three phrases, you want more beds, higher fees, and fewer handcuffs. Other sources of dissatisfaction are the lack of less restrictive alternatives to hospitalization, the absence of adequate mechanisms to implement mandatory outpatient treatment, the unrealistic nature of current statutory time requirements, and a failure to provide a meaningful opportunity to appeal.

We have an historic opportunity to set in motion the engine of reform for a part of the mental health code long overdue for change. It has been more than twenty years since the last time legislative attention was focused on this topic. I remember it well because I still bear the scars of battle from that failed initiative. Perhaps I ought to say a few words about this history.

Prior Efforts at Reform

The story begins in 1982 when three separate activities converged. The most important development was the appointment of a Joint Subcommittee of the General Assembly to study the commitment process. This legislative initiative was stimulated and chaired by a young Delegate from Arlington, Warren Stambaugh, who observed and participated as counsel in a number of commitment hearings. He felt that the process needed to be fixed.

A second strand was the interest of the State Human Rights Committee (SHRC), which I then chaired. Responding to complaints about civil commitment in Virginia, the SHRC appointed several task forces to look at the commitment process, including an examination of particular concerns associated with the involuntary hospitalization of children, people with substance abuse disorders, and long-term patients in state facilities.

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[1] Edited remarks from the Keynote Address presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

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[3] Responses to this questionnaire are on file with Patricia A. Sliger, Executive Assistant, Virginia State Bar Association, 707 E. Main St., Suite 1500, Richmond, Virginia 23219-2800, (804) 775-0500.

The third thread was research conducted by the Institute of Law, Psychiatry and Public Policy (ILPPP). We had conducted a study involving systematic observations of about 200 commitment hearings across several Virginia jurisdictions. The data showed that most hearings took only a few minutes, with very little participation by the person for whom involuntary hospitalization was sought, or even by the attorney appointed to represent the person. There were also distinct variations in attitude and practice among the special justices conducting these hearings, ranging from solicitous concern to apparent indifference.

Following a conference featuring the ILPPP's research findings, the SHRC and the Joint Subcommittee held a joint meeting in Charlottesville in the summer of 1982 and took the first step in what became a two-year process of consensus-building in the drafting and re-drafting of legislation. After several false starts, the proposed legislation passed the Virginia House of Delegates, unanimously as I recall, but eventually failed in the Virginia Senate by one vote in 1984.

Current Environment

Here we are, more than twenty years later, with many of the same complaints: a lack of due process, a lack of clarity in the statutory requirements, and a lack of uniformity in the interpretation and application of these requirements. The result is great variation in the implementation of civil commitment, not only across jurisdictions but even within a given jurisdiction. And some problems have gotten worse, such as a shortage of beds for evaluation and temporary detention, as well as for involuntary admissions.[4] This shortage of beds, as well as the layered evaluation and detention sequence, have also increased the demands on sheriffs and other law enforcement officers charged with transporting individuals subject to civil commitment.

I invite you to take a look at the survey results; they are quite sobering. What they clearly show is that reforming involuntary hospitalization is a complicated assignment. The structure and practice of involuntary commitment cannot be understood or designed in isolation. It must always be viewed in the context of the services that are available in the mental health system.

On the one hand, an effective and accessible services system—with suitably intensive services in the community for people in crisis—can reduce the need for involuntary commitment. On the other hand, a weak system with many service gaps leads to more commitments. It also causes distortions in an already strained services system. For example, people who might have participated voluntarily if an adequate crisis intervention system had been available may have deteriorated to the point where there is no alternative to commitment. These service gaps also lead, inevitably, to more criminal arrests, as the jails become the overload valve for a system in distress.

In short, we should look at civil commitment reform not as a simple task of "fixing" a fairly arcane chapter of Title 37.2 of the Code of Virginia, but rather as a component of a larger vision for improving mental health services in Virginia, both public and private.

The Vision

So what is that vision?

In part, it is a vision that has remained unfulfilled for thirty years, namely, shifting the locus of mental health services from large

[4] Under existing Virginia law, an individual can be detained (1) pursuant to an emergency custody order (ECO) for a maximum of four hours for an assessment of that person's need for hospitalization or treatment (Va. Code § 37.2-808 (2006)), (2) pursuant to a temporary detention order (TCO) for a maximum of forty-eight hours (not inclusive of weekends or legal holidays) (Va. Code § 37.2-809 (2006)), and (3) pursuant to an involuntary admission order for a maximum of 180 days (Va. Code § 37.2-817 (2006)).

state institutions to communities where a full array of service modalities is available in a timely manner to people who need them. Such an approach minimizes the disruption to the lives of the persons to whom these services are being provided, as well as to their families and loved ones. At the same time, high-quality, short-term residential services in down-sized and modernized state-operated facilities should be in place to assist those individuals for whom community services have proven ineffective.

Governor Warner's proposed budget for the upcoming biennium would constitute a great leap forward in this direction.[5] Our first assignment should be to help Commissioner Reinhard persuade the General Assembly to make these long-overdue investments in mental health services.[6]

Moving from the general need to enhance the mental health system to focusing on civil commitment reform per se, I would sketch a three-part vision: (1) close the service gaps, especially for people in crisis; (2) facilitate voluntary engagement to the maximum possible extent; and (3) when coercion is necessary, do it with a genuine commitment to due process. Let me elaborate.

It Should Be Easier for People in Crisis to Get Access to the Mental Health Services They Need

Individuals experiencing a mental health crisis should receive effective services in the least restrictive and least costly setting when that will satisfy their needs, but they should also be able to access care in a more intensive setting when that is what is needed.

We now have many gaps in the system, including a shortage of inpatient beds in many communities and waiting lists in state facilities. As recently pointed out by Inspector General Jim Stewart in an excellent report on the Emergency Services Programs of Virginia's Community Services Boards (CSBs),[7] we also have large gaps in the continuum of community services, especially intensive crisis intervention services. Ideally we would be able to plug all these gaps, but—even under the most optimistic scenario—funding will not be adequate to do all these things. We will need to set priorities. Three specific goals should guide us in setting these priorities.

- We must continue to build community capacity to provide intensive crisis intervention services.[8] Filling this gap will relieve some of the pressure on the civil commitment system.

- We must end unnecessary criminalization of people with mental illness. People in mental health crises should have access to services of appropriate intensity. Keeping people with a mental illness out of jail will undoubtedly increase pressure on state mental health facilities, but the diversion of people with a serious mental illness from our jails is a moral imperative.

- Whenever a person with mental illness needs to be taken into protective custody for evaluation or treatment, secure transportation should be provided in emergency services vehicles with an appropriate capacity for restraint, not in police cars where shackles and handcuffs may be mandated. This

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[5] The announcement by Gov. Mark H. Warner of his proposed budget and mental health restructuring can be found at http://www.governor.virginia.gov/Press_Policy/EventsandSpeeches/2005/BudgetSpeech-Dec05.htm#9. On January 14, 2006, Timothy M. Kaine succeeded Gov. Warner as the new Governor of Virginia.

[6] A description of how Gov. Warner's proposal would be implemented, as provided by James S. Reinhard, M.D., Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services, can be found at http://www.dmhmrsas.virginia.gov/PressReleases/admPR-CommissionerBudgetMessage.htm.

[7] JAMES W. STEWART, III, OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, REVIEW OF THE VIRGINIA COMMUNITY SERVICES BOARD EMERGENCY SERVICES PROGRAMS (Report #123-05) (Aug. 2005).

[8] *See id.*

transition will take time and money, but we should not shy away from it.

When the process of involuntary commitment is initiated, it is the government's responsibility to ensure that there is a suitable facility for evaluation and treatment within a reasonable distance from the individual's home. If there are insufficient "willing facilities," appropriate incentives should be offered to induce their participation. Ultimately the responsibility to make suitable arrangements with CSBs and private facilities for needed services should lie with Virginia's Commissioner of Mental Health, Mental Retardation and Substance Abuse Services.

The System Should Encourage and Facilitate Voluntary Engagement During a Mental Health Crisis or While the Individual's Condition Is Deteriorating Rather Than Waiting Until Individuals Reach Committable Status or Find Themselves in Jail

This point is closely linked to the first one. Making high-quality services accessible to people in need, and thereby attracting or pulling them into services they want, reduces the occasions for pushing them into unwanted services. Today, unfortunately, too many people who seek care are unable to get it voluntarily in either the private or public systems.

Let me say a word about voluntary hospitalization in this context. By embracing dangerousness as the sole clinical indication justifying hospitalization, managed care plans, especially when their plans do not cover intensive crisis stabilization services, have been too restrictive in approving admission. I stand to be corrected if I am wrong, but I understand state facilities have followed suit.

I think this is a mistake. When clinically indicated, intensive stabilization services should be available to people in crisis, even in the absence of dangerous behavior or threats. Similarly, voluntary hospitalization should be available if no other suitable stabilization modality is available. The failure of private plans or Medicaid to cover intensive stabilization interventions while restricting hospitalization is not good care and tends to delay needed interventions when individuals are most likely to accept them. The result of such a truncated services system is to increase the use of involuntary commitment, and to necessitate its use at a later time when it has become more difficult to provide needed care and treatment. To address this failure, it may be necessary to mandate increased mental health benefits and to enhance needed Medicaid waivers.

When Individuals in Crisis Do Refuse Treatment, They Are Entitled to a Fair, Respectful, and Impartial Review Process Before Involuntary Commitment Can Be Ordered

This was and continues to be one of the genuine weaknesses of the commitment process in Virginia. One sometimes hears of cases in which the individual for whom commitment is sought reports that the judge never made eye contact with the person. The fees for attorneys, judges, and independent evaluators should be raised so that a lack of fees can not be cited as a rationale for failing to devote the proper time and attention to these proceedings.

At the time a temporary detention order (TDO) is executed, the person for whom commitment is sought should be given notice of the hearing and counsel should be appointed. The attorney should actually interview the person and carry out the other investigative and adjudicative responsibilities specified in the Virginia Code.[9] The hearing itself should

[9] *See* VA. CODE § 37.2-814(E) (2006) ("To the extent possible, during or before the commitment hearing, the attorney . . . shall interview his client, the petitioner, the examiner . . . , the community services board or behavioral health authority staff, and any other material witnesses. He also shall examine all relevant diagnostic and other reports, present evidence and witnesses, if any, on his client's behalf, and otherwise actively represent his client in the proceedings.").

be conducted with genuine respect for the person's dignity and his or her right to be heard, the most fundamental requisites of due process.

Some will say that the trappings of due process in this context are a charade. For example, one of the lawyers filling out the Chief Justice's questionnaire observed that many of the persons who are the focus of these hearings are so disordered that they lack the capacity to participate meaningfully in the proceedings. That may be true of some, but is not true of most. Plus, these persons will know whether they have been treated with dignity and respect, and whether the judge and the lawyer paid attention to them. In fact, when the MacArthur Research Network on Mental Health and the Law studied the outcomes of 1000 acute admissions in various sites across the country almost a decade ago, we found that one of the strongest predictors of whether patients perceived that they had been coerced into a mental health facility was whether they felt that (1) they had been treated fairly during the hospital admission process and (2) the participating psychiatrists and judges had cared about hearing their side of the story.[10]

Along the same line, some of the respondents to the Chief Justice's questionnaire said that the lawyer's role should be to represent the best interests of the person for whom civil commitment is sought, as a guardian ad litem, rather than advocating on behalf of that person's declared wishes, as the Virginia Code prescribes.[11] Even if permitted by law, taking this approach would be a mistake. Providing due process is in the person's best interests. The testifying clinicians can describe why intervening best promotes the interests of the person, and the judge or special justice has the responsibility for achieving the beneficent purposes of civil commitment (within the contours of the statutory criteria). The lawyer's role is to assure that the person's voice has been heard. Protecting that person's rights also serves the person's needs and is a responsibility to which the attorney should remain faithful.

Another objection to genuine due process is that it costs money. It was the price tag that doomed commitment reform in 1984. Here is where the rubber meets the road. If we are going to honor the constitutional demand for due process articulated by the United States Supreme Court in *Addington v. Texas* in 1979,[12] we have to pay for it. As the reform process moves forward, it will be important to specify the costs and make the necessary financial projections.

I want to take a small detour here. I earlier noted the state's obligation to meet the needs of individuals with a mental illness by establishing and supporting an adequate system of mental health services. My immediately preceding comments have focused on respecting the rights of individuals for whom civil commitment is sought. Some of you may wonder whether it is really possible to do both. It is often said that there is a basic tension in mental health law between beneficence and autonomy, or, in this case, between serving the needs of individuals in a mental health crisis and respecting these individuals' rights. Err too far in the direction of serving the person's mental health needs and one runs the risk of denigrating his or her prerogative to shape his or her own life, including making his or her own choices about mental health treatment. Err too far in the other direction by honoring the person's right to be left alone, and one takes the risk that the person will "die with their rights on."

I readily concede that such a conflict cannot always be avoided, but one lesson that I have learned during thirty years in this field is that

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[10] MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW, THE MACARTHUR COERCION STUDY (May 2004), http://www.macarthur.virginia.edu/coercion.html.

[11] *See* VA. CODE § 37.2-814(E) (2006) ("The role of the attorney shall be to represent the wishes of his client, to the extent possible.").

[12] 441 U.S. 418.

civil commitment is not a zero sum game. Again, protecting the person's right to be heard is not incompatible with serving the person's needs. The overwhelming majority of consumers of mental health services understand and accept the need for hospitalization in a crisis, even over their objection, as long as (1) the care is of high quality, (2) treatment choices are guided, to the maximum possible extent, by their previously expressed preferences, and (3) their residual capacity for making their own decisions is respected. For similar reasons, this respect for the individual should also carry over into the hospital environment.

Possible Proposed Changes to the Virginia Code

I now want to start the conversation that will be continued in the coming months about specific changes to the Code that should be considered as we move forward. The changes we make should be designed to enhance access to needed treatment, including hospitalization, while reducing unnecessary restraint and stigmatization and strengthening due process protections for individuals for whom involuntary hospitalization is sought. In other words, these changes are attentive to "needs" as well as "rights." I have already mentioned a number of ideas in sketching the vision that should inspire civil commitment reform. I will now add some other ideas to the list.

(1) Let me start with a symbolic suggestion. As part of the effort to de-stigmatize and decriminalize mental health treatment, I suggest that we eliminate the word "detention" from the vocabulary of civil commitment. All restrictions should be regarded as protective custody, not detention. Although I will not try to invent a new vocabulary here, the initial two orders in the Virginia civil commitment scheme might be called, in sequence, the temporary evaluation order and the emergency custody order.

(2) People who are seriously mentally ill should not be in jails and prisons. I understand that a number of advisory groups are recommending that the provisions for the involuntary hospitalization of prison inmates[13] be expanded to permit emergency evaluation and custody pursuant to an ECO/TDO, that the criteria for the involuntary hospitalization of prison inmates be applied as they are for all other persons in need of involuntary admission, and that the fact that the inmate is currently in custody in a secure environment should not be taken into account in determining whether the inmate needs hospitalization. I agree wholeheartedly with these recommendations.

(3) It seems that everyone agrees that the four-hour maximum for an ECO is too short. Perhaps we should lengthen the time for an evaluation under an ECO to six hours, or allow one renewal of an initial four-hour order for good cause, which would include a need for additional time to (a) obtain a medical evaluation, (b) identify a suitable facility for placement pursuant to a TDO, or (c) transport the person to the TDO facility.

(4) One important question about the current process is whether the forty-eight hours (exclusive of weekends and legal holidays) now allowed for the evaluations conducted in conjunction with a TDO is the right amount. Some of the survey respondents suggested that the time be shortened in order to expedite judicial review of the basis for involuntary hospitalization. However, many more respondents, and many other people with whom I have spoken, believe that the evaluation process should be lengthened rather than shortened. Why forty-eight hours? What is the right length of time?

I realize that increasing the TDO period has fiscal implications, which I want to put to one side for a moment. There are two arguments for a longer evaluation period before a commitment hearing is held. The first is that more time will permit a more thorough evaluation, not only by the attending clinician,

[13] *See* VA. CODE § 53.1-40.2 (2006).

but also by the "independent evaluator,"[14] thereby allowing a more reliable decision to be made regarding the person's need for commitment, both by the clinicians and by the judge at the hearing. The second argument is that allowing more time would most likely lead to fewer hearings and fewer commitments. Individuals would have more time to become sufficiently stabilized during the evaluation process to allow them to be discharged prior to a hearing. Additionally, during this extended period more individuals will accept voluntary hospitalization, also dispensing with the need for a hearing. The longer the evaluation period, the greater the likelihood these outcomes will occur.

I do not want to devalue the person's right to an expeditious hearing, but the Constitution does not require a hearing in forty-eight hours. Virginia's process is much more expedited than it is in most states. So I would like to put on the table the possibility of allowing the evaluation period for a TDO to extend for up to four days.

Full disclosure is in order at this point. I made a similar suggestion in 1982 when we were beginning the reform effort the last time around, and I had not studied the possible cost implications. However, I would like to raise this issue once again. When the costs are calculated, the accounting should take into account (1) the reduced number of commitment hearings that will result and (2) the possibility that the length of subsequent hospital stays will be reduced, with an associated decrease in overall hospitalization costs.

One complicating factor may be that the costs associated with extending the TDO evaluation period may fall disproportionately on the locale or the facility where the evaluation is taking place. For an indigent individual, the cost of care during this period may be the responsibility of the locale or the facility where the individual is hospitalized. In contrast, the cost of care during involuntary admission for such individuals may be the responsibility of the state. Involuntary admissions may be decreased by lengthening the TDO evaluation period, thereby saving the state money, but with an increase in the financial burden placed on the locale or facility. If this time period is extended, it may be necessary for the state to assume responsibility for the proportional increase in costs that occur, recognizing that it will incur a net financial savings by decreasing the overall length of time the person is involuntarily hospitalized.

(5) We also need to take a look at the various screening and gatekeeper functions that are served by the attending clinician, the "prescreener,"[15] and the independent evaluator in light of the goals of the commitment process, and consideration given to the incentives that now exist for them to either favor or oppose commitment in general. For example, a prescreener may feel an obligation to help a state facility manage its census by applying civil commitment criteria in a narrow manner to limit the number of involuntary admissions, while an attending clinician may be applying the criteria in a less restrictive manner – perhaps due to worries that the patient is too ill to be released or perhaps due to a desire to move the patient to a state hospital (if a bed is available there).

I do not believe the commitment criteria should constitute a "moving target." Ultimately, however, it is the responsibility of the judge or special justice to hear the full range of evidence and to resolve what may be a relatively few number of cases where conflicting recommendations are generated. Because such pressures or biases may exist, none of the reports generated should be

[14] Prior to the involuntary commitment hearing, the person for whom hospitalization is sought must be examined by a licensed and qualified psychiatrist or psychologist, or, if not available, by a licensed and qualified mental health professional. VA. CODE § 37.2-815 (2006).

[15] Prior to the involuntary commitment hearing, a preadmission screening report from a community services board or behavioral health authority must be generated. VA. CODE § 37.2-816 (2006).

binding or outcome determinative. For example, a prescreener's determination that commitment is not warranted should not preclude a commitment hearing when the attending physician or the independent evaluator thinks commitment is warranted. Neither the prescreener nor the independent evaluator should be regarded as gatekeepers with veto power.

(6) Where should hearings be held? Although most are held at the facility where the person for whom commitment is sought is in custody, some are held in courtrooms at the local courthouse. Perhaps local variation should be permitted, and the matter studied. However, my view is that the additional transportation required for courthouse hearings is costly and clinically undesirable. The fees for the judges and lawyers involved, however, should be increased in part to offset the costs and inconvenience they incur in the "circuit riding" that is necessitated as they attend hearings at facilities. At the same time, judges and lawyers should remain mindful of their duty to maintain their independence when facility-based hearings are held.

(7) I do not envision major changes in the commitment criteria. However, I do want to put one idea on the table. Perhaps the "imminence" requirement should be removed from the criteria for emergency custody,[16] temporary detention,[17] and involuntary admission.[18] Only a handful of states are so restrictive, and the meaning of this term seems to be a significant source of confusion and inconsistency around the Commonwealth. One possible formulation is that the person must present a significant risk of causing serous injury to himself or others in the near future.

(8) With enhancements in medical treatment, long-term hospitalization is infrequently needed these days. I suggest that we reduce the length of involuntary admission orders to thirty days. Even if the period of time associated with a TDO is extended, the opportunity for evaluation and observation prior to an involuntary admission hearing is limited. By reducing the length of involuntary admission orders, an opportunity is provided for a prompt re-examination of the initial order. In the rare cases when extended involuntary hospitalization is needed, a genuinely adversarial hearing should be afforded with a meaningful opportunity for appeal.

(9) Mandatory outpatient treatment in appropriate cases should be made a real option in Virginia.[19] As New York's recent experience in implementing outpatient commitment under Kendra's Law has demonstrated, such an approach can be successful if needed community resources and services are in place and a viable monitoring mechanism is instituted.[20] While I have discussed the need for increased community services, the capability of CSBs and behavioral health authorities to provide a

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[16] Before an emergency custody order can be issued under existing law, a magistrate must have probable cause to believe the person "presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself." VA. CODE § 37.2-808(A) (2006).

[17] Before temporary detention can be ordered under existing law, a magistrate must find that the person "presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself." VA. CODE § 37.2-809(B) (2006).

[18] Before involuntary admission can be ordered under existing law, the judge or special justice must find 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." VA. CODE § 37.2-817(B) (2006).

[19] Although mandatory outpatient treatment is infrequently utilized as the result of a lack of less restrictive alternatives to hospitalization and the absence of adequate implementation mechanisms, it is available under existing law. VA. CODE § 37.2-817(C) (2006).

[20] *See* OFFICE OF MENTAL HEALTH, NEW YORK STATE, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT (March 2005).

meaningful monitoring mechanism when outpatient treatment is ordered should also be enhanced, and their willingness to provide this service encouraged. Also, short-term hospitalization (perhaps for up to three days) of a person who is non-compliant with a mandatory outpatient treatment order should be considered. Perhaps hospitalization should be available when it becomes apparent that the person's condition is deteriorating without waiting until the involuntary admission criteria are met. However that issue is resolved, it should be possible to mandate outpatient treatment for up to either 90 or 180 days, at which point a hearing and judicial renewal should be required.

Need for Better Training

Clearly we need better training for all the participants in the legal process, as so many of you observed in response to the Chief Justice's survey. Specifically, we need:

- a mechanism for continuing judicial training, and for clarifying ambiguities in the law and promoting its fair and consistent administration;

- specialized training opportunities for lawyers, independent evaluators, and prescreeners designed to promote fair and consistent administration of the civil commitment process; and

- a mechanism for judicial oversight of this process, such as periodic observations of commitment hearings by designees of the Circuit Courts, the Court of Appeals, or the Supreme Court (e.g., they might rate the level of respect given to the individual's right to be heard and to be treated with dignity).

Closing Thoughts

I want to close these remarks with two questions. I do this to stimulate creative thinking rather than to move the discussion toward any concrete proposals. Each of these questions could serve as themes for subsequent conferences.

First, are there ways in which we can use the law to assist and support the recovery movement and the consumer-driven approach to recovery?[21] For example, can we facilitate the beneficial use of such tools as psychiatric advance directives? Can we build a legal framework that promotes access and engagement rather than coercion? Using a catchy phrase, can we move from coercion to contract?

Second, do we want to develop tools for quality assurance in the civil commitment process?[22] And, if so, what would they be? This is the irony of the OIG report. There is no such mechanism now. Even appellate review, the customary mechanism that provides judicial oversight of a state's activities, is all but absent in civil commitment.[23]

We are just at the beginning of a long road. I ask whether you are prepared to commit yourselves to the task that the Chief Justice has set before you—to identify the major problems associated with civil commitment and the shape of the most plausible solutions to these problems, to develop a well-crafted legislative proposal that encompasses these solutions, and then to see this bill through the political process. This will take at least two years. But the Chief Justice thinks that it can be done, I am willing to help him, and I hope all of you will be willing to join us.

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[21] For a call for a consumer-driven and recovery-oriented approach in the mental health system in general, see THE U.S. PRESIDENT'S FREEDOM COMMISSION ON MENTAL HEALTH, FINAL REPORT TO THE PRESIDENT (2003).

[22] For a discussion of the need for and use of quality assurance mechanisms in the mental health and substance abuse fields, see COMMITTEE ON CROSSING THE QUALITY CHASM, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS (2006).

[23] Virginia does authorize the appeal of involuntary admission or certification orders. *See* VA. CODE § 37.2-821 (2006). However, various barriers associated with this mechanism have resulted in its virtually never being used.

UPCOMING ILPPP MENTAL HEALTH AND LAW EDUCATIONAL PROGRAMS

3/16-17: *Juvenile Evaluation Update*, Charlottesville, VA

3/24: *Jail Diversion: Innovative Practices That Work*, Omni Hotel, Charlottesville, VA
Fred Osher, M.D.
Director, Center of Behavioral Health, Justice, & Public Policy
University of Maryland School of Medicine
"Responding to Co-Occurring Disorders in the Justice System"

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A History of Civil Commitment and Related Reforms in the United States: Lessons for Today[1]

By Paul S. Appelbaum[2]

I am pleased to be here with you today. The discussions conducted thus far have focused on Virginia's existing civil commitment statute and its procedures, and related successes and failures. My intent here is to add a historical dimension to your considerations by describing the history of commitment law in the United States. This law has evolved over time primarily through cycles of reform and reaction, which I will briefly describe. I will then address what we know about the consequences of the latest round of reform, which began in the 1970s, and end with a few thoughts about the implications of this research for future reform efforts, including changes that you are considering at this conference.

Colonial and Early America

During the colonial era of this country, individuals with a mental illness were generally not dealt with in a systematic manner. If possible, they were ignored. When it was not possible to ignore them, they were frequently confined in local jails.

Colonies in New England also had a quaint custom that was called "warning out." Each township, the equivalent of counties in other colonies, was responsible for the people in that jurisdiction. If an individual with mental illness disturbed the peace, that individual was walked or bodily carried to the township line and "warned out," that is, told to get out and never come back. If you had a mental illness, you could see a good part of New England this way as you were transported from one town to another.[3]

If not warned out and not confined in a local jail, significantly incapacitated individuals with mental illness typically were subject to confinement under the poor laws. Each township or county generally had an almshouse and a set of poor laws based on those that existed in England at the time. Under these laws, an individual who failed to pay his or her debts could be placed in an almshouse until these debts were redressed. Because this placement generally precluded the individual from generating any revenue, confinement was often lengthy. Individuals with a severe mental illness, unable to work or otherwise support themselves, were often swept up by these laws and forced to reside for a long and indefinite time in an almshouse.

By the end of the Colonial Period and into the early years of the Republic, jails and almshouses were filled with people with mental illness. These individuals were subject to neglect when they were lucky and overt abuse when they were not.

There were a small number of people with mental illness who were treated in the few hospitals that existed at the time. Indeed, the second patient admitted to the Pennsylvania Hospital, which opened in 1751 in Philadelphia as the first hospital of any kind in the United States and which continues to exist today, was a mentally ill person. The facility

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[1] Edited remarks presented on December 9, 2005, in Richmond, Virginia, at a conference on "Reforming the Involuntary Commitment Process: A Multidisciplinary Effort" sponsored by the Virginia State Bar at the behest of Virginia Chief Justice Leroy Rountree Hassell, Sr.

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[3] Ironically, a variant of this approach exists today in some parts of this country, sardonically referred to as "Greyhound" therapy.

found such a demand for care for people with mental illness that it soon devoted a whole floor to them and quickly thereafter opened what later became the Institute of the Pennsylvania Hospital, a separate campus just for the treatment of the mentally ill.

If persons with a mental illness required hospitalization during this era, they were dealt with as any other medical patient was, that is, they were usually signed in and out by their families. The only other routine requirement prior to admission was that a deposit be made to cover the costs of care.

One additional requirement that began to develop during this period was that of a doctor's concurrence. This requirement necessitated that a doctor agree that hospitalization was necessary and appropriate, often referred to as "signing-off" on the admission. There still exists a slip of paper signed by Benjamin Rush, one of the signers of the Declaration of Independence and the man whose image appears on the Seal of the American Psychiatric Association and who is often thought of as the founder of American psychiatry. Benjamin Rush's note on this scrap of paper said, "[p]lease admit this patient, B. Rush." This slip of paper appears to be the original, albeit rushed, form of medical certification that is widely employed today.[4]

In general, what existed during this time was an informal system that evolved without statutory authority, criteria, or procedures, and that placed commitment decisions entirely in the hands of family members and the medical profession, without any role for the state or the courts. This approach, in fact, was endorsed in 1845 in a famous opinion of the Supreme Judicial Court of Massachusetts in a case called *In re* Josiah Oakes.[5] In its ruling, the Massachusetts court cited the "great law of necessity and humanity" as supporting the right of "[t]hose who are about him," including family members, friends, and acquaintances, to involuntarily hospitalize an apparently mentally ill person for that person's own benefit. The court saw no need for any authorizing law, but found this authority extant since the time the Constitution was adopted.

First Cycle of Reform: 1830-1865

The process just examined essentially existed almost everywhere in the early Republic until the 1830s, when the first cycle of reform occurred. The period from the 1830s to roughly the end of the Civil War, 1865, was one in which recognition began to arise that jails and almshouses are poor places to care for people with mental illness.[6]

Reformers during this era, such as Dorothea Dix from Cambridge, Massachusetts, drove this change in popular sentiment. Dix, sometimes ungenerously referred to as a spinster school teacher, began visiting jails and almshouses and discovered to her amazement that they were full of people with mental disorders. Dix traveled the country documenting this occurrence and writing extensive memos to state legislatures to persuade them both that a problem existed and to propose a solution, namely the establishment of state psychiatric facilities.

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[4] The completion of a medical certification form by one to three physicians is frequently a prerequisite for involuntary hospitalization under current civil commitment laws. *See, e.g.,* VA. CODE § 37.2-815 (2006) (establishing that prior to involuntary admission, a psychiatrist or psychologist must provide oral or written certification that he or she has personally examined the person and address (1) whether the person presents an imminent danger to self or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for self, and (2) whether the person requires involuntary inpatient treatment).

[5] *In re* Josiah Oakes, 8 Law Reporter 122 (Mass. 1845), http://www.disabilitymuseum.org/lib/docs/1305.htm?page=print (last visited Jan. 5, 2006).

[6] We may soon reach this advanced state of awareness again, at which point hopefully a new cycle of reform will begin. Currently, there are vastly more people with a serious mental illness confined in American jails and prisons than in all psychiatric facilities combined.

Indeed, the state hospital system as we know it today dates to the 1830s. This movement is often cited as beginning in Worcester, Massachusetts, where Worcester State Hospital was established.[7] The model provided by this facility rapidly spread throughout the rest of the country.[8]

With the establishment of state facilities and government involvement, however, came a concomitant need for legislation authorizing the use of these facilities. No longer could admission decisions be left in the hands of family members and physicians, at least not without some sort of formal recognition of this practice. Legislation ensued although, not surprisingly, most early pre-Civil War statutes merely codified existing practices. Families presented patients for admission. Doctors certified them in and out.

The basis for admission was simply whether the individuals for whom admission was sought were mentally ill and in need of treatment. To the extent that the courts were involved—and this is when they first became involved—this involvement was required only for indigents, for whom counties would be responsible for the costs of their care. Judicial involvement was seen largely as a cost-control measure. Governmental officials did not want to allow family members and facilities to admit everyone they thought might benefit from hospitalization at public cost. Some public official had to oversee the process, and this is how the judiciary first became involved in this country in overseeing the civil commitment process.

[7] The University of Massachusetts Medical School now exists on these grounds.

[8] Although the facility constructed in Worcester served as a model for similar facilities across the country, the first building in North America devoted solely to the treatment of individuals with a mental illness was established in Williamsburg, Virginia. The Public Hospital for Persons of Insane and Disordered Minds admitted its first patient on October 12, 1773. Public Hospital, http://www.history.org/Almanack/places/hb/hbhos.cfm (last visited Jan. 5, 2006). A second public facility was built, of all places, on the frontier in Kentucky.

Second Cycle of Reform: 1865-1890

The period before the Civil War was dominated by therapeutic optimism based on principles first developed in England. Kindness was a cornerstone of care, individuals with a mental illness were viewed as people like everyone else, and they were given what is called today occupational therapy as preparation for their reentry into society. This optimism diminished in the years following the Civil War.

Dissatisfaction with the mental health system began to be expressed widely as the costs of the institutions increased and the quality of the care provided declined. Legislators who thought there would be just a few mentally ill citizens who required hospitalization were taken aback at the numbers who poured out of almshouses and jails into the new public facilities. They watched the portion of their budgets devoted to these facilities climb. They were not prepared to cut back on the number of existing facilities; indeed, they could not even avoid building new ones. But they certainly did not want to pay for the quality of care or the level of care that was provided prior to the Civil War.

In many states, reluctance to provide increased financial support to the mental health system was driven in part by the increased number of residents of these asylums, as they were often called, who were members of unpopular and disfavored populations. For example, Massachusetts' Taunton State Hospital, which still exists today, was built originally as an asylum for Irish immigrants suffering from mental illness. The first significant wave of Irish immigration to this country began in the 1840s, with Massachusetts a prime destination for Irish immigrants. Many of the Yankee settlers who had dominated the state until then resented this influx. They saw the Irish as something less than human or certainly inferior to themselves and believed it was inappropriate to mix Irish and Yankee patients in the same facility. As a result, Taunton State was built just for the Irish.

A sense that individuals with a mental illness from classes of persons perceived to be inferior should be placed in separate facilities became very widespread in this country. Similar segregated treatment was frequent for black persons with a mental illness, although they often were not even considered eligible for hospitalization until well after the Civil War. The care provided for members of these disfavored groups was only reluctantly and minimally funded by governmental officials. Perceptions that they constituted a growing proportion of the mentally ill population dampened further the dwindling enthusiasm legislators felt for supporting facilities for the mentally ill in general.

Ultimately, however, complaints of family members about conditions in these post-bellum facilities began to arise. Further, people who had been hospitalized were able to publish reports that were circulated nationally that alleged that they had been railroaded into these facilities by disingenuous family members and conniving physicians.

The most famous of these reports was by Elizabeth Packard from Illinois.[9] She asserted that her husband, with the cooperation of a physician friend, had gotten her certified into a state facility in an effort to get her out of the way. There had been nothing wrong with her, she declared, but she had been unjustly hospitalized for many months before she could win her freedom. She claimed that her husband, a preacher, was disconcerted by statements she had made that seemed to suggest that she was a re-embodiment of the Virgin Mary. Embarrassed when these statements circulated among his parishioners, her husband had sought to have her removed from the community.

A review of Mrs. Packard's story suggests that it is possible that this woman may have been experiencing delusions and needed hospitalization, and as a result this placement did not constitute railroading. But that was not the widely-held view at the time. Mrs. Packard was an outspoken and popular lecturer and writer on these issues. As part of her efforts, she pushed for a particular reform. She believed no person should be involuntarily committed to a state hospital unless that person was found by a jury to be insane.

In the years following the Civil War, procedural reform occurred in many states. One of the most popular reforms was the institution of trial by jury.[10] Along with this option, many states in the 1870s and '80s mandated judicial review of civil commitment;[11] established a right to representation by an attorney and an associated right of free communication with the attorney; and dictated the process through which individuals could be certified as mentally ill and in need of hospitalization, including that physicians could not benefit financially from the certification and must

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[9] E. P. W. PACKARD, MODERN PERSECUTION, OR INSANE ASYLUMS UNVEILED, AS DEMONSTRATED BY THE REPORT OF THE INVESTIGATING COMMITTEE OF THE LEGISLATURE OF ILLINOIS (1973) [reprint of 1875 edition].

[10] There are still states that retain a right to a trial by jury for people who are alleged to qualify for involuntary commitment, with Texas being the place where such trials occur most frequently. *See, e.g.*, TEX. HEALTH & SAFETY CODE § 574.032 (2005) (directing that a hearing for temporary mental health services may be held before a jury if the proposed patient or his or her attorney requests it, and a hearing for extended services must be held before a jury unless the proposed patient or his or her attorney waives it). *But cf.* VA. CODE § 37.2-821 (2005) (limiting the right to jury trial to appeals of involuntary admission rulings previously made by a district court judge or special justice).

[11] This mandated review approximates the hearing process used in many states today. *But see* NEB. REV. STAT. § 71-915(2) (2005) (requiring that civil commitment proceedings be presided over by a three-member "mental health board" consisting of a lawyer and two of the following: a physician, a psychologist, a psychiatric social worker, a psychiatric nurse, a clinical social worker, or a layperson with a demonstrated interest in mental health and substance dependency issues).

actually have seen these patients before certifying them.

Interestingly, one change that was implemented in the early 1880s is something that might have been assumed to have existed all along. In Massachusetts in 1881 and New York in 1882, the first statutory recognitions of voluntary hospitalization were adopted. Involuntary commitment existed in practice for more than a century in this country before anybody recognized that people with a mental illness requiring hospitalization might retain the capacity to sign themselves into the hospital. Only with this wave of reform did the concept of voluntary hospitalization become embedded in this country's laws.

What did not happen during this reform period, which essentially lasted until 1890, was any change in the substantive criteria for civil commitment. The criteria that continued to be applied were basically that an individual must be mentally ill and in need of treatment before involuntary hospitalization could occur.

Subsequent Cycles of Reform: The Twentieth Century

Reform efforts since the 1890s have gone through repeated cycles driven primarily by whether the public at the time is (1) concerned that people with mental illness are not getting the treatment they need or (2) focused on the possibility of unjust detention. As a result, reforms have tended to alternate between making it easier to get people into the hospital and increasing procedural protections that limit this hospitalization.

For example, during the progressive era in the early part of the twentieth century, police were allowed on their own initiative to petition for involuntary hospitalization. In many states, a so-called "2 PC" (two physician certificate) procedure was implemented whereby the courts could be by-passed at least for the initial emergency hospitalization if two physicians certified the patient as meeting involuntary commitment criteria.[12]

In contrast, in the 1930s when there was less concern that individuals with a mental illness needed to be rapidly hospitalized and more concern about a lack of procedural protections, changes were adopted that made the process more akin to the procedures required within the criminal justice system. Provisions such as judicial approval of warrants prior to detention and tighter restrictions on hospitalization began to be imposed. Again, however, the substantive criteria were not challenged. The criteria for commitment remained whether the person was mentally ill and in need of treatment.

During the 1970s, however, a combination of factors came together that led to dramatic changes in these historical approaches. In the '60s, a group of influential sociologists, the so-called labeling theorists, began to raise questions about the reality of mental illness.[13] Their highly influential arguments asserted that mental illness does not exist as an entity in any objective sense. Rather, because society has adopted expectations that individuals with mental illness will act in a prescribed deviant manner, once people are labeled as mentally ill, they feel compelled to fill this role. Thus, by labeling people as mentally ill, society induces the behaviors that are used to justify the designation.

At the same time, some influential psychiatrists, such as Thomas Szasz and R.D. Laing, began to claim that mental illness is either a myth or simply an alternative form of consciousness, and perhaps even a preferable form of consciousness to the one in

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[12] In many states, a procedure similar to this continues to exist. *See* N.Y. MENTAL HYG. LAW § 9.27 (2006) (establishing that the director of a hospital may admit and retain any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians for up to sixty days).

[13] *See* Thomas J. Scheff, *Cultural Stereotypes and Mental Illness*, 26 SOCIOMETRY 438 (1963).

which most of the rest of society is mired.[14] Simultaneously, a new breed of sociological critics began to question the value of long-term hospitalization, provided exposes on abuses within state facilities, and pointed to community-based alternatives as preferable to institutional care.[15] Legislators, who noticed that mental health constituted the single largest line item in their budgets by the middle part of the twentieth century, began to ask why so much money was being spent to treat disorders that do not exist in ways that professionals were now telling them made patients worse instead of better.

Potentiating these changes was a revolution in constitutional law in the '50s and '60s that began with the civil rights revolution for blacks but which extended to other disenfranchised groups and ultimately encompassed the mentally ill. For the latter, the revisions that resulted were first embodied by statute in Washington, D.C., in the Ervin Act of 1964,[16] and followed by the Lanterman-Petris-Short Act in California in the late '60s.[17] By the end of the '70s similar provisions were enacted in almost every state in the country.

The result of these revisions was that if physician control over commitment was acceptable at all, it was only acceptable for a short period of time, a matter of a few days at most, after which judicial review was required. Further, commitment could no longer take place merely because somebody was mentally ill and in need of treatment. Any standard broader than dangerousness to one's self or others fell outside the legitimate scope of the state's powers and was unjustified.

By the end of the 1970s, every state, either by court decision or more typically by statute, had both constricted its substantive standard for commitment to dangerousness to self or others (with grave disability or inability to meet one's basic needs being a subcategory of the self-danger criterion), and provided procedural protections that until that point had been characteristic of the criminal justice process but had not been seen in full-fledged form in mental health proceedings. These procedural protections included rights to notice, to counsel, to confront and cross-examine witnesses, to exclude hearsay (in many states), and the like.

Although there has been some tinkering since then, the most significant of which has been the authorization of outpatient commitment as an alternative to hospitalization in approximately a third of the states, this is basically the structure employed today. What happened in the 1970s still controls the use of civil commitment around the country today.

Impact of These Reforms

It is worth considering how much of a change in practice these significant alterations in civil commitment law in the 1970s actually caused. On paper, the process is far different than when Benjamin Rush admitted patients to the Pennsylvania hospital. Physicians and family members are no longer the sole decision makers, the judiciary is routinely involved, procedural protections are in place to guide its use, and only individuals dangerous to themselves or others can be hospitalized.

But there are good reasons to believe that the changes in who gets hospitalized and under what circumstances are much less profound than they appear on paper. There are

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[14] *See* R. D. LAING, THE POLITICS OF EXPERIENCE (1967); THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1961).

[15] *See* RICHARD BARTON, INSTITUTIONAL NEUROSIS (1959); ALBERT DEUTSCH, THE SHAME OF THE STATES (1948); ERVING GOFFMAN, ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES (1961); MIKE GORMAN, EVERY OTHER BED (1956); GERALD GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991).

[16] D.C. CODE §§ 221-501 to -509 (Supp. V. 1966), *reprinted in* R.C. ALLEN, E.Z. FERTSER, & J.G. RUBIN, READINGS IN LAW AND PSYCHIATRY 277-84 (1975).

[17] CAL. WELF. & INST. CODE § 5150ff.

substantial variations in how strictly the laws are applied across jurisdictions, and differences in involuntary hospitalization today compared with the 1950s and '60s probably have more to do with changes to the mental health system than with any changes to civil commitment law.

A study done shortly after legislators in Pennsylvania in the 1970s tightened that state's civil commitment law provides an example of an absence of effects resulting from this new generation of laws.[18] Conducted by Mark Munetz and his colleagues at the Western Psychiatric Institute and Clinic, the study looked at the records of three groups of fifty patients each. One group was drawn from the pre-reform era when all that was required for involuntary hospitalization was a showing of mental illness and a need for treatment, with few procedural protections in place. They also examined a second group shortly after the reforms were implemented. A third group consisted of patients involuntarily hospitalized two years after the statutory reforms were put in place.

The researchers found no significant differences in demographic or diagnostic composition across the three groups. Fewer patients were committed on the basis of suicidality after the change in the law because it became more difficult to establish that this condition met the criteria for hospitalization. Offsetting this reduction, however, the authors found that more patients were hospitalized based on their inability to care for their basic needs. The authors inferred that this latter category constituted a catch-all for patients who did not meet the specific criteria in the statute but for whom hospitalization appeared to be warranted on clinical grounds.

Although this is just one study from one jurisdiction, in fact it is typical of the empirical literature from other jurisdictions as well.[19] I have not found a study in this country showing significant changes before and after statutory reform, at least if you look more than a year or two after statutory reform, that can be attributed to changes in the statute rather than to trends that were ongoing prior to the statutory adoption.

The reasons for a lack of effect from alterations in civil commitment statutes may be worth contemplating as you undertake to reform civil commitment in Virginia. Although these statutes are enacted based on the assumption that they control the behavior of the participants in the civil commitment process, the last wave of reform in the '70s indicates that everybody involved in this process has a great deal more discretion than we imagine or than it looks like on paper.

For example, studies have shown repeatedly that one reason why the statutes have limited impact is because judges, the ultimate protectors of due process, flex the criteria to permit the hospitalization of people who they think need to be in the hospital.[20] Consider the following comment by a Virginia lawyer responding to the survey conducted in preparation for this conference. He or she wrote:

> The statute goes too far in protecting a patient's civil rights. In my view over 90% of the patients I represented have not met the statutory criteria, yet it has been in the best interest of the same percentage of patients to be committed. Fortunately, the local special justice pays more attention to the patient's needs than to his rights,

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[18] Mark R. Munetz, Kenneth R. Kaufman, & Charles L. Rich, *Modernization of a Mental Health Act: I. Commitment Patterns*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 83 (1980).

[19] *See, e.g.,* ENKI RESEARCH INSTITUTE, A STUDY OF CALIFORNIA'S NEW MENTAL HEALTH LAW (1969-1971) (1972).

[20] *See* Virginia A. Hiday & Lynn N. Smith, *Effects of the Dangerousness Standard in Civil Commitment*, 15 J. PSYCHIATRY & L. 433 (1987); Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 L. & SOC'Y REV. 629 (1977).

fudges the criteria, and commits the patient for the treatment he need[s].

If that suggests a certain degree of flexibility among at least some judicial decision makers, it also suggests some flexibility, if you want to call it that, among attorneys representing the individuals for whom involuntary hospitalization is sought.

Indeed, there have been studies of attorney behavior under the new more rigorous statutes suggesting that many of them—particularly the more experienced attorneys who have had an opportunity to see people come back three, four, or five times through the process—moderate their advocacy for the liberty interests of their clients.[21] The basic finding of these studies is reinforced by a very compelling study that Norm Poythress did in Texas some years ago.[22] He trained attorneys in all the arguments that could be used to rebut testimony by psychiatrists regarding their clients' need for involuntary commitment. He followed up six months later to determine whether they were using the information that he gave them and discovered that almost none of them were. When he asked them why not, they said roughly: well, we represent these very sick people, and we couldn't sleep at night if we went home and knew that we helped these people stay out of the hospital when that's what they really needed.

This attitude is not true of all judges and attorneys or in all jurisdictions. Some judges and attorneys follow the letter of the law. But others believe they have more leeway in their behavior.

If judges and attorneys exercise a good deal of discretion, so do mental health professionals and families. Mental health professionals have been shown to allege a need for hospitalization under whatever criterion is available.[23] Thus, in states that have gotten rid of the grave disability criterion, an increase occurs in the number of petitions based on the suicidality criterion. Conversely, when the grave disability criterion is added, petitions based on suicidality diminish and grave disability petitions increase.

Similarly, families have learned to shape the accounts they provide to meet the criteria for hospitalization.[24] In fact, mental health professionals often train them to do so. Further, I have seen attorneys train them to do so. For example, a family member is told: "Well, you know, it might be different if your husband had punched you and even a punch in the arm would give us something to work with here." Lo and behold, it seems the husband actually did punch his wife in the arm and, even though there is no bruise, she was certainly frightened by it. As a result, the husband is involuntarily hospitalized.

The various parties that I have described here seem to be responding to some common-sense notion of who should be hospitalized and are massaging the system to make it happen. This is not to say that everybody behaves in this way or that reforms have no effect. But in the borderline cases, the ones that could go either way, there is often a tendency to flex the standards and the

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[21] *See* Virginia A. Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027 (1982); Robert D. Miller, Rebecca M. Ionescu-Pioggia, & Paul B. Fiddleman, *The Effect of Witnesses, Attorneys, and Judges on Civil Commitment in North Carolina: A Prospective Study*, 28 J. FORENSIC SCI. 829 (1983); Serena D. Stier & Kurt J. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979).

[22] Norman G. Poythress, *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1 (1978).

[23] *See* ENKI RESEARCH INSTITUTE, *supra* note 19; Munetz et al., *supra* note 18; Roger Peters et al., *The Effects of Statutory Change on the Civil Commitment of the Mentally Ill*, 11 LAW & HUM. BEHAV. 73 (1987).

[24] *See* Jonathan I. Marx & Richard M. Levinson, *Statutory Change and 'Street-level' Implementation of Psychiatric Commitment*, 27 SOC. SCI. & MED. 1247 (1988).

procedures because it is perceived to be in the individual's interest to receive care.

And yet it is common knowledge that the number of hospitalized persons has dropped sharply over the last thirty-five years. If that is not the result of statutory changes, what did cause it? I suggest that this trend started in 1955 when deinstitutionalization began to take off and it continues essentially unchanged, regardless of the nature of the civil commitment laws that are in place, as hospital beds are closed, particularly in public facilities.[25]

Ultimately, the availability of beds has had more of an impact on the use of civil commitment than any statute ever written (just as the availability of community alternatives can have a huge impact on the need for hospitalization today). The reason why psychiatric beds and private psychiatric facilities are closing is because facilities tend to lose money on psychiatric beds, and when the charity becomes too much to bear, they simply close these units.

More recently, managed care has had a similar impact. These organizations have adopted a de facto admission standard of dangerous to self or others. If this standard is not met, insurers will not pay for hospitalization, whether it be voluntary or involuntary. With an increasingly smaller number of publicly-funded beds available, if managed care does not sign-off on admission, admission does not occur, regardless of the existing criteria for civil commitment.

[25] *See* RAEL J. ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL (1990); ANN B. JOHNSON, OUT OF BEDLAM: MYTHS OF DEINSTITUTIONALIZATION (1990); Joseph Morrissey, *Deinstitutionalizing the Mentally Ill*, *in* DEVIANCE AND MENTAL ILLNESS 147 (Walter R. Gove ed., 1982); E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988); Paul S. Appelbaum, *Crazy in the Streets*, 83(5) COMMENTARY 34 (1987).

Conclusion

Does this mean that reform of civil commitment law is pointless because people are going to do what they are going to do anyway and external factors are outcome determinative? Clearly not.

Although it is true that the impact of commitment law reform may be greater if the unavailability of services is not a significant barrier to admissions, it is also clear that subpopulations can be identified that can benefit from focused reforms. For example, outpatient commitment statutes adopted in many states target what you might call "rapid cyclers," people with a mental illness who come in and out of hospitals repeatedly and become destabilized after failing to take their medication soon after discharge. If these individuals can be kept on their medications while they are in the community, that cycle of ten, fifteen, sometimes even twenty hospitalizations a year can be broken.

It is also clear that there are discrete dysfunctions in our statutes and procedures that can be identified and ameliorated. For example, the frequent transportation of patients by law enforcement officers in handcuffs, which seems to be a problem in Virginia, can be addressed. Similarly, provisions that leave inadequate periods of time in which to conduct meaningful and reliable evaluations can be ameliorated.

But there is another reason to try and get it right, and that is because the law has symbolic as well as practical value. To the extent that we get it wrong and every player in the system feels a need to circumvent the law, we undermine the legitimacy of our legal system as a whole. After all, for many people the commitment process will be their only contact with the legal system. Moreover, a just and well-functioning system is important for the well-being of those persons subject to the civil commitment process. Therefore, there is value in bringing statutes into closer conformance with what are perceived as the realities of the situation, at least as embodied

in the views and practices of the participants. That may be the most important reason to look carefully at what we do both on paper and in practice, and try to get it right.

Thank you very much for your time.

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Jessie M. Kokrda, *Juvenile Sex Offenders and the Virginia Transfer Statute: Let Treatment Fit the Crime*

Adria N. Bullock, *Parents Forced to Relinquish Custody to Get Treatment for Their Children*

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Developments in the United States Supreme Court

Burden Placed on Parents to Show School District's Planned Services Will Not Provide the "Appropriate" Education to Which Children with Disabilities Are Entitled

A frequently litigated mental health question involves disputes over the nature of services owed children with disabilities by school systems under the federal Individuals with Disabilities Education Act (IDEA). There are nearly seven million students in the country who receive special education services under the IDEA. This law, which dates from 1970, requires school districts to provide a "free appropriate public education" and to work with parents to develop an individualized education program (IEP) for each student with a disability. When parents and school officials cannot agree, an "impartial due process hearing," typically before an administrative law judge (ALJ), must be held.

In a case that arose in Maryland's Montgomery County, where 17,000 students receive special education services and a few dozen cases a year reach administrative hearings, a dispute arose between a local school district and the parents of a young boy with learning disabilities and speech-language impairment. From pre-kindergarten through seventh grade he attended a private school and struggled academically. At that point, officials at the school informed the parents that he needed a school that could better accommodate his needs.

The parents contacted the local public school system and requested a placement. The school system offered to place the boy in either of two middle schools, neither of which satisfied the parents who believed their son needed smaller classes and more intensive services. The parents challenged the school system's IEP and initiated a due process hearing at which the presiding ALJ found the evidence in "equipoise."

The United States Supreme Court was asked to decide who has the burden of proof at these hearings. The Court, in a 6-2 decision, noted that the federal enactment itself is silent on this issue. The parents argued that the burden of persuasion should be placed on the school district because it has greater access to the information and the expertise relevant to these hearings and having to carry this burden would encourage schools to do a better job of preparing IEPs. The Court rejected this argument. The general rule, it determined, is that the party who brings a lawsuit bears the burden of proof and, because there was no reason to think that Congress intended otherwise, that rule applied here.

The majority opinion asserted that very few of these cases will be in "evidentiary equipoise" (although one report asserted the decision is likely to affect hundreds of cases a year nationwide). The Court focused on the considerable administrative expenses incurred by school systems under the IDEA, cited a study from the Department of Education that estimated that litigating a case costs schools approximately $8,000 to $12,000, and reasoned that marginal dollars should be allocated to educational services rather than to litigation and administrative expenditures. It added that a contrary ruling would have the effect of assuming every IEP is invalid until the school district demonstrates its validity, which would be contrary to the IDEA's heavy reliance on the expertise of school districts to meet the goals of the enactment.

While acknowledging that school districts have a natural advantage in information and expertise, the Court found that the IDEA redressed this imbalance by providing parents with a right to review all school records pertaining to their child, the right to an independent educational evaluation of their child at public expense, and various procedural protections.

In closing, the Court noted that several states (including Alabama, Alaska, Connecticut, Delaware, Minnesota, and Virginia) have placed the burden of proof on the school district at these hearings. However, it left for another day the question of whether states have the discretion to do so under the IDEA. Schaffer v. Weast, 126 S. Ct. 528 (2005).

Police Cannot Be Sued Under the Federal Constitution for Failing to Enforce a Restraining Order

The U.S. Supreme Court, in a 7-2 opinion, ruled that the failure of the police to adequately enforce a restraining order does not constitute a constitutional violation and therefore individuals can not pursue a federal claim for harm resulting from this failure. In this Colorado case, a woman involved in divorce proceedings had obtained a restraining order that commanded her husband to not molest or disturb her or their children and to remain at least 100 yards from the family home. The order directed police officers to "use every reasonable means to enforce this restraining order."

One evening the husband, unannounced, took his three daughters while they were playing outside the family home. When the woman discovered the children were missing, she contacted the police and showed them the restraining order. Officers said there was nothing they could do and refused to act despite repeated requests from the woman. At 3:20 a.m. the next morning, the husband arrived at the local police station and opened fire with a semiautomatic handgun. The police shot back, killing him. Inside his pickup truck they found the bodies of his daughters, all murdered.

The woman filed a federal lawsuit. She asserted that the town where she lived had violated her due process rights because its police department had "an official policy or custom" of not responding to complaints of restraining order violations and the town tolerated the non-enforcement of restraining orders by its police officers.

The Supreme Court acknowledged that the Fourteenth Amendment to the U.S. Constitution establishes that a State shall not "deprive any person of life, liberty, or property, without due process of law" and that there is a federal cause of action for the deprivation of any constitutional rights under 42 U.S.C. § 1983. Although the Due Process Clause does not generally require a State to protect citizens from invasions of these rights by private actors, the Court noted a State may be obligated to act where the government has created an "entitlement" to protective services.

The Court ruled, however, that neither the restraining order's language nor a Colorado statute that requires that restraining orders be enforced when certain specified conditions are met made enforcement of this protective order mandatory. Citing a general tradition of affording police discretion in deciding whether to make an arrest, the Court determined that an entitlement to protective services was not created here. Although it granted that Colorado and other states mandate arrest for a domestic-violence offense, the Court responded that this mandate only applies when the offender is present.

The Court added that even if enforcement was deemed mandatory, this would not necessarily mean that the requisite entitlement had been established. The court noted that criminal law is generally established to serve the public rather than promote an individual's "private ends."

The Court also questioned whether this entitlement would constitute the requisite "property" interest needed to establish a due process claim. The Court concluded that the benefit a third party receives from having someone arrested for a crime generally does not trigger protections under the Due Process Clause and it was reluctant to permit the Fourteenth Amendment to serve as a basis for related tort actions.

States are free to provide victims with personally enforceable remedies, the Court asserted. However, the Fourteenth

Amendment and § 1983 do "not create a system by which police departments are generally held financially accountable for crimes that better policing might have prevented."

The dissent argued that by directing police to "use every reasonable means to enforce a restraining order," the Colorado restraining order statute established a mandatory directive, created an entitlement, and formed the basis for a federal constitutional claim. The dissent contended that the nationwide movement in the 1980s and 1990s that led to the enactment of these mandatory arrest laws in some nineteen states resulted from studies showing low arrest rates for domestic violence offenses when police officers are allowed to exercise their discretion. The dissent argued these statutes create an entitlement to have police enforce restraining orders and the fact that police have a range of enforcement options is irrelevant, as the critical point is that "they lacked the discretion to do nothing." Town of Castle Rock, Colo. v. Gonzales, 125 S. Ct. 2796 (2005).

Death Sentence Overturned Because Defendant's Lawyers Did Not Examine Case File from an Earlier Conviction That Would Have Indicated Defendant's Diminished Mental Capacity

A defendant charged with murder and facing a possible death sentence has a right to present mitigating evidence that weighs against the death penalty. This can include evidence of a mental illness or mental retardation that demonstrates the defendant's diminished capacity and reduced criminal responsibility. The U.S. Supreme Court in *Strickland v. Washington*, 466 U.S. 668 (1984), established that a defendant has a Sixth Amendment right to "effective assistance" of counsel in discovering and presenting this evidence during the sentencing phase. In *Wiggins v. Smith*, 539 U.S. 510 (2003), the Court indicated that this right required the defendant's attorney to diligently explore potentially mitigating mental health evidence.

In a 5-4 decision, the Court overturned a Pennsylvania man's death sentence because his lawyers failed to examine the file of a rape conviction from fourteen years earlier that would have led to evidence of the defendant's limited mental capacity, his abuse as a child, and likely diagnoses of fetal alcohol syndrome and schizophrenia. The Court determined counsel should have examined this file because the prosecution had announced its intention to use this case at the sentencing hearing to show that the defendant was a previously convicted violent felon, one of the "aggravating circumstances" on which Pennsylvania law permits a jury to rely in imposing a death sentence.

The Court noted the file was easily obtainable in the same courthouse where the murder trial was taking place and the defendant's lawyers had not independently extracted the information it contained from other sources. The Court asserted that "no reasonable lawyer would forgo examination of the file" and there was a "reasonable probability" that the outcome would have been different but for the failings of defense counsel.

A dissenting opinion denounced the ruling for imposing on defense counsel the time-consuming task of reviewing all documents in the case file of any prior conviction that the prosecution might rely on at trial, which it characterized as looking for a "needle-in-a-haystack." Noting that capital defendants often have a history of crime and that case files can "comprise numerous boxes," the dissent argued such a responsibility would further strain the already limited resources available to a capital defense and divert counsel's "limited time and energy away from more important tasks." The dissent also asserted that by implication the majority opinion labeled incompetent the work done by the three mental health professionals who examined the defendant prior to sentencing. Rompilla v. Beard, 125 S. Ct. 2456 (2005).

It has been noted that in the first sixteen years after the *Strickland* test was established the Court did not find any case in which a

defendant's representation was inadequate. Beginning in 2000, however, it has now found representation to have been constitutionally deficient in three consecutive rulings, suggesting the Court is increasingly troubled by problems of adequate representation for capital defendants and is putting some "teeth" in the *Strickland* test. Linda Greenhouse, *Justices Overturn a Death Sentence, Citing an Inadequate Defense Counsel*, N.Y. TIMES (June 21, 2005).

Federal Act Trumps State's Medical Marijuana Law

The federal Comprehensive Drug Abuse Prevention and Control Act of 1970 classifies all controlled substances into one of five schedules, with Schedule I drugs considered to have the highest potential for abuse and to lack any accepted medical use. Since the enactment of this law, marijuana has been classified as a Schedule I drug despite considerable efforts to change this classification. As a Schedule I drug, the manufacture, distribution, or possession of marijuana is a federal criminal offense, with no exception provided for its medicinal use.

Eleven states, however, have enacted laws that authorize, within those states, the use of marijuana for medicinal purposes, including California, which passed by referendum the Compassionate Use Act of 1996. California residents who use marijuana for medicinal purposes filed a lawsuit and argued that the federal law could not apply to the manufacture and possession of marijuana for medical purposes where this activity occurred exclusively within a state and did not enter into interstate commerce.

The Supreme Court in a 6-3 opinion rejected this argument and ruled that the federal law could permissibly regulate this activity because the activity has a substantial effect on interstate commerce. The Court reasoned that these individuals were cultivating a fungible commodity for which there is an established, albeit illegal, interstate market. The Court determined that Congress had a rational basis for concluding that leaving home-consumed marijuana outside federal control would have a substantial influence on price and market conditions as the high demand for this commodity was likely to draw it into the interstate market and excluding it from the reach of the federal law would frustrate federal efforts to eliminate interstate commercial transactions in marijuana.

The Court rejected the notion that a distinction should be made because under state law this marijuana could only be used "on the advice of a physician." The Court contended that an exemption for physicians provides them with an economic incentive to permit patients to use the drug and "our cases have taught us that there are some unscrupulous physicians who overprescribe when it is sufficiently profitable to do so." The Court asserted this exception would result in some recreational uses being viewed as therapeutic and increase the amount of marijuana in the California market. The Court thus upheld the reach of the federal law, although it explicitly noted that it was not reaching a possible medical necessity defense.

The dissent argued that Congressional enactments that regulate purely intrastate activity violate the Commerce Clause of the U.S. Constitution. Justice O'Connor contended that this federal law impinged on the important ability of States to serve as a laboratory for novel social and economic experiments without risk to the rest of the country. Because the States' core powers have always included the authority to define criminal law and to protect the health, safety, and welfare of their citizens, she asserted that this ruling extinguished a permissible experiment within California without any proof that this activity has a substantial effect on interstate commerce. She also expressed concern that this ruling left few meaningful bounds on the ability of Congress to regulate economic activity.

Justice Thomas agreed that it had not been shown that permitting this activity would compromise the effective enforcement of the

interstate ban on drug trafficking or have a substantial effect on interstate commerce. He concluded that, based on this ruling, Congress "can regulate virtually anything." Gonzales v. Raich, 125 S. Ct. 2195 (2005).

Competence to Stand Trial Determination Should Be Closely Reviewed; Stale Evaluations Insufficient Basis for Findings of Competence; Ruling Not Disturbed

The Ninth Circuit ordered a rehearing on a California trial judge's ruling that a defendant was competent to stand trial (CST). Although considerable deference is typically given to a trial judge's factual determinations, the Ninth Circuit held that CST determinations should be reviewed more closely because a defendant who is incompetent to stand trial is also incompetent to develop an adequate factual record on this issue or to assist his or her attorney in doing so. The Ninth Circuit added that a trial judge has a continuing, affirmative responsibility to ensure that a defendant is not tried while incompetent and the judge should not conclude that a defendant is CST merely because the attorney representing the defendant did not pursue the matter.

The Ninth Circuit cited six aspects of the proceedings that caused it to question whether this defendant was CST. First, in the interval between the competency hearing and the trial, the defendant was found on numerous occasions during hospitalization proceedings to be gravely disabled or a danger to self or others as a result of mental disorder. Second, during the trial the defendant was involuntarily hospitalized for attempted suicide. Third, the defendant's behavior at trial was erratic and strange. Fourth, the defendant's behavior was erratic whether he was in court or in jail and was sustained over the course of a year. Fifth, because the defendant repeatedly waived his right to be present at trial, the jury that convicted the defendant never actually saw him. Finally, not only had thirteen months lapsed between the CST determination and the trial, but the competency determination itself was based on medical reports that were themselves a few months old.

Noting that dramatic changes can take place in a defendant's mental state in even a short period of time, the Ninth Circuit concluded it was unreasonable for the trial court to rely solely on a stale competency determination in the face of contradictory evidence. The U.S. Supreme Court declined to review this ruling. Maxwell v. Roe, 113 Fed. Appx. 213 (9th Cir. 2004), *cert. denied*, 125 S. Ct. 2513 (2005).

Florida Sex Offender Registration and Notification Scheme Upheld; Ruling Not Disturbed

The U.S. Supreme Court has rejected a series of challenges to the sex offender registration and notification statutes of various states. *See Connecticut Dep't of Pub. Safety v. Doe*, 538 U.S. 1 (2003); *Smith v. Doe*, 538 U.S. 84 (2003). Among the issues not directly addressed by the Supreme Court are whether these laws violate these individuals' constitutional rights to substantive due process, equal protection, and travel. The Eleventh Circuit of the U.S. Court of Appeals has rejected such claims in upholding Florida's sex offender registration and notification scheme.

The Eleventh Circuit joined at least three other circuits in rejecting the substantive due process argument. The court determined that even though registration and notification requirements may result in the person being shunned by others who have discovered his past offense, this does not constitute an infringement of a fundamental right when Florida is publishing truthful information that is already available to the public. As a result, the state had only to show that this enactment is rationally related to a legitimate government interest. The court concluded this test was met because it has long been in the interest of government to protect its citizens from criminal activity. The court noted that every state requires convicted sex offenders to register their residence with local law enforcement officials and that the purpose of these laws is

to notify the public about local sex offenders and to aid law enforcement in identifying and locating suspects in local sex-related crimes.

As for the equal protection claim, the court ruled that it is permissible to treat sex offenders differently from other felony offenders and that various classifications contained in the Florida scheme (e.g., those imposing lesser registration requirements on offenders under the age of nineteen and not requiring registration of defendants found not guilty by reason of insanity or individuals civilly committed) are rationally related to legitimate governmental purposes.

The court also found that although the registration requirement is burdensome, it does not unreasonably burden these individuals' right to travel because the state has a strong interest in preventing future sexual offenses by alerting local law enforcement and its citizens to the whereabouts of individuals that could reoffend. The U.S. Supreme Court declined to review this ruling. Doe v. Moore, 410 F.3d 1337 (11th Cir. 2005), *cert. denied*, 126 S. Ct. 624 (2005).

Texas Supreme Court Upholds SVP Commitments and Concludes That Incompetent Individuals Can Be Committed; Ruling Not Disturbed

Like at least sixteen other states, Texas permits a court to commit individuals who suffer from behavioral abnormalities that make them likely to engage in a predatory act of sexual violence. Unlike other states, persons adjudged to be a sexually violent predator (SVP) in Texas are committed to outpatient treatment and supervision. However, a violation of an associated imposed constraint is categorized as a third-degree felony and can result in jail or prison time.

Following a challenge to this scheme, the Supreme Court of Texas upheld its constitutionality. Relying on the U.S. Supreme Court's analysis in *Kansas v. Hendricks*, 521 U.S. 346 (1997), the Texas Supreme Court determined that SVP commitment involves civil rather than criminal proceedings and thus criminal procedural safeguards are not necessarily applicable. The court acknowledged that SVP commitment in Texas does impose limitations, as individuals are required to reside at a particular location, cannot leave the state without permission, may be fitted with satellite monitoring equipment, cannot use alcohol, inhalants, or controlled substances, and must participate in and comply with a particular course of treatment. However, the court cited rulings from courts in fifteen other states that have determined that their SVP commitment schemes are civil, not criminal, and added that Texas, unlike these other states, does not require that SVPs be housed in a secure facility similar to a prison.

Further, the court found that commitment under the Texas statute does not implicate either of the two primary objectives of criminal punishment, namely, retribution or deterrence, but instead promotes the goals of public safety through long-term supervision and treatment. While the Texas approach is unique in imposing severe criminal penalties for violating a condition of confinement, the court concluded that this punitive aspect is offset by the opportunity to "live at large in the community," oftentimes at home with their families.

The court also dismissed an assertion that it should find the scheme unconstitutionally vague because (1) treatment is not individualized by assigning risk levels to individuals facing commitment, (2) commitment is predicated on a "behavioral abnormality," and (3) the conditions of commitment are subject to arbitrary enforcement.

The court further determined that the competence to stand trial requirement mandated for criminal proceedings is not applicable to SVP commitments. The court reached this conclusion because involuntary commitment in general does not trigger the entire range of criminal procedural protections

and the purpose of commitment is to encompass individuals who suffer from a mental disorder and who are "unable to comprehend reality or to respond to it rationally."

However, the court held that when a SVP is facing a prosecution for violating a condition of commitment, the full array of criminal procedural rights is applicable, including a right to be competent at related proceedings. The U.S. Supreme Court declined to review this ruling. *In re* Commitment of Fisher, 164 S.W.3d 637 (Tex. 2005), *cert. denied*, 126 S. Ct. 428 (2005).

Sex Offender Registration and Therapy Cannot Be Imposed as a Condition of Parole on Texas Inmates Convicted of a Non-Sexual Offense Without a Hearing in Which They Are Found to Constitute a Threat to Society Because of Their Lack of Sexual Control; Ruling Not Disturbed

Texas sometimes requires sex offender registration and sex offender therapy as a condition of release on parole from incarceration. While SVP commitment requires a hearing and is generally limited to offenders convicted of a specified sexual offense, these parole conditions could be imposed without a hearing and regardless of whether the inmate had been convicted of a sexual offense.

An inmate on whom these parole conditions were imposed had been indicted for aggravated sexual assault of a child but convicted of only misdemeanor assault. The Fifth Circuit of the U.S. Court of Appeals did not rule out the imposition of sex offender registration and therapy as conditions of parole for inmates who had not been convicted of a sex offense. But it concluded that these conditions may be imposed on such inmates only after a hearing where it has been determined that they constitute a threat to society because of their lack of sexual control.

The court reasoned that where inmates have not been convicted of a sex offense, they have not had an opportunity to contest their asserted sex offender status. Although the constitutional rights of parolees are limited, they are guaranteed some process before the government can impose conditions that are qualitatively different from the conditions characteristically imposed on a person convicted of a given crime, particularly where the conditions, as here, have stigmatizing consequences. The Fifth Circuit determined that although many parolees are required to participate in some form of counseling or treatment as a condition of release, the highly invasive nature of Texas' sex offender therapy program is "qualitatively different" from other conditions that may attend an inmate's release. The U.S. Supreme Court declined to review this ruling. Coleman v. Dretke, 395 F.3d 216 (5th Cir. 2004), *cert. denied*, 126 S. Ct. 427 (2005).

Coverage Denied Under Homeowner's Insurance Policy Because Acts That Resulted from Mental Illness Considered "Intentional" Acts; Ruling Not Disturbed

For no apparent reason, a married couple's son shot a woman outside a health care facility. They and their son, who lived with them, were sued by the shooting victim. They attempted to rely on their homeowners' insurance policy to cover damages that might be awarded to the shooting victim. The insurance company responded that the policy did not apply because it specifically excluded intentional acts from coverage. The family argued the policy did apply because their son suffered from schizophrenia at the time and their son's actions were not intentional.

The Michigan Court of Appeals ruled that the shooting was an intentional act and the insurance company was relieved of any obligation under the policy to indemnify or defend the family. The court determined that nothing indicated the shooting was an accident in which the son had not meant to hurt anyone. Although the son provided conflicting accounts of what occurred during a forensic evaluation, the court noted that he stated that he "went off." The court construed

this to undercut an assertion that the gun had discharged accidentally or that the shooting was unintentional. The court also noted that he had kicked the victim after she fell to the ground, laughed, walked back to his car, and drove away.

The family also argued that even if the son had not mistakenly shot the gun, he lacked the mental capacity to expect or intend that injury would result from his conduct. Even though the criminal charges against the son were dismissed because he was found incompetent to stand trial, the court concluded that the son's mental illness did not establish that the shooting was an unintentional act. Further, an inability to form criminal intent did not establish that the individual did not expect or intend that injury would result. The focus under an insurance policy, the court continued, is what a reasonable person would expect to occur and a person who fires a sawed-off shotgun from close range toward a person at the entrance of a public building can be expected to know that it is highly likely that injury or death will result.

Although the son attempted to pursue several arguments for why a different rule should be adopted that did not interpose the level of understanding expected of a reasonable person on an individual with mental illness, the court rejected these arguments. The U.S. Supreme Court declined to review this ruling. Hastings Mut. Ins. Co. v. Rundell, No. 238549, 2003 WL 21508515 (Mich. Ct. App. July 1, 2003), *cert. denied*, 126 S. Ct. 372 (2005).

Social Workers Immune from Liability for Failure to Adequately Investigate and File Documents Concerning Reported Child Abuse; Ruling Not Disturbed

Every state has a mechanism for the reporting and investigation of child abuse and neglect, with many states, including Virginia, establishing similar mechanisms for abuse and neglect involving "aged or incapacitated adults." The United States Supreme Court in *DeShaney v. Winnebago County Dep't of Soc. Servs.,* 489 U.S. 189 (1989), held that although a state may violate the federal constitution when it fails to protect individuals who are placed in state custody or who are exposed to danger created by the state, the Constitution does not require a state to protect individuals from abuse committed by private actors. A series of lawsuits since then have attempted to find means by which *DeShaney* can be side-stepped to hold state officials responsible under the federal constitution for a failure to adequately investigate reports of child abuse in the community.

In a Missouri case, five children, two of whom died, were "cruelly tortured and starved" by their mother and her live-in partner. A lawsuit was filed against two social workers employed by the Missouri Department of Social Services Division of Family Services (DFS) for their failure to comply with mandated procedures for investigating reports of child abuse and neglect and argued that their failure to abide by state law pertaining to such investigations violated the federal Due Process Clause.

The Eighth Circuit ruled that such a claim can be pursued only when the state official is specifically mandated by law to act under the circumstances and fails to do so. Here, the court reasoned, the social workers were afforded considerable discretion and were not mandated to act, and thus the victims had not been entitled to the state's services. Although it was argued that the social workers' filing of a family assessment report with material omissions and false representations made the children more vulnerable to continued child abuse and ensured needed services would not be provided, the court concluded that the filed report did not create greater risks to the children than the ones to which they were originally exposed. Thus the state action was effectively the same as if it had done nothing, which meant *DeShaney* controlled and liability was precluded under the federal constitution.

The court also rejected an argument that the social workers' actions had been so egregious or outrageous that they should be seen as conscience-shocking and thereby invoke constitutional protection. The court found that

completing a safety assessment without personal knowledge of conditions inside the home and the well-being of each family member, or failing to conduct an investigation, contact law enforcement, and verify the whereabouts of the children, while arguably negligent, is not sufficiently depraved to constitute a constitutional violation. The court noted the evidence did not show that the social workers (1) knew their representations were false or (2) deliberately disregarded a known risk of harm to the children. The court added that state courts, not federal courts, are the appropriate forum to enforce state child protection laws. The U.S. Supreme Court declined to review this ruling. Forrester v. Bass, 397 F.3d 1047 (8th Cir. 2005), *cert. denied,* 126 S. Ct. 363 (2005).

Guardian Ad Litems, Social Workers Given Immunity for Efforts to Protect Individuals Lacking Decision-Making Capacity; Ruling Not Disturbed

Every state has a mechanism that enables a state or local agency to intervene to protect vulnerable individuals when the care they are receiving is deemed inadequate. This protection is typically afforded children, elder persons, and adults who lack decision-making capacity. Among the interventions this agency may pursue are periodically monitoring the care being provided, obtaining a protective order, removing the person from the custody of the current care giver, or initiating guardianship proceedings. When guardianship proceedings are initiated, a guardian ad litem will often be appointed to insure the person at risk is represented and has a spokesperson in the proceedings. The current care provider may contest the actions taken, assert they are unwarranted and improper, and file a lawsuit for damages that resulted. The Court of Appeals of North Carolina has established that it will be rare in North Carolina that such cases can be successfully pursued.

The daughter of an elderly man who was in poor health claimed that she was providing appropriate care for her father, who lived with her, but county officials unjustifiably initiated guardianship proceedings and conspired to separate her from her father. She also asserted an appointed guardian ad litem negligently failed to fulfill her duty to her father when she did not advocate for his best interests.

The court ruled that the agency and its officials are shielded under the doctrine of sovereign immunity, which, unless waived, affords the state, its counties, and its public officials, when acting in their official capacity, an unqualified and absolute immunity from law suits. The court also ruled that county officials are protected under the doctrine of public official immunity, which provides immunity to a public official who "exercises some portion of sovereign power and discretion," and can only be held liable if their conduct is malicious, corrupt, or outside the scope of their authority. Finally, the court ruled that guardian ad litems are entitled to quasi-judicial immunity, which provides an absolute bar to lawsuits for actions taken while they exercise their judicial function. The court noted that several other courts, including the Fourth Circuit, have held that guardians ad litem are entitled to this immunity so they can carry out their functions as an advocate without worrying about possible later harassment and intimidation from dissatisfied parties.

After reviewing the facts presented, the court dismissed the lawsuit, finding that each of the defendants was entitled to immunity under the applicable standards. The U.S. Supreme Court declined to review this decision. Dalenko v. Wake County, N.C., Dep't of Human Servs., 578 S.E.2d 599 (N.C. Ct. App. 2003), *cert. denied*, 124 S. Ct. 1411 (2004).

High Court of New York Affirms Dismissal of Complaint Focused on Sexual Relationship Occurring During Pastoral Counseling; Ruling Not Disturbed

A married couple obtained individual counseling services from their church pastor. In the course of this counseling, the wife and the pastor developed a sexual relationship

that lasted several months. After the husband discovered the affair, the couple filed a suit against the pastor and the church for sexual battery (for unwanted touching) and for clergy malpractice stemming from a breach of fiduciary duties. Because the pastor was not licensed as a professional counselor, a complaint could not be filed with a licensing body. The New York Court of Appeals ruled that the lawsuit could not be pursued.

The battery action could not prevail, the court held, because the evidence established that the sexual relationship between the wife and the pastor was consensual. The court noted (1) the wife initiated discussions concerning her attraction to the pastor, (2) e-mails exchanged expressed a shared affection, and (3) the wife sent these e-mails to the church congregation after the affair was discovered to show the relationship was "very mutual." The court added that the record did not establish that the wife's physical or emotional condition or prescribed medication impaired her ability to consent to physical contact with the pastor.

As for the clergy malpractice claim, the court determined that the complaint failed to indicate the nature of the alleged fiduciary breach. Also, exploring an alleged fiduciary duty would improperly require the courts to examine ecclesiastical doctrine in an effort to determine the standard of care owed to parishioners undergoing ministerial counseling.

A dissenting opinion argued that there is a difference between an allegation of clergy malpractice, which would improperly involve the courts in ecclesiastical matters, and breach of a fiduciary relationship. The latter, the dissent continued, is raised when (1) a pastor holds himself out as a person qualified to give marital counseling, (2) a couple seeks counseling for marital problems from him, and (3) he breaches a duty owed to them. The dissent found that the plaintiffs were making allegations similar to those that could be pursued against a psychiatrist. A cause of action based upon a breach of fiduciary duty rests not on the violation of a generalized professional standard, the dissent added, but on the abuse of a particularized relationship of trust. Because the plaintiffs alleged that the pastor breached a duty of trust by engaging in sexual encounters during marital counseling, they should be able to proceed with their claim. The dissent cited other states (including New Jersey, Texas, and Colorado) that have concluded that an action for breach of a fiduciary duty can be maintained where a pastor engages in an inappropriate sexual relationship during pastoral counseling.

The U.S. Supreme Court declined to review this ruling. Wende C. v. United Methodist Church, 827 N.E.2d 265 (N.Y. 2005), *cert. denied*, 126 S. Ct. 346 (2005).

Personal Property of Homeless on Public Property Cannot Be Destroyed Without Notice and an Opportunity to Reclaim Removed Items of Value; Ruling Not Disturbed

Like many municipalities, Cincinnati periodically conducts cleanup activities targeting municipally-owned areas where homeless individuals reside. It was not asserted that the city lacked the authority to remove the personal property of these individuals. The Sixth Circuit ruled, however, that the city cannot destroy it without notice and without an opportunity to reclaim the items taken. The court reasoned that "there can be little doubt" that these individuals have a protected property interest in their items of value under the federal constitution.

As for the notice required, the Sixth Circuit determined that the key inquiry is whether the notice given is reasonably calculated under the circumstances to appraise interested parties of the pendency of the action and affords them an opportunity to present their objections. The city contended sufficient notification was provided when it published a notice in the local newspaper. Counsel for the homeless responded that such a notice is insufficient, particularly when the educational and financial restraints of the homeless are considered. The Sixth Circuit ruled that this

was an issue for the lower court to resolve on remand. The U.S. Supreme Court declined to review this ruling. Cash v. Hamilton County Dep't of Adult Prob., 388 F.3d 539 (6th Cir. 2004), *cert. denied*, 126 S. Ct. 396 (2005).

Random Drug Tests of State Employees Providing Mental Health Services to Prisoners and to Residents of State Hospitals Upheld; Ruling Not Disturbed

The U.S. Supreme Court declined to review a decision by the Sixth Circuit that upheld a random drug testing program imposed by the State of Michigan on various state employees. Among the employees subject to testing are psychiatrists, psychologists, social workers, and nurses who provide health and mental health services to prisoners and residents at state hospitals for the mentally ill and developmentally disabled. It has been established that random drug tests constitute a "search" and the Fourth Amendment generally protects individuals from searches without an "individualized suspicion" justifying the search. However, an exception to this requirement exists when a state can show a special need for the drug test.

Even though there was no evidence of a pre-existing or pervasive drug problem among these employees, the Sixth Circuit ruled that a special need for the drug tests had been established. The court reasoned that because these employees have access to medications, including controlled substances, they might abuse this access, and the health and safety of their patients may be put in jeopardy if these employees are under the influence of drugs or alcohol. In addition, for the care providers working in prisons, their unsupervised access to and direct contact with prisoners raised concerns that drugs or alcohol might be introduced into the correctional facility. The court concluded the state is entitled to attempt to prevent the harm that results from drug use and this testing program will deter drug use in these settings.

The court also noted that health care is heavily regulated and thus these employees have a diminished expectation of privacy. The court further found that the privacy intrusion associated with this drug testing program was not excessive. Int'l Union v. Winters, 385 F.3d 1003 (6th Cir. 2004), *cert. denied*, 125 S. Ct. 1972 (2005).

"Psychological Parent" Doctrine Applies Even When Established in the Course of a Same-Gender Relationship; Ruling Not Disturbed

In Colorado, as in a number of states, a "psychological parent" doctrine may be applied in disputes over parental rights. This doctrine is based on the importance of a child being able to maintain emotional attachment to a long-term caretaker. In Colorado, a psychological parent is recognized when deep emotional bonds are formed with a person from whom the child receives daily guidance and nurturance (other requirements preclude claims by neighbors, baby sitters, nannies, and au pairs). Even the existence of a developed relationship with a fit legal parent will not prevent nonparents from acquiring parental rights if they can prove that the child will experience emotional harm should the child's relationship with the psychological parent be significantly curtailed or terminated.

A Colorado Court of Appeals has added that it sees no reason why the doctrine should be applied differently when the relationship with the child was established in the course of a same-gender relationship with the child's legal parent. The U.S. Supreme Court declined to review this decision. *In re* E.L.M.C., 100 P.3d 546 (Colo. Ct. App. 2004), *cert. denied*, 125 S. Ct. 2551 (2005).

Showing That a Father Poses a Serious Risk of Psychological or Emotional Harm to His Children Is a Sufficient Basis to Award Custody to Grandparents; Ruling Not Disturbed

Following a divorce, a bitter court battle over who should have custody of the children from the marriage often ensues. The dispute may focus on who is the children's "psychological

parent" (i.e., the parent to whom the children are most emotionally attached) or whether one of the parents pose a risk of psychological or emotional harm to the children.

In an Oregon case, the mother of two young children died shortly after a divorce was finalized that granted her custody of the children. The father then sought custody, but was opposed by the mother's parents (i.e., the children's grandparents), who argued that they should have custody. In court, the father argued that as the biological parent he had a supervening right to custody unless he was shown to be unfit, which could only be established if it was shown that (1) he was unable to adequately care for the children or (2) placement with him would physically harm the children.

On appeal, the Supreme Court of Oregon determined that the U.S. Supreme Court, in *Troxel v. Granville*, 530 U.S. 57 (2000), established that a fit parent does have a constitutionally protected right to make decisions for a child, but that this right can be overcome and not only when there is a showing that the parent poses a risk of physical harm to the child. Thus, the court upheld an Oregon statute that establishes a presumption that the parent acts in the best interest of the child, but allows a court to award custody to a psychological parent if the court determines the parent does not act in the best interest of the child.

In the case before it, the court determined that a child-parent relationship did exist between the grandparents and the children. However, relying on the report of a court-appointed psychologist, the court did not find evidence that the father was unable to provide adequate care. The court also dismissed as irrelevant the grandparents' assertion that they were better able to care for the children, and further ruled that its analysis could not focus on whether the children <u>might</u> experience psychological or emotional harm in the future because of the father's actions. To obtain custody, the court concluded, the non-parent (in this case the grandparents) must show the parent poses a serious present risk of psychological, emotional, or physical harm to the child.

The court found that this showing had been made. The court noted, in part, the testimony of the psychologist and others that the father did not understand his children's emotional and developmental needs, had difficulty controlling his anger, failed to recognize the children's emotional attachment to their grandparents and other relatives of their mother, did not appreciate the impact on the children of his multiple changes of residence, and was unable to acknowledge his weaknesses as a parent. The court determined that granting custody to the father would pose a serious risk of psychological or emotional harm to the children, and awarded custody to the grandparents. The U.S. Supreme Court declined to review this decision. *In re* Marriage of O'Donnell-Lamont, 91 P.3d 721 (Or. 2004), *cert. denied*, 125 S. Ct. 867 (2005).

Developments in Virginia

Virginia Supreme Court

Virginia Supreme Court Rejects Constitutional Challenges to Sexually Violent Predator Commitment Law

The U.S. Supreme Court in *Kansas v. Hendricks*, 521 U.S. 346 (1997), and *Kansas v. Crane*, 534 U.S. 407 (2002), defused most federal constitutional challenges to the civil commitment of sexual offenders under the sexually violent predator (SVP) statutes enacted by many states in recent years. State constitutions could, nevertheless, provide an alternative basis for challenging these enactments.

The Virginia Supreme Court, however, determined that the due process protections afforded under the Virginia Constitution are co-extensive with those of the federal constitution and, in a case of first impression, upheld Virginia's SVP civil commitment legislation under both the federal and state constitutions. The court ruled that this legislation, which permits a sex offender to be civilly committed upon the completion of his prison term, did not violate double jeopardy prohibitions and was not an ex post facto enactment because its purpose is not to punish offenders but to protect public safety.

The court also concluded that the Virginia scheme satisfied the constitutional criteria established by *Crane*. The court determined that (1) proper procedures and evidentiary safeguards were provided, (2) the criterion that there be a finding of dangerousness either to one's self or to others was met by a required finding that the individual "constitutes a menace to the health and safety of others;" and (3) the obligation to link proof of dangerousness and lack of control to the condition of the individual was met by a required finding that the individual "because of a mental abnormality or personality disorder, finds it difficult to control his predatory behavior which makes him likely to engage in sexually violent acts." The Virginia Supreme Court rejected an argument that *Crane* required that the third criterion could only be established by showing that the individual has a "serious" difficulty in controlling his behavior, noting that the U.S. Supreme Court used various phrases in describing this criterion but ultimately established that the inability to control behavior did not have to be demonstrated with "mathematical precision" and only needed to be sufficient to distinguish such individuals "from the dangerous but typical recidivist convicted in an ordinary criminal case."

The court also rejected an argument that the SVP legislation was "void for vagueness" because of a lack of preciseness in the definition of a "sexually violent predator." The court found the definition provided sufficiently clear. As for the requisite evidentiary standard, while noting that Arizona, California, and Illinois have adopted a "beyond a reasonable doubt" standard for SVP civil commitment, the Virginia Supreme Court concluded that the U.S. Supreme Court has established that the minimum standard that may be used is a "clear and convincing" standard and Virginia's use of this standard thus met due process requirements. The court also found that the evidence presented at trial justified the commitment of the two offenders whose cases were before the court. Shivaee v. Commonwealth, 613 S.E.2d 570 (Va. 2005).

Virginia Court of Appeals

Lay Testimony to Support an Insanity Defense Permitted Only When Accompanied by Expert Testimony; Testimony by Licensed Clinical Social Worker Excluded

The challenge faced by the defendant at trial was that the court-appointed evaluator had determined that, although the defendant experienced psychotic symptoms (including

hearing voices that he believed to be from God) at the time of the offense, the defendant's cocaine use had initiated and exacerbated these symptoms and thus the defendant was not legally insane at the time of the crime. In response, the defendant sought to introduce the testimony of a licensed clinical social worker who worked at the jail where the defendant was held and who saw the defendant two weeks after the offense and ten times over the next six months. Because the symptoms continued during incarceration when the defendant had no access to illicit drugs, the social worker was prepared to testify that the psychotic symptoms were unrelated to drug use.

The defense also wanted to introduce the testimony of the defendant's mother and a former roommate to establish that he began hearing voices before he became a heavy user of cocaine. Although the defense conceded that in Virginia (1) lay witnesses are not allowed to provide opinion testimony and can only recite observed behavior and (2) clinical social workers have not been authorized to provide expert testimony on the insanity defense, it maintained that the social worker was more than a lay witness and in any case should be allowed to provide testimony that would undercut the court-appointed expert's factual basis for determining the defendant was sane at the time of the offense.

The Virginia Court of Appeals, sitting en banc, acknowledged that Virginia allows lay testimony to support an insanity defense. However, because Virginia also requires that the defendant establish insanity by a preponderance of the evidence, the court ruled that before such lay testimony will be permitted, supporting expert testimony must be introduced by the defendant. The court rejected the notion that a "quasi-expert" category exists that would permit the social worker to fill this role. Further, although the lay testimony in this case might refute the factual basis for the expert's diagnosis of a drug-induced psychosis, the court concluded it could not establish that some other psychosis was present as required for the insanity defense. Because the defendant could not produce the required expert testimony, the court ruled that the defendant could not introduce his lay witnesses in an effort to pursue the insanity defense at trial.

A dissenting opinion asserted that lay testimony on insanity is excluded in Virginia only when there has been no evidence supporting an insanity defense introduced, but here the court-appointed expert established that the defendant was "most likely psychotic" at the time of the killing. Although the social worker could not provide an opinion that the defendant was legally insane, the dissent argued that he could testify that there was a non-drug-induced cause of the defendant's psychosis and, together with the expert's testimony, this and the other lay testimony provided a sufficient basis for the defendant to establish a prima facie case for an insanity defense. Thus, the testimony of the social worker and the other lay witnesses should have been permitted. White v. Commonwealth, 616 S.E.2d 49 (Va. Ct. App. 2005).

Request for New Trial and Opportunity to Raise Insanity Defense Based on Newly Discovered Evidence of Dissociative Identity Disorder Refused

The use of diagnoses of Dissociative Identity Disorder (DID) (formerly known as multiple personality disorder) tends to be particularly controversial in the legal system. Concerns have been raised about the validity of this diagnosis, its identification, its potential for manipulation, and its application in legal proceedings.

A criminal defendant in Virginia who did not raise an insanity defense had been found guilty of the second-degree murder of her husband. Following her conviction, she was diagnosed for the first time as having had a DID at the time of the crime. The defendant argued that this diagnosis could provide the basis for a finding of legal insanity under the "irresistible impulse" prong of the Virginia insanity defense and she was entitled to a

new trial where she could attempt to establish this defense.

The Virginia Court of Appeals, sitting en banc, refused the defendant's request. After a detailed review of the case, the court ruled that (1) the defendant and her counsel could have secured evidence before trial that she suffered from DID through the exercise of reasonable due diligence and (2) the DID diagnosis would not have produced a different result upon retrial. The court added that, in effect, the defendant was asking the court to establish that a different post-trial diagnosis of a preexisting mental illness necessitated a new trial, but that this is something that the law does not favor.

A dissenting opinion argued that the defendant had done everything reasonably possible prior to trial to discover grounds for an insanity plea but that the evidence supporting a DID diagnosis did not present itself until after her conviction. The dissent asserted that DID is not easily diagnosed, that earlier evaluations had been thorough and extensive and explanations provided for why DID had not been earlier considered, that the defendant did not have control over the timing of the emergence of symptoms, that there was evidence that she was not feigning the symptoms, and that the out-of-state decisions from Wisconsin, Oklahoma, and Michigan on which the majority relied were factually dissimilar. The dissent concluded that a new jury could have found that one or more of the defendant's alter personalities was responsible for the murder and that the defendant suffered from an impulse that was sudden, spontaneous, unpremeditated, and overwhelming. Orndorff v. Commonwealth, 613 S.E.2d 876 (Va. Ct. App. 2005).

Children's Therapist Can Not Testify at Divorce Proceedings About Mother's Behavior

A court presiding over divorce proceedings in Virginia must consider the "mental condition of each parent" in making custody or visitation arrangements. At the same time, as in most states, statements made to a licensed mental health care provider by a client are privileged (i.e., the provider cannot testify regarding any information obtained while examining or treating a client without the client's permission). Formerly, this privilege was often disregarded during custody or visitation proceedings because the client was considered to have placed his or her mental condition at issue in these proceedings. However, a new law (VA. CODE § 20-124.3:1) was passed that limits the admissibility of mental health records in these proceedings.

In its first ruling on the scope of this new law, the Virginia Court Appeals held that this statute prevents the children's therapist from testifying about their mother's behavior even though the mother was not the client of the therapist. The mother had custody of the children but under Virginia law she is required to "foster" her children's relationship with their noncustodial parent. The children's therapist had testified that the mother during clinical sessions with the children had denigrated their father and as a result the trial court held the mother in contempt for this behavior.

The Virginia Court of Appeals ruled that this testimony should not have been admitted and reversed the contempt finding. The court determined that the new law was not limited to when the parent was a client of the therapist but encompassed any information obtained during or from therapy concerning a parent. Although the new law permits a licensed mental health provider to testify regarding suspected child abuse or neglect or pursuant to a court ordered independent mental health evaluation, the appellate court concluded that a mental health provider's testimony was not allowed merely to promote the administration of justice or to ascertain the best interests of the child. Because the therapist's testimony was given without the mother's permission and this was the only independent testimony about the mother's criticism of the father in the presence of the children, the court reversed the contempt finding. Schwartz v. Schwartz, 616 S.E.2d 59 (Va. Ct. App. 2005).

Young Girl Competent to Testify During Criminal Proceeding

The Virginia Court of Appeals ruled that a young girl, whose exact age was not given, was competent to testify in a criminal proceeding. The defendant in the case had been convicted of animate object sexual penetration of a child under the age of 13. He claimed that the alleged victim was incompetent to testify because she did not independently remember the incident, had a limited capacity to recall the events, and did not understand or affirm the oath administered prior to her testimony.

The appellate court noted that in Virginia age alone does not make a child incompetent to testify. The requisite test is that the child must possess the capacity to (1) observe, recollect, and communicate events and (2) intelligently frame answers with a consciousness of the duty to speak the truth. The court determined that this girl demonstrated the capacity to observe, recall, communicate, and respond by answering questions on the stand about her home, school, and events from her last birthday, and added that her account of the events paralleled the defendant's version. A conclusion that she had no independent memory of the event could not be drawn merely from the fact that she had spoken to others about the incident. A lack of detail in her testimony might lead the trier of fact to discount her credibility as a witness, but did not pertain to her competence to testify. The court also determined that the oath requirements were met when the child promised at trial that she would tell the truth about what had happened, stating that it would be "bad" to do otherwise. Avalos v. Commonwealth, No. 2874-03-4, 2005 WL 1429772 (Va. Ct. App. June 21, 2005).

Wife Was Competent to Execute a Settlement Agreement Even Though Treating Psychiatrist Testified That When He Saw Her Four Days Later She Was in "Acute Stage" of Bipolar Affective Disorder

To be binding, both parties to a contractual agreement must be mentally competent. Under Virginia law, each party is presumed to be competent and a party later seeking to establish incompetence has a "heavy burden" to show by clear and convincing evidence that the person "lacked the capacity to understand the nature and consequences" of the transaction. A failure to exercise good judgment or to make wise decisions will not establish a party's incompetence.

In a case before the Virginia Court of Appeals, a woman argued that her property settlement agreement with her husband should be set aside because she was incompetent to execute the agreement at the time. The wife's psychiatrist testified that the woman was in an "acute stage" of bipolar affective disorder when he saw her four days after she signed the agreement and that it was his opinion that she would not have been able to "appreciate" the consequences of signing the settlement agreement at the time she signed the agreement.

On appeal, the court ruled that there was insufficient evidence to support the wife's claim that she was incompetent at the time. The court noted that the wife's psychiatrist on cross-examination testified that he could not say the wife had been in the same condition four days earlier. Further, weight was given to a psychiatrist testifying on behalf of the husband who reviewed a journal contemporaneously kept by the wife and found the entries grammatically correct and "consistent with logical thought." This psychiatrist also pointed out that the wife was being seen on an outpatient basis at the time and associated medical records stated she was not delusional. The psychiatrist also found it significant that the wife actively participated in creating the agreement by drafting the portion she signed.

The court also determined that it was acceptable to rely on lay testimony in assessing a party's competency when the individual was familiar with the person's demeanor. The court noted that three witnesses who saw the wife on almost a daily

basis testified that she appeared "normal" during the relevant time period. The court also cited as significant the wife's own testimony that she was working at the time on a full-time basis, had a clear recollection of the events, was aware of the property that the parties owned, and recognized her husband got most of the property under the agreement. Arey v. Arey, No. 0801-05-3, 2005 WL 2205646 (Va. Ct. App. Sept. 13, 2005).

Parental Rights of Woman with Schizophrenia Terminated for Failing to Take Needed Medication

The Virginia Court of Appeals ruled that a woman's failure to consistently take the medication needed to control her mental illness could serve as the basis for terminating her parental rights. Diagnosed with schizophrenia, the woman lost custody of her son immediately after his birth. At the hospital she had initially said that she did not know she was pregnant and then stated that she had become pregnant from a tomato seed she had eaten in a can of spaghetti. She lived alone at the time in a condemned house with no running water and only one working electrical outlet.

The relevant governmental agency advised her that to regain the custody of her son she needed to attend counseling sessions, take parenting classes, find suitable housing, and take her daily medication for her mental illness. Following a period of psychiatric hospitalization and a three-month stay in an adult home, she did find housing. However, the court found that she generally refused to take parenting classes and during supervised visits with her child did not show appropriate parental skills, failed to attend scheduled counseling sessions, insisted she did not need treatment, and did not regularly take her medication but only when she thought she needed it. Meanwhile, her child had bonded with his foster family and this family was willing to adopt him. When the child was two years of age, termination proceedings were begun.

The court held that there was clear and convincing evidence that termination of the woman's parental rights was in the child's best interests. The court refused to admit into evidence letters written by a pair of mental health professionals that discussed the woman's diagnosis and lack of treatment adherence because the letters constituted inadmissible hearsay evidence. Nevertheless, the court determined there was sufficient evidence showing the woman remained unwilling to accept her mental illness and to obtain the treatment and medication that might permit her to parent the child successfully. The court added that the woman had not demonstrated an ability to bond with the child or to recognize that his needs changed as he developed.

Notwithstanding that the woman had remedied the conditions under which she was living when the child was born, the court concluded it was not in a child's best interests to wait for a lengthy period of time to find out when, or even if, a parent will be capable of resuming parental responsibilities, and thus terminated the woman's parental relationship. Fields v. Dinwiddie County Dep't of Social Servs., 614 S.E.2d 656 (Va. Ct. App. 2005).

Circuit Courts of Virginia

Statute of Limitations Held to Bar Personal Injury Suit Against Catholic Diocese Based on 25-Year-Old Recovered Memories of Sexual Abuse

A man who alleged that he recently recovered memories of sexual abuse some twenty-five years earlier by a nun who taught at his Catholic school had his lawsuit against the Catholic Diocese of Richmond dismissed because the claim was barred by the Virginia statute of limitations on filing personal injury claims. In Virginia, a lawsuit to recover for personal injuries generally must be filed within two years from the time the harm occurred, although if the injured person is a minor the two-year period does not begin to run until the person reaches the age of eighteen.

In 1994, the Virginia Constitution was amended to permit the General Assembly to retroactively change this rule for personal injury actions arising from the sexual abuse of minors. In 1996, the General Assembly changed the statute of limitations so that if a person discovered during discussions with a licensed physician, psychologist, or clinical psychologist that he or she had been sexually abused as a minor, the time limitation would not begin to run until those discussions occurred.

The man in this case asserted that he had repressed his memories of the abuse and it was not until the last two years that he discovered his abuse following communications with the requisite mental health professional. He argued that the 1996 change permitted him to pursue his lawsuit.

The Norfolk Virginia Circuit Court, however, ruled that the constitutional amendment only permitted retroactive changes to the statute of limitations for law suits that targeted "natural persons" and thus the legislature in its 1996 enactment could not retroactively extend the statute of limitations for suits that target entities, such as the Catholic Diocese, that are not a "natural person." Thus, the court determined the man could not pursue his lawsuit against the Catholic Diocese because the statute of limitations had expired. McConville v. Rhoads, No. L04-422, 2005 WL 1463850 (Va. Cir. Ct. June 8, 2005).

Commonwealth Pays $85,000 After Resident at Geriatric-Psychiatric Facility Attacks Another Resident; Greater Number of Violent Attacks on Geriatric Residents in General Linked to Increase in Lawsuits

A medical malpractice claim brought against the Commonwealth of Virginia following the death of a resident at a state-operated geriatric/psychiatric facility was settled prior to trial for $85,000. Two days after being admitted, the resident was attacked by another resident, suffered a cerebral hematoma from being knocked down, and died a week later of complications from her injuries. Family members in their lawsuit alleged the Commonwealth failed to provide a safe environment and inadequately supervised the aggressive resident, especially in light of evidence that staff knew or should have known about the aggressive resident's threatening behavior and violent tendencies. Depositions revealed facility staff were aware of previous acts of violence by the aggressive resident and the facility had the ability to separate and restrict aggressive residents from coming into unsupervised contact with other residents. Fink, Ex'r Estate of Sarah Ann Lipscomb v. Commonwealth, *Med-mal Death Settles for $85,000 Prior to Trial*, 19 VA. LAW. WKLY. 1204 (Apr. 25, 2005).

It has been asserted that there is a growing number of nursing home resident-on-resident assaults that are in part due to a lack of proper supervision and in part the result of a mixing of populations where defenseless older individuals with Alzheimer's or dementia are housed with younger individuals with a mental disorder or a criminal history. Florida and North Dakota are reported to be considering legislation that would require nursing homes and assisted-living facilities to conduct background checks of prospective residents and ban convicted sex offenders. A nursing home industry spokesperson has expressed concerns about the delay and added expense associated with such mandated screening.

In May of 2005, a lawsuit filed against a nursing home by the Minnesota Attorney General for a failure to warn residents, families, and case workers that sex offenders were living at the home along with vulnerable adult residents was settled without an admission of wrongdoing by the nursing home. Two of the home's former operators, however, pleaded guilty in October of 2004 to charges of criminal neglect for housing sex offenders who subsequently sexually assaulted other residents.

Concerns have been expressed that breaches of legal protections of privacy and confidentiality, including those provided by the federal Health Insurance Portability and

Accountability Act, might result from such disclosures, although the Alaska Supreme Court in Bryson v. Banner Health Sys., 89 P.3d 800 (Ala. 2004), ruled that confidentiality laws do not necessarily negate the duty of a facility to protect a resident from another resident. Nora Lockwood Tooher, *Nursing Home Violence Spurs Increase in Lawsuits,* 2 VA. MED. L. REP. 3, 13 (July 2005).

U.S. Court of Appeals, Fourth Circuit

Capital Defendant Not Entitled To New Trial When His Attorney Failed to Investigate a Psychological Report Suggesting a Possible Organic Brain Disorder

A defendant charged with murder and facing a possible death sentence has a right to present mitigating evidence that weighs against the issuance of the death penalty. This can include evidence of a mental illness or mental retardation that demonstrates the defendant's diminished capacity and reduced responsibility for the crime. The U.S. Supreme Court in *Strickland v. Washington*, 466 U.S. 668 (1984), established that a defendant has a Sixth Amendment constitutional right to "effective assistance" of counsel in discovering and presenting this evidence during the sentencing phase, and the Court indicated in *Wiggins v. Smith*, 539 U.S. 510 (2003), that this right required the defendant's attorney to diligently explore potentially relevant mental health evidence.

In a Virginia case, the Fourth Circuit ruled that defendant's counsel had acted reasonably in not further investigating or sharing with defendant's court-appointed mental health expert a 1984 psychological report contained in the defendant's school records that was received three days before trial and suggested the possibility of "organic brain deficiency" in the defendant. The court reasoned that (1) the attorney had already amassed enormous amounts of information confirming that the defendant was not mentally impaired to a degree that could be reasonably considered mitigating, (2) the nature of the defendant's crimes did not indicate a mental impairment at the time of their commission, (3) an independent evaluation of the defendant had concluded that he had an I.Q. of 86 and thus was not mentally retarded, (4) the remainder of the defendant's school records did not suggest any possibility of mental retardation or organic brain dysfunction, (5) the attorney's own interactions with the defendant had not suggested to her that he was mentally retarded, and (6) the attorney had reasonably concluded that the testimony of the defendant's family would not have supported an argument that he was somehow brain damaged.

The court added that the attorney had chosen to pursue a reasonable strategy that focused on the defendant's responsiveness to structured settings in an effort to refute the Commonwealth's contention that the death penalty was justified because the defendant posed a future danger to others, and that evidence of an organic brain disorder would have undercut this strategy.

A dissenting opinion noted that the attorney admitted that an organic brain dysfunction could serve as a mitigating factor and that post-trial examinations had established the accuracy of this diagnosis, and argued that when an attorney receives a good lead along these lines from her client's records, particularly when her expert has requested any such records, her failure to further pursue this information constituted ineffective assistance of counsel in violation of the Sixth Amendment. Walker v. True, 401 F.3d 574 (4th Cir. 2005), *petition for reh'g en banc denied*, 411 F.3d 467 (4th Cir. 2005).

Requirements for Forcibly Medicating a Defendant Found Incompetent to Stand Trial Delineated by Fourth Circuit

The U.S. Supreme Court in *Sell v. United States*, 539 U.S. 166 (2003), held that the government may involuntarily medicate a criminal defendant to render the defendant competent to stand trial even though the defendant does not pose a danger to self or others. The Supreme Court authorized such

treatment under limited circumstances, but left it to the lower courts to flesh out the details of the requisite test. While reviewing a ruling by a federal judge in the Western District of Virginia, the Fourth Circuit provides many of these details.

The defendant, seventy-four years old at the time, had confronted a U.S. Department of Agriculture agent in Wytheville, Virginia, about a late-payment notice he received on a housing loan. Arrested on a misdemeanor charge of assaulting, resisting, or impeding a federal employee, the defendant was diagnosed as suffering from paranoid schizophrenia, found incompetent to stand trial, and placed in a federal correctional institution for further evaluation. During the next year, he refused antipsychotic medication and told a fellow inmate that he was going to kill the judge responsible for his continued incarceration. For the latter, he was charged with threatening to murder a federal judge, which has a statutory maximum punishment of ten years. Pursuant to *Sell*, the government also sought a court order to medicate the defendant over his objection.

The Fourth Circuit determined that *Sell* established medication can be administered if: (1) the government has an "important" interest in trying the defendant, (2) involuntary medication will "significantly further" that interest, (3) involuntary medication is "necessary" to further the government's interest, and (4) administration of the drugs is "medically appropriate."

As for the first part of the test, the Fourth Circuit ruled that an "important" governmental interest exists when the defendant is accused of a "serious" crime and the seriousness of a crime is determined by its maximum penalty. The court rejected the defendant's argument that the focus should be the sentence he was likely to receive under the federal sentencing guidelines (14-20 months for this defendant). While not indicating what maximum term was needed for a charged crime to be a "serious" crime, the court concluded it was "beyond dispute" that a felony carrying a maximum punishment of ten years imprisonment was a "serious crime."

However, the Fourth Circuit determined that the government had failed to satisfy the second and fourth elements of the *Sell* test. The court found the government did not establish that involuntary medication will "significantly further" its interest in trying the defendant because although the government's proposal generally discussed the benefits of atypical antipsychotic medication over conventional antipsychotics, it did not state the particular type of atypical antipsychotic medication staff planned to administer. The court ruled the government must specify the particular drug it will administer before it can obtain an order authorizing treatment over objection.

Similarly, the Fourth Circuit found that while the government's proposal asserted that medication is the "primary" way to treat schizophrenia, it did not establish that it was "medically appropriate" here because it failed to address the defendant's "particular mental and physical condition" in reaching its conclusions. The court noted that the proposal did not address concerns that treatment might be ineffective in ameliorating the defendant's delusions of a governmental conspiracy that had been ongoing for forty years, particularly when it was the government that was administering the medication over the defendant's objection. It also cited the proposal's failure to redress fears that giving this type of medication to an elderly man who takes a number of medications to treat diabetes, hypertension, and asthma might cause adverse side effects.

The Fourth Circuit ruled that the government must articulate the particular medication, including the dose range, it proposes to administer and must relate the proposed treatment plan to the individual defendant's particular medical condition. Specifically, the government must spell out why it proposed the particular course of treatment, provide the estimated time the proposed treatment plan will take to restore the defendant's

competence, indicate the criteria it will apply when deciding when to discontinue the treatment, describe the plan's probable benefits and side-effect risks for the defendant's particular medical condition, show how it will deal with probable side effects, and explain why the benefits of the treatment plan outweigh the costs of its side-effects. United States v. Evans, 404 F.3d 227 (4th Cir. 2005).

Federal District Court in Virginia

Use of Five-Point Restraints on Inmates for 46-48 Hours Without Procedural Checks Ruled Unconstitutional

Incarcerated individuals with a mental illness may be particularly prone to engage in disruptive behavior. When an inmate engages in disruptive behavior, correctional officials may respond in various ways. They may reduce the inmate's privileges, place the inmate in isolation or segregation, or employ four- or five-point restraints to subdue the individual. Under Virginia state policy, an inmate who tried to escape or demonstrated violent or unmanageable behavior could be positioned face up on a bed with leather straps applied to the wrists, ankles, and across the chest for up to forty-eight hours if initial approval had been provided by the Warden or Administrative Duty Officer. This policy was challenged by an inmate who had been placed in five-point restraints for 46-48 hours on five occasions (six to nine meal and restroom breaks were provided each time).

A federal judge in Virginia held that placing state prisoners in five-point restraints for such lengthy periods of time without procedural protections constituted a violation of the Eighth Amendment's prohibition of the use of excessive force on incarcerated individuals. Noting that there were generally significant passages of time between the disruptive behavior and the use of the restraints, the court reasoned that this length of time in restraints was not necessary to "control" the inmate. Thus, the court concluded, the intent of the prison officials must have been to inflict unnecessary and wanton pain and suffering, which constitutes cruel and unusual punishment prohibited by the Eighth Amendment.

The court also ruled that placing an inmate in five-point restraints for this length of time without procedural protections violated the Fourteenth Amendment's Due Process Clause. Classifying these restraints as an "atypical and significant hardship" substantially more restrictive than the conditions of confinement of the general prison population, the court determined that placing an inmate initially in restraints to gain control over him did not justify their indefinite imposition. The court refrained from dictating the precise nature of the process that was due the inmate. It also abstained from indicating the exact point in time when the inmate was entitled to due process, but the court did determine that this point occurred "well before" the expiration of 46-48 hours. Card v. D.C. Dep't of Corr., No. 2:00CV631, 2005 WL 2260167 (E.D. Va. Sept. 13, 2005).

Virginia General Assembly

Virginia's Civil Commitment Provisions Recodified Effective October 1, 2005

During its 2005 session, the Virginia General Assembly recodified Title 37.1, which contains Virginia's civil commitment provisions. This revision was the product of a legislatively-designated study group (the Virginia Code Commission), which was charged in 2003 with updating this title that was last revised in 1968. The revisions are found primarily in new Title 37.2 and took effect on October 1, 2005. Although there are some minor changes, the general approach to civil commitment in Virginia remains basically the same and can be found generally at VA. CODE § 37.2-800 to -847 (2005).

Virginia Legislature Targets Bullying in Schools

School officials are increasingly being required by legislatures to be vigilant for and to take prescribed steps in response to

incidents that threaten the physical and psychological well-being of students. In particular, greater attention is being given to the deleterious effects of student harassment and bullying.

The Virginia General Assembly enacted laws, effective July 1, 2005, that (1) mandate school boards include in their code of student conduct prohibitions on bullying; (2) require schools to institute programs that address the inappropriateness of bullying; (3) added stalking to the list of incidents that must be reported to school superintendents and principals and that principals must immediately report to a local law-enforcement agency if the act constitutes a criminal offense; (4) require principals to report these incidents to the parents of students who are the targets of this conduct, notify these parents that the incident has been reported to local law enforcement officials, and inform the parents that they may contact the law enforcement officials for further information if they so desire; and (5) provide immunity from civil damages to any school volunteer or employee who makes a prompt food faith report to the appropriate school official of any alleged acts of bullying or crimes against others. 2005 Va. Acts ch. 461, 462 (codified at VA. CODE §§ 8.01-220.1:2, 22.1-208.01, 22.1-279.3:1, 22.1-279.6).

Virginia Mental Health Reports

Report Addresses Quality of Care Provided by Virginia's Community Programs for Mental Health, Mental Retardation, and Substance Abuse Services

Virginia's Office of the Inspector General has completed what it describes as the first review of community programs licensed by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The report studied from May to August 2005 the state-wide system of emergency services programs (ESPs) operated by the forty community services boards (CSBs) in Virginia. The report notes that 49,000 individuals are served annually by these programs and provides a series of findings and recommendations.

Among the more negative findings were that the majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for individuals with mental illness and substance use disorders. The primary identified deficiency was that very few offer "critical" mid-range community crisis stabilization programs that can stabilize difficult crisis situations in the community and thereby avoid greater dependence on costly and more restrictive inpatient hospital care. The study also found that most communities do not have access to appropriate crisis intervention for consumers with mental retardation.

At the same time, the study found that Virginia's CSB system of emergency services is staffed with well qualified, experienced, highly motivated, and well-supervised staff, and that consumers report a general satisfaction with the emergency services provided. OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, REVIEW OF THE VIRGINIA COMMUNITY SERVICES BOARD EMERGENCY SERVICES PROGRAMS (REPORTS: #123-05) (Aug. 2005).

Other recent Virginia mental health reports include: JOINT COMMISSION ON HEALTH CARE, INTERIM REPORT ON MENTAL HEALTH NEEDS AND TREATMENT OF YOUNG MINORITY ADULTS (2005), and VIRGINIA DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, CONSUMER SATISFACTION SURVEY 2004 ANNUAL REPORT: OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES (April 2005).

Virginia State Bar

Defense Attorneys Not Bound to Adhere to Directions of Irrational Capital Defendants Seeking to "Commit Suicide by State"

A member of the Virginia State Bar asked its ethics committee whether an attorney can do

anything counter to the directions of a criminal defendant charged with capital murder who wants to "commit suicide by state" and directs the attorney not to present a trial defense nor introduce mitigating evidence at sentencing. The committee acknowledged that it had previously concluded that when an attorney has a reasonable basis to believe that a client's preference for the death penalty is rational and stable, the client's decision not to present mitigating evidence at sentencing controls. However, the committee said the result is different when the client is asking the attorney to forgo the presentation of evidence at both the guilt and sentencing phases and the attorney has a rational basis for believing that the client is unable to make a rational, stable decision about this matter.

Irrational capital defendants who want to be executed, the committee concluded, cannot force their attorneys to refrain from mounting a defense at their trial and the attorneys can take various steps to protect their clients, including seeking a mental health evaluation, asking that a guardian be appointed, or pursuing a defense in spite of a client's directive to the contrary. The precise steps to be taken depended on the attorney's conclusion regarding the degree of the client's impairment.

A prior determination by a forensic mental health professional that the defendant is competent to stand trial, the committee added, does not establish that the defendant is competent to make this decision, in part because the requisite competence may be different and in part because the defendant's mental state may have deteriorated since the prior evaluation. VIRGINIA STATE BAR STANDING COMM. ON LEGAL ETHICS, OP. 1816 (Aug. 17, 2005).

Virginia Board of Medicine

New Standards of Professional Conduct for the Practice of Medicine Issued

The Virginia Board of Medicine has issued new regulations governing the professional conduct of practitioners of medicine (as well as osteopathy, podiatry, and chiropractic), many of which have relevance for mental health professionals. A violation of these standards can result in the imposition of sanctions by the Board.

Under the new standards, a bona fide practitioner-patient relationship must exist before treatment or prescriptions can be provided. The practitioner can not prescribe to himself or a family member a controlled substance unless there is an emergency or no other qualified practitioner is available, or the prescription is for a single episode of an acute illness through one prescribed course of medication.

A practitioner is generally required to accurately inform a patient or the patient's legally authorized representative (LAR) of the medical diagnosis, prognosis, and prescribed treatment or plan of care. Further, a practitioner cannot deliberately make a false or misleading statement regarding the practitioner's skill or the value of a particular treatment or medication. Information regarding care must be provided to the patient or his LAR in understandable terms and participation in decisions regarding the patient's care encouraged.

Informed consent must be obtained before any invasive procedure is performed and the patient must be informed of the risks, benefits, and alternatives that a reasonably prudent practitioner in a similar practice in Virginia would tell a patient. If the patient is a minor or is incapable of making or communicating an informed decision because of a physical or mental disorder, consent must be obtained from the LAR.

Any recommendation of vitamins, minerals, or food supplements must be based on a reasonable expectation that they will result in a favorable patient outcome. Certain modifications were also made to a practitioner's responsibilities in prescribing medications for weight reduction or control.

The new standards also clarify that a willful or negligent breach of confidentiality between a practitioner and a patient is subject to sanction. However, a breach that is required or permitted by applicable law or that is beyond the control of the practitioner is not considered negligent or willful.

The practitioner generally cannot terminate the relationship with a patient or make his or her services unavailable without providing documented notice to the patient that gives the patient a "reasonable time" to obtain the services of another practitioner. If the relationship is terminated, the practitioner must generally make a copy of the patient record available.

Patient records must be maintained for a minimum of six years from the last patient encounter, unless (1) the patient is a minor, in which case the records must be maintained until the minor reaches the age of eighteen or becomes emancipated, (2) the records have been transferred to a health care provider or given to the patient or the patient's personal representative, or (3) federal law or a contractual obligation requires that they be maintained for a longer period of time. Practitioners must post information or otherwise inform patients of the time frame for record detention and destruction.

Records must be destroyed in a manner that protects patient confidentiality (e.g., by incineration or shredding). If a practice is being closed, sold, or relocated, notice must be given that copies of the records can be sent to the patient or to another provider of the patient's choice.

The standards also address the practitioner who is abusive in his or her interactions with other individuals. The standards prohibit providers from engaging in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with or could reasonably be expected to adversely impact patient care.

The practitioner is responsible for the actions of subordinates. The practitioner cannot delegate patient care to a subordinate who is not properly trained and supervised and cannot knowingly allow subordinates to jeopardize patient safety or provide patient care outside the subordinate's scope of practice.

Finally, the standards establish that not only is sexual contact with a patient prohibited, but also sexual contact with a key third party if the contact is the result of an exploitation of trust, knowledge, or influence derived from the professional relationship with the patient or if the contact has or is likely to have an adverse effect on patient care. Key third parties are defined as the patient's spouse, partner, parent, child, guardian, or legal representative. Similar restrictions are placed on sexual contact between a medical supervisor and a medical trainee. 18 VA. ADMIN. CODE §§ 85-20-25 to -105 (2005).

Developments in Other Federal Courts & Federal Legislation

Sixth Circuit/ Tennessee District Court

HIPAA Did Not Preclude Psychotherapist from Reporting That 16-Year-Old Boy Saw Child Pornography on His Father's Home Computer

A sixteen-year-old boy disclosed to his psychotherapist that he saw (1) pornographic images of children on his father's computer at home and (2) his father sitting naked at his computer in front of a webcam. Although there was no indication the father had sexually abused his son, the psychotherapist reported the disclosure to law enforcement authorities, which ultimately led to the arrest of the father. The father asserted that this report violated the Health Insurance Portability and Accountability Act (HIPAA) and, thus, all evidence generated as a result of this report, including a search of the father's computer, should be suppressed.

A federal district court in Tennessee rejected the father's motion to suppress. First, the court ruled, the information disclosed by the psychotherapist did not fall within HIPAA's definition of protected "health information." The court noted that the privacy protections of HIPAA apply to "past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual." In contrast, the information conveyed by the psychotherapist pertained to the defendant's conduct in possessing and viewing child pornography and contained neither information about the physical or mental health treatment of her client nor medical or billing records.

Second, the court determined, even if the disclosure had contained protected health care information, HIPAA provides an exception that authorized this disclosure. The court cited a HIPAA provision that permits disclosure about an individual reasonably believed to be a victim of abuse, neglect, or domestic violence to a governmental authority to the extent the disclosure is expressly authorized by statute or regulation and the person providing the report believes, in the exercise of professional judgment, that the disclosure is necessary to prevent serious harm to the individual or other potential victims. The court noted that Tennessee law requires psychotherapists to report child sexual abuse to law enforcement and found that the psychotherapist, in the exercise of her professional judgment, reasonably believed that disclosure to law enforcement was required by law and necessary to prevent serious harm to the children depicted in the images or other potential child sexual abuse victims. The court added that even though there was no evidence that the father sexually molested his son, minors who are exposed to graphic images of child sexual abuse are also at risk and it was likely the son experienced psychological trauma by his exposure to the child pornography.

Further, the court stated, the psychotherapist-patient privilege that existed between the psychotherapist and the boy did not prevent disclosure because the Tennessee statute that establishes this privilege states that it does not apply to any situation involving known or suspected child sexual abuse and can not serve as a basis for a failure to report this abuse. Because the psychotherapist had no choice but to report the information to law enforcement authorities, the court held no HIPAA violation resulted from the disclosure, and resulting evidence would not be suppressed. United States v. Mathis, 377 F. Supp. 2d 640 (M.D. Tenn. 2005).

Seventh Circuit

Administering the MMPI to Prospective Employees Violates the ADA

Concerned that individuals with disabilities often face barriers to joining the workforce

based on unfounded stereotypes and prejudice, Congress in enacting the Americans With Disabilities Act of 1990 (ADA) limited the ability of employers to use "medical examinations" as a condition of employment. The ADA prohibits the use of pre-employment medical tests, the use of medical tests for existing employees that lack job-relatedness and business necessity, and the use of medical tests that screen out (or tend to screen out) people with disabilities. An Illinois employer asked prospective employees 502 questions from the Minnesota Multiphasic Personality Inventory (MMPI) as part of a battery of tests. The employer claimed that the MMPI simply measured potentially relevant personality traits and thus was not a prohibited medical exam.

The Seventh Circuit ruled that psychological tests that are designed to identify a mental disorder or impairment constitute a medical exam, while those that measure personality traits such as honesty, preferences, and habits are not. Because the court determined that the MMPI is designed, at least in part, to reveal and diagnose certain mental disorders and has the effect of harming the employment prospects of individuals with mental disorders, the Seventh Circuit held that the MMPI is a medical exam and the employer violated the ADA when it was administered to prospective employees (including existing employees seeking a new position within the company).

The court said it did not matter that the MMPI was only used as part (albeit a significant part) of a battery of tests. However, the court did not rule out its use with existing employees when its use is job-related and consistent with business necessity. Karraker v. Rent-A-Center, Inc., 411 F.3d 831 (7th Cir. 2005).

Eighth Circuit

Sovereign Immunity Bars ADA Suit Against a State for Failing to Fund Community-Based Services Through Medicaid

In many states there is a shortage of community placements and services for individuals with a developmental disability, even though these states created an entitlement to these community programs under their Medicaid program. Because the absence of community programs may necessitate that such individuals be institutionalized, various lawsuits asserting these individuals' legal rights are being violated have been brought against states and state officials.

One set of lawsuits has relied on the Americans with Disabilities Act of 1990 (ADA) for its legal foundation. Title II of the ADA prohibits disability-based discrimination in public services furnished by governmental entities. The U.S. Supreme Court in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), held that Title II can require placement of institutionalized persons with mental disabilities in community settings provided "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

Although the Eleventh Amendment of the federal constitution generally recognizes the sovereign immunity of the States and limits the ability of individuals to bring lawsuits against a State, the Supreme Court in *Tennessee v. Lane*, 541 U.S. 509 (2004), ruled that residents of Tennessee with a disability, including one who refused to crawl or be carried up to a second-floor courtroom to answer a traffic complaint, could pursue a lawsuit against that state under Title II of the ADA. The decision in *Lane*, however, was limited to where access to a court of law was denied. *Lane* necessitates in other Title II suits a case-by-case approach that focuses on whether (1) the act of discrimination impinges on "basic constitutional guarantees" and (2) there is a significant history of official mistreatment of individuals with a disability in the context under review.

The Eighth Circuit of the U.S. Court of Appeals has held that the exception to Eleventh Amendment sovereign immunity recognized in *Lane* does not apply to a State

that has refused to provide home and community-based Medicaid-funded services to adults with a developmental disability. The lawsuit had asserted that Nebraska's withholding of funding for home and community-based services had left these individuals without adequate services to meet their needs and placed them at imminent risk of unnecessary institutionalization.

The Eighth Circuit concluded that *Lane* was limited to the distinct set of facts considered there and that until the Supreme Court extends its ruling to the type of claim being asserted here, the court was governed by its own en banc decision in a 1999 case that ruled that Title II of the ADA did not abrogate a State's Eleventh Amendment immunity. As a result, the Eighth Circuit dismissed the plaintiffs' Title II ADA claim. Bill M. v. Neb. Dep't of Health & Human Servs. Fin. & Support, 408 F.3d 1096 (8th Cir. 2005).

Ninth Circuit

States Can Limit the Number of Individuals with a Developmental Disability Participating in a Community Placement Medicaid Waiver Program Without Violating the ADA

The federal Medicaid Act furnishes funds to the states to help them provide care to eligible low-income persons. Although states are not required to participate, if they accept this federal funding, which all fifty states do, they must comply with federal requirements and regulations. Washington, like many states under the Medicaid waiver program, provides a variety of non-institutional care options for qualified persons with a developmental disability who desire to live at home or independently. Medicaid, and in turn the State of Washington, limits the availability of these services to a given number of individuals (9,977 when this lawsuit was commenced) to control the program's costs, which are jointly paid by the federal and state governments. Because all available slots are full and because openings generally occur only when a person who is currently receiving home or community-based services dies or becomes ineligible for services (which occurs relatively infrequently), extended delays may occur before a qualified individual is able to obtain these services.

A lawsuit brought on behalf of individuals with a developmental disability waiting for these openings claimed that Washington's cap on home and community-based services violated Title II of the Americans with Disabilities Act of 1990 (ADA). The ADA prohibits states from discriminating on the basis of a disability in providing access to their services, programs, or activities. Regulations associated with the ADA mandate that services be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Plaintiffs asserted that the State of Washington, in maintaining its cap on enrollment, violated the ADA and that these services must be provided to all eligible individuals who desire them.

The Ninth Circuit disagreed. It declared that the policy behind the Medicaid limited waiver provision is one of experimentation, that the ADA requirements are not boundless, and that to read the ADA to dictate unlimited enrollment "might break Medicaid's back." As a result, the court ruled that the ADA does not disallow the cap provisions in the Medicaid law and that Washington, as well as other states, can limit the number of individuals with a developmental disability able to access the home and community-based services provided in conjunction with its Medicaid waiver program. Arc of Wash. State Inc. v. Braddock, 403 F.3d 641 (9th Cir. 2005).

Federal Legislation

Congress Extends Mental Health Parity Requirement

On December 30, 2005, the President signed a bill (H.R. 4579) passed by Congress that extends by one year the Mental Health Parity Act (MHPA). Originally enacted on September 26, 1996, this law was scheduled to expire on December 31, 2005. In recent

years, this extension has been authorized on a year-to-year basis. The MHPA applies to group health plans that provide both medical and mental health benefits. The MHPA requires parity between these benefits with regard to annual and lifetime dollar limits (but not with regard to co-pays, deductibles, maximum out-of-pocket costs, outpatient visits, or hospital days). Pub. L. No. 109-151 (2005).

Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 Enacted

On June 29, President Bush signed legislation (H.R. 1812) that authorizes appropriations of $25 million over the next five years to fund demonstration projects designed to provide "patient navigator services" to individuals with "cancer or other chronic disease." These patient navigators are to assist patients in overcoming obstacles to the prompt diagnosis and treatment of health problems, in part by identifying sources of care and insurance, coordinating services and referrals, and facilitating enrollment in clinical trials. Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, Pub. L. No. 109-18, 119 Stat. 340.

Patient Safety and Quality Improvement Act of 2005 Enacted

On July 29, President Bush signed legislation (S. 544) that recognizes "patient safety organizations" and makes "patient safety work product" (PSWP) reported by health care providers to these organizations confidential. These organizations are expected to analyze the reported information to identify ways to prevent medical errors, with the criteria and means for being certified as a patient safety organization described.

The law generally prohibits the disclosure of the PSWP in criminal, civil, and administrative disciplinary proceedings, although a limited exception is provided for criminal proceedings. A fine of up to $10,000 for each violation is authorized. The legislation does not shield a patient's medical record or any information that is developed separately from a patient safety evaluation system.

The legislation also requires that a network of patient safety databases be established that can accept, aggregate, and analyze non-identifiable reported PSWP and provide an interactive evidence-based management resource for health care providers and patient safety organizations. An assessment is to be conducted of the feasibility of providing qualified researchers a single point of access to the network. Reported information is to be used to assess trends and patterns of health care errors and is to be included in annual quality reports. Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424.

Developments in Other States & the District of Columbia

Connecticut

Connecticut Supreme Court Mandates That Juries Generally Be Informed of the Risks Inherent in Eyewitness Identification Procedures When the Eyewitness Has Not Been Warned That the Perpetrator May Not Be Present

A unanimous Connecticut Supreme Court has crafted a jury instruction that generally must be given in trials when an eyewitness identification is entered into evidence. The court noted that psychological studies document that a witness is more likely to misidentify an innocent individual as the perpetrator of a crime during an identification procedure (e.g., during a photo array or lineup) where the witness is not warned that the perpetrator might not be present. The court added the research also shows that warning the witness that the perpetrator might not be present does not significantly decrease the percentage of correct identifications.

The procedure used in this case was described as a "street show-up" where the victim of a crime, while sitting in a police cruiser in a well-lit setting twenty minutes after having been attacked, was asked to observe five handcuffed suspects and to indicate whether any of them had attacked him. In reviewing a subsequent identification, the court noted that several factors are to be considered in determining whether an identification is reliable, including the victim's opportunity to view the criminal and degree of attention at the time of the crime, the accuracy of the victim's prior description of the criminal, the level of certainty demonstrated at the identification, and the amount of time between the crime and the identification. Although the court cited psychological research that indicates that (1) there is a poor correlation between the expressed level of certainty in an identification and its accuracy and (2) a witness' level of confidence is malleable and susceptible to cues from the administrator of the identification procedure, the court determined that these studies were not sufficient to require a change in the test used to ascertain the reliability of an eyewitness identification procedure. Neither was the court willing to bar all eyewitness identifications when a warning was not provided to the eyewitness that the perpetrator may not be present.

Nevertheless, referring to case studies that have consistently shown mistaken identifications as a significant source of wrongful convictions of innocent people, the court concluded that the risks of an inaccurate identification were sufficiently high when the administrator of an identification procedure fails to provide a warning that the perpetrator may not be present as to generally necessitate a cautionary instruction to a jury when an eyewitness identification produced under these circumstances is introduced into evidence. The jury instruction notes the relevant psychological studies, states that a failure to provide such a warning increases the probability of a misidentification, and tells the jury that it is jury's duty to determine whether the eyewitness identification evidence is to be believed. State v. Ledbetter, 881 A.2d 290 (Conn. 2005).

District of Columbia

Misrepresentations by Insurance Plan of Availability of Mental Health Benefits Can Not Serve as Basis for Consumer's Claim of Common-Law Fraud

Individuals contemplating enrollment in a behavioral managed care plan are typically provided a description of available mental health services. When these services are not forthcoming following enrollment, they may file a legal claim against the administrators of the plans that asserts that the advertisements and materials they were provided were misleading and thus fraudulent.

A woman who switched jobs had to choose a health insurance provider for herself and her husband through her new employer. One plan offered three different types of insurance coverage: a managed care (HMO) option, a preferred provider organization (PPO) option, or an indemnity plan. While she was making her decision, a new fee schedule was implemented for the plan that reduced by 30-40% the amount mental health providers were paid for their services. Approximately 100 out of a total panel of 1000 mental health providers left the provider network as a result of the rate cut.

The woman's husband had been receiving mental health treatment for several months. The benefits booklet associated with the HMO option said that mental health treatment was covered in full for "up to 52 visits" per calendar year, but a month after enrolling the woman switched from the HMO to the PPO option, notwithstanding its higher co-payments. She claimed she was forced to switch after a case manager told her that after 6-10 sessions she and her husband would be denied all insurance coverage for mental health treatment on the grounds that the treatment was not "medically necessary" unless they switched to the more expensive PPO or indemnity coverage.

In her lawsuit, the woman asserted the plan's actions constituted common law fraud because: (1) the informational materials for the plan said that the HMO option would cover up to fifty-two medically necessary sessions but only five sessions were covered before she was induced to switch to the PPO option, and (2) the size and stability of the panel of providers was falsely represented because a rate cut was being instituted that consumers were not warned about in the plan's recruiting materials.

The District of Columbia Court of Appeals agreed that a promise contained in a contract can provide the basis for the tort of fraudulent misrepresentation if the party making the promise at the time the contract was made had no intention of carrying out the promise. However, the court found that the plan had not explicitly denied coverage of more than five sessions under the HMO and it had not been shown that the woman had been coerced to switch to the PPO coverage as the result of an undisclosed policy to limit HMO coverage. Even though prior authorization was required after 6-10 mental health treatment sessions under the HMO option (and not under the PPO option), the court did not find any evidence showing a flat limit on HMO services contrary to the plan's promise of fifty-two sessions. As a result, the court concluded there had not been a breach of contract, much less that the defendants had entered into the contract with the woman with the intent to breach the contract, as required for a claim of fraud.

As for the reduced provider list, the court noted that while it was possible to conceive of circumstances where the composition of the provider list is so markedly changed that a breach of contract could fairly be inferred, it did not find sufficient evidence to establish such a change occurred here. The court concluded there was no evidence that the plan intended to breach the contract by not having a sufficient mental health provider panel, even though it was aware of possible difficulties in obtaining services.

It should be noted that the District of Columbia has a Consumer Protection Procedures Act (D.C. CODE §§ 28-3901 *et seq.*) that might provide the woman with an alternative means of recovery for unlawful trade practices, but the court ruled that she had raised a claim under this act too late in the proceedings to be considered here. Va. Acad. of Clinical Psychologists v. Group Hospitalization & Med. Servs., Inc., 878 A.2d 1226 (D.C. 2005).

Illinois

Illinois Limits Placement of Convicted Sex Offenders in Long-Term Care Facilities

Placement in a long-term care facility may be necessitated by a significant cognitive impairment, such as may occur in individuals

with dementia. Because of these impairments or other infirmities, residents of these facilities are highly vulnerable. Incidents have been reported of residents being sexually assaulted by other residents of a facility who were subsequently discovered to be convicted sex offenders. In some instances, a facility did not know about this background, while in other instances staff knew about it but believed they could not act because of privacy concerns.

In response, Illinois has passed legislation and promulgated regulations that significantly increase what such facilities must do with regard to such individuals. For example, skilled nursing and intermediate care facilities must screen prospective residents and complete a criminal history check to determine if the candidate has been convicted of various specified felonies, is a registered sex offender, or is serving a term of parole, mandatory supervised release, or probation for a felony. If the prospective resident falls within one of these categories (referred to as an "identified offender"), a social evaluation must be completed by the Illinois Department of Corrections prior to admission and the facility must review this evaluation and supporting documentation to determine whether admission of the individual to the facility is appropriate.

These facilities are also required at least every six months to visit the Illinois Sex Offender Registration website and the Illinois Department of Corrections registered sex offender database to determine if any current residents are listed there. The facility must also request criminal record information for all current residents. If an identified offender is a current resident, the facility must (1) inform county and local law enforcement offices of their presence, (2) conspicuously post in an area accessible to staff, current and prospective residents, family members, and visitors a notification that an identified offender is residing at the facility, (3) notify every resident or resident's guardian in writing of the offender's presence, (4) communicate with any assigned probation or parole officer, and (5) meet with local law enforcement officials to establish policies and procedures regarding the identified offender.

In addition, for each prospective and current resident who is an identified offender, the facility must conduct a risk assessment to determine the appropriateness of the admission of this individual to the facility and the amount and nature of supervision required to ensure the safety of the other residents. For residents who are registered sex offenders, they cannot share a room with another resident. Further, their room must be in direct view of the main nurses' station and be separate from the rooms of residents who are at risk. The facility must continually review incident reports involving an identified offender and if it finds it cannot protect the other residents from misconduct by the identified offender, the facility must transfer or discharge the individual. For the legislation, see 2005 Ill. Legis. Serv. P.A. 94-163 (West). For related regulations, see ILL. ADMIN. CODE tit. 77, §§ 300.110-.7080 (2005).

Indiana

Medical Center Has a Duty to Protect Emergency Room Patients from Attacks but Not When the Attack Was a Surprise

The Indiana Court of Appeals ruled that although a medical center has a duty to protect emergency room patients from criminal attacks, a hospital is not liable for the injuries that resulted when a teenage boy attacked a woman seated in the waiting area of its emergency room.

The court noted that violent and intoxicated individuals, persons involved in crimes, and people injured in domestic disputes are routinely brought to emergency rooms for treatment, and sometimes violent and criminal behavior erupts there. Even though a doctor's office does not generally have a duty to maintain security measures to protect its patients, the court held that a medical center has a duty to implement and maintain reasonable measures to protect emergency room patients from criminal acts of third

parties. The court did not state what specific measures must be taken, but said hospitals are not required to go so far as to have a security guard watch over each person in the emergency room at all times. What is required is that a plan be implemented in which security procedures can be increased as the need arises.

In the case before it, the court concluded it was not foreseeable that this attack would occur and thus no liability was incurred. The court cited statements by the woman and a son-in-law who was with her that they were surprised by the attack and did not know what triggered it. Because it concluded the injury suffered by the woman was not foreseeable, the court dismissed the woman's claims.

A dissenting judge argued that many acts of violence happen suddenly and victims are often surprised when they are victimized, and thus a lack of foreseeability was not established by the surprise of the woman and the son-in-law at the attack. The dissent further noted that the attack was stopped by the son-in-law, not a hospital security officer, suggesting that the injury might have been attributed to an inadequate security plan by the hospital. Lane v. St. Joseph's Reg'l Med. Ctr., 817 N.E.2d 266 (Ind. Ct. App. 2004).

Officials at Designated Hospital That Refused to Admit Emergency Detainee Can Be Held in Contempt, but Permitted to Refuse Admission if Hospital Lacks Adequate Space or Staff

In a case characterized as exemplifying "a national trend," the Indiana Court of Appeals held that a trial court has the authority to determine that hospital officials violated the law when they refused to admit a man deemed mentally ill and dangerous and judicially committed for a seventy-two-hour emergency detention. However, the appellate court vacated a contempt order and ordered a rehearing because the trial judge failed to give hospital officials an opportunity to explain their decision to deny admission.

In Indiana, designated community mental health centers (CMHCs) contract with the state to provide services within exclusive geographic territories to individuals with mental health needs and to provide a continuum of care. Each CMHC "is obligated to provide accessible services for all individuals, within the limits of its capacity, in its exclusive geographic primary service area."

In this case, a trial judge sought to use Indiana's emergency detention statutes to obtain mental health care for an individual who had come before the court on a criminal charge and who was well known because he had been previously arrested several times. When two physicians at a CMHC hospital declined to accept the individual after the trial court approved the emergency detention, the individual was taken to another hospital where he remained strapped to a bed. In response, the trial court ordered a "show cause" hearing.

At the hearing, a sheriff testified that physicians at the CMHC hospital indicated the hospital had bed space available. The judge complained the hospital had refused for three days to accept the individual even though it was the "catch basin" for this community and as a result the individual was placed in another hospital unprepared to handle such individuals with the county paying for this stay. The judge also noted that physicians at the hospital indicated they absolutely refused to admit anyone after seven o'clock and this was the third time this year this had happened.

As a result, the trial court ordered two hospital officers present at the hearing jailed for twenty-four hours, ordered the hospital to reimburse the county for the individual's medical expenses and the cost of posting police officers at the hospital where the individual was currently placed, and ordered the hospital to immediately find an appropriate placement for the individual. Later that day, the individual was admitted to the CMHC hospital pursuant to a new emergency detention order. The CMHC hospital appealed the court's contempt order.

The appellate court acknowledged that the problem the trial court identified is significant and that trial judges, whose responsibilities include protecting public safety and supporting humane conditions in local jails, are frustrated by the lack of immediate, acute mental health treatment for incarcerated individuals. The court noted that in many communities, jails and prisons have become the largest providers of mental health services. The court added that if trial judges are not provided adequate tools, individuals with significant mental illness will not receive needed treatment and will instead disrupt the judicial and correctional systems.

However, the appellate court continued, under Indiana law a CMHC facility can decline to receive a committed patient if the facility is unable to provide adequate treatment at that time, a refusal that can be based permissibly on a lack of appropriate space or staff. Even though this may frustrate justice in some situations, the court determined this arrangement represented the legislature's determination that the ultimate authority over admission decisions should rest with the institutions themselves. The court further stated that this arrangement recognized that admission decisions implicate professional judgment and expertise about treatment alternatives, that facilities are generally in a better position to make admission decisions than trial courts, and that difficulties arise when facilities lack control over the size of the populations they are required to treat.

At the same time, the appellate court determined that under Indiana law CMHCs should provide "substantial assistance" to an emergency detainee through treatment planning or by helping to locate an appropriate placement or treatment if inpatient admission is not possible. In addition, the trial court can review a facility's reasons for declining to admit an emergency detainee to ascertain whether this decision is in fact predicated on inadequate or inappropriate space or staff. The trial court can require reports or status conferences from the CMHC and direct it to assist in treatment planning, case management, and other relevant services, to the extent permitted by available resources.

As for the contempt order issued in this case, the appellate court ruled it was invalid because the hospital and its officers were not provided an opportunity to be heard. The court noted that hospital officers were present and willing to testify and ruled that declining to hear their testimony at the contempt hearing deprived the hospital of due process. The court concluded the hospital should have been permitted to explain its reasons for declining to admit the individual so the trial court could determine whether the hospital was acting in accordance with the law.

A concurring opinion argued that hospital officials making emergency detention admission decisions must balance a myriad of concerns—including patient and staff safety, economic and liability concerns, and compliance with licensing and accreditation requirements—almost instantaneously under the pressure posed by an emergency detention order, and should not face being second guessed in contempt proceedings. *In re* Contempt of Wabash Valley Hosp., Inc., 827 N.E.2d 50 (Ind. Ct. App. 2005).

New York

New York's High Court Rules That Testimony by Prosecutor's Forensic Psychiatrist That Recounts Third-Party Statements Where the Third Parties Are Not Available for Cross-Examination Violates the Federal Constitution and Is Not Admissible

In recent years forensic evaluators have been encouraged to expand the information on which they rely beyond their examination of the defendant and the clinical record to include third-party data from sources such as family and acquaintances of the defendant. A ruling by the high court of New York has placed limits in that state on testimony based on this practice and raised issues that may reverberate in other states.

The ruling focuses on the trial and conviction of Andrew Goldstein. Goldstein gained national notoriety in 1999 when he pushed Kendra Webdale, a woman he did not know, into the path of an approaching subway train in New York City. Goldstein had been diagnosed as having schizophrenia some ten years earlier, had been treated in a number of mental health facilities in the interim, and was reported to have failed to take prescribed anti-psychotic medication. This act served as the impetus for New York's enactment of Kendra's Law, which created a procedure for obtaining a court order to mandate outpatient treatment for individuals with a mental illness.

Goldstein was charged with murder in the second degree and his principal defense was insanity. His first trial ended in a hung jury. At his second trial, the two main witnesses were forensic psychiatrists, one called by the defense and one called by the prosecution. Both agreed the defendant was mentally ill. Both supported their opinions by describing their own examinations of the defendant and by reviewing voluminous clinical records.

However, the prosecution's expert also relied on facts she had obtained from interviews of third parties and her testimony described what she had heard during these interviews. On the stand, she distinguished forensic psychiatry from traditional clinical psychiatry by noting that the latter largely confines itself to what the client says and to the clinical record. She testified that the purpose of forensic psychiatry is "to get to the truth" and that she believed interviews of people with firsthand knowledge are an important way of accomplishing this goal.

Ultimately, the jury in this second trial rejected the insanity defense and found the defendant guilty. Because the third-party individuals referenced by the prosecution's forensic psychiatrist were not called as witnesses and made available for cross-examination, the defense appealed the conviction.

The New York Court of Appeals began by rejecting the defendant's argument that the testimony by the prosecution's forensic psychiatrist recounting statements of the individuals interviewed was inadmissible hearsay under New York law. The court determined that previous cases had established that a psychiatrist's opinion may be received in evidence even though some of the information on which it is based is inadmissible hearsay if the out-of-court information "is of a kind accepted in the profession as reliable in forming a professional opinion."

The court added that this acceptance in the profession can be established by the expert who is seeking to rely on the out-of-court material. Here the prosecution's psychiatric expert testified that the interviewing of third parties by forensic psychiatrists is "becoming more and more the practice," even though "many good forensic psychiatrists might . . . disagree." The court noted the defense could have challenged this depiction of accepted professional practice on cross-examination or by introducing evidence to the contrary, but had failed to do so. The court determined it was sufficient to show the approach has gained "widespread acceptance by professionals of good reputation" and it was not necessary to demonstrate universal acceptance of the practice.

As a result, the court concluded that the prosecution's forensic psychiatrist could base her opinion on third-party statements made out of court. However, the court warned that it was not addressing a related issue, namely, whether the expert was free under New York law to repeat to the jury the hearsay information on which her opinions were based. The court cautioned that it could be argued that some limit should be placed on the ability of an expert to put before a jury or judge information that is otherwise not admissible because this could effectively nullify the hearsay rule by making a party's expert a "conduit for hearsay." Although no New York case has addressed the issue, the court cited a recent change to the Federal Rules of Evidence (Rule 703) that provides that "[f]acts . . . that are otherwise

inadmissible shall not be disclosed . . . by the proponent of the opinion . . . unless the court determines that their probative value in assisting the jury to evaluate the expert's opinion substantially outweighs their probative effect." Because the defense had not raised this issue, the court did not resolve the question in its ruling, leaving the matter open but also permitting changes to the New York rules of evidence to clarify that such testimony is not prohibited.

However, the court then proceeded to endorse a second argument raised by the defense (which can not be ameliorated by a change to the state's rules of evidence). The court held that the admission into evidence of these statements violated the defendant's federal and state constitutional rights to confront the witnesses against him. The court determined that a recent ruling by the U.S. Supreme Court in *Crawford v. Washington*, 541 U.S. 36 (2004), establishes that the Confrontation Clause of the 6th Amendment generally prohibits the use of "testimonial" hearsay against a defendant in a criminal case, even if the hearsay is reliable, unless the defendant is given an opportunity to cross-examine the person who made the out-of-court statement.

The court acknowledged that the exclusion of out-of-court statements is not necessarily required when the third-party statement is not presented to establish the truth of what the third party said. However, the court rejected the prosecution's assertion that these statements were admitted not to establish the truth of what was said, but only to help the jury in evaluating the forensic psychiatrist's opinion. The court responded that the jury could not use this information for this purpose without determining whether the statements were true or false. The court also noted that the prosecution clearly wanted and expected the jury to take the statements as true. The court concluded the third-party statements were offered for their truth and thus were hearsay subject to the protections of the Confrontation Clause.

The court also found that this was "testimonial" hearsay because it could be inferred that the third parties knew that they were responding to questions from an agent of the State engaged in trial preparation, were not making "a casual remark to an acquaintance," and reasonably expected their statements to be used by the prosecution. As a result, the court ruled that the defendant's rights under the Confrontation Clause were violated when the prosecution's psychiatric expert was allowed to tell the jury what third parties had said to her without providing the defendant an opportunity to cross-examine them.

After reviewing the various reported third-party statements, the court concluded they may have affected the jury's verdict and thus the admission of these out-of-court statements was not harmless error and necessitated that the defendant be retried. People v. Goldstein, 2005 N.Y. Slip Op. 09654, 2005 WL 3477726 (N.Y. Dec. 20, 2005).

New York Enacts Geriatric Mental Health Act

New York has passed legislation entitled the Geriatric Mental Health Act, which has been described as the first enactment in the country designed to address the growing mental health challenges posed by older adults. Beginning April 1, 2006, the law will fund grants to mental health care providers to support geriatric service demonstration programs for older adults with mental disabilities. The programs must include one or more of the following: community integration, improved quality of treatment, integration of services with alcohol, drug, health, and other support services, workforce enhancements, family support, innovative financing methodologies to support the delivery of best practices, outreach to cultural minorities, an information clearinghouse, or staff training.

In addition, the law requires that an interagency geriatric mental health planning council be established prior to April 1, 2006.

This council is to generate recommendations regarding geriatric mental health needs. Further, the law mandates that the commissioner of mental health and the director of the state office for the aging produce an annual report beginning no later than March 1, 2007, that provides a long-term plan regarding the geriatric mental health needs of the residents of New York and recommendations to address those needs. 2005 N.Y. Sess. Laws Ch. 568 (McKinney).

A Memorandum in Support of the enactment generated by the New York State Senate states that older adults with mental disorders are currently underserved and will become increasingly underserved with the rapid increase in the number of older adults in the state. Asserting that neither the state nor the nation is prepared for the mental health challenges that will emerge during the "elder boom," the memo projects that the number of older adults will increase from 35 million to 70 million over the next quarter century, and the number of older adults with mental disorders will increase from 7 million to 14 million. The memo identifies twelve critical needs and asserts that this law begins to remedy these shortcomings.

New York's Involuntary Hospitalization of Sex Offenders Upon Release from Prison Ruled Illegal

Since 2001, at least five bills have been introduced but not enacted in New York to establish involuntary civil confinement of sex offenders. In October 2005 it was reported that New York's governor, unwilling to wait any longer for such legislation, charged state officials to "push the envelope" on existing state mental health law to use it as a vehicle for the involuntary hospitalization of inmates determined to be sexually violent predators who were being released from state prisons upon completion of their sentence.

Twelve such ex-prisoners who were transferred from prison to a psychiatric hospital challenged the legality of these transfers in a writ of habeas corpus. They had been committed under a section of New York law that permits involuntary hospitalization for a period of sixty days without court approval based upon the certificates of two examining physicians.

A New York Supreme Court judge ruled that this section was inapplicable to these individuals and thus they were being illegally detained. The court determined that a different section that governs the transfer of mentally ill prisoners to mental health facilities should instead have been applied. This section, which had been crafted to conform to the U.S. Supreme Court's ruling in *Vitek v. Jones*, 445 U.S. 480 (1980), provides various procedural protections, including a required examination by two independent physicians appointed by a judge and subsequent judicial approval of any proposed transfer.

The court dismissed the argument that this section was not applicable to these individuals because their prison sentences had ended. The court noted that each of these individuals were, in fact, imprisoned at the time of their civil commitment and it had not been shown why, if they were mentally ill and in need of hospitalization, they were not hospitalized prior to their release date, which in turn would have permitted their continued detention after their terms of imprisonment had expired.

The court added that several of these individuals had not been receiving any psychiatric care while they were incarcerated; that several of the petitions seeking involuntary hospitalization did not provide any facts regarding their mental condition; that two of them were diagnosed only with Antisocial Personality Disorder, the criteria of which are met by 75% of the prison population according to the American Psychiatric Association; that at least one medical evaluation may have consisted of a 10-15 minute interview conducted by teleconference; and that one of the examining physicians later admitted that she did not want to send the inmate to a psychiatric hospital but was following a directive that had "come down from Albany."

While expressing concern about the risks posed to the public by repeat sex offenders, the court stated that it could not ignore the possibility that some of these individuals "may involuntarily have been placed in the mental health system by executive fiat." She reasoned that requiring the state to adhere to those statutory provisions that mandate court intervention before an inmate can even be evaluated for psychiatric confinement "would help ensure that this type of alleged misuse of the mental health system could not occur." Release was ordered unless the state within five days sought the requisite court intervention. State v. Consilvio, No. 403590/05, 2005 WL 3134237 (N.Y. Sup. Ct. Nov. 15, 2005).

Ohio

Ohio Supreme Court Upholds Statute Permitting Grandparents to Seek Visitation Rights But Requires That Special Weight Be Given to Parents' Objections

Historically, grandparents had no legal right to continue their relationship with their grandchildren when their own child (the grandchild's parent) died, divorced, or had his or her parental rights terminated. This position was based on the view that custodial parents should generally be able to decide who can associate with their child. During the 1980s and '90s, what are generally referred to as "grandparent visitation laws" were widely enacted to facilitate grandparents' ability to maintain contact with their grandchildren after a rift developed between the grandparents and a grandchild's custodial parent.

In 2000, the United States Supreme Court struck down a Washington state law that permitted "any person" to obtain court-ordered child visitation rights over the objection of the child's parent if that person could establish that visitation was in the best interests of the child. *Troxel v. Granville*, 530 U.S. 57 (2000). Although *Troxel* struck down what was characterized as the "breathtakingly broad" Washington statute and recognized that parents have a fundamental constitutional right to make decisions concerning the care, custody, and control of their children, it did not find such statutes to be inherently unconstitutional. Its deeply splintered opinion, however, provided little guidance to courts reviewing the enactments of other states.

When asked to review Ohio's enactment, the Ohio Supreme Court began by ruling that because it infringes on a fundamental constitutional right, it must be reviewed under the most exacting standard, the strict-scrutiny standard, which requires that a statute be narrowly tailored to promote a compelling governmental interest. This standard was met, the Court determined, because Ohio's law was more narrowly drawn than the Washington statute in that it limits who can petition for visitation (relatives of a child's parent) and under what circumstances (e.g., the mother or father of the child is deceased). Further, unlike the Washington statute, the Ohio approach specifically identifies the parents' wishes and concerns regarding visitation as a factor a judge must consider in making its visitation decision.

However, the court noted that the Ohio law also lists fifteen other factors that must be considered in determining a child's best interest. The court read *Troxel* to establish that a court must give "at least some special weight" to the parent's determination of whether non-parental visitation is in the best interests of the child and to require a presumption that fit parents act in the best interest of their children. Nevertheless, the court stated, *Troxel* did not require that this presumption be irrefutable or the sole determinant of a child's best interest. After requiring that a judge give special weight to a parent's wishes and concerns regarding visitation, the Ohio Supreme Court ultimately held that the Ohio approach met constitutional requirements.

As for the case before it, the Ohio Supreme Court determined that the burden of proving that visitation would be in the best interest of the child had been properly placed on the grandparents seeking visitation and that the

trial court had expressly weighed and given due weight to the parent's opposition to the proposed visitation. Because the grandparents had raised the child for the first five years of her life, the court concluded that a schedule should be established to facilitate visitation between the grandparents and the child. Harrold v. Collier, 836 N.E.2d 1165 (Ohio 2005).

Psychiatrist's Professional License Permanently Revoked for Sexual Misconduct

Licensing boards and reviewing courts have become less tolerant of sexual conduct by a mental health professional during therapy, with a number of jurisdictions adopting a per se rule that sex with a client violates professional rules of conduct. However, less attention has been given to the sanctions to be attached to such misconduct, particularly when the misconduct can be construed as a single instance rather than a pattern of misconduct.

The Ohio Court of Appeals upheld a ruling by the Ohio Medical State Board (Board) that permanently revoked the license of a psychiatrist found to have engaged in improper sexual conduct with a patient, notwithstanding that there was a single instance of sexual intercourse. The patient was initially referred to the psychiatrist for medication management, was diagnosed as having a bipolar disorder, and had been sexually and psychologically abused by her father for fifteen years during her childhood.

During the course of therapy, the patient professed her attraction to the therapist and became increasingly flirtatious and provocative. Interpreting the therapeutic maxim that "a patient can say anything but not act" to mean that the patient "can do anything [they] want in therapy[,] I can only watch," the psychiatrist acknowledged that he had allowed the patient during clinical sessions on many occasions over a multi-year period to disrobe and/or engage in sexual self-stimulation in his presence and ultimately on one occasion engaged in sexual intercourse with her. There was no evidence the psychiatrist had engaged in this behavior with any other patient.

The court ruled that the evidence of the psychiatrist's misconduct was overwhelming and that the Board members had based their decision on this evidence. The court rejected the psychiatrist's argument that the sanction imposed should be reversed because permanent revocation was disproportionate to the sanctions imposed in similar cases. The court determined that the Board was not required to inventory all sexual abuse-related disciplinary cases and engage in a proportionality review when reaching its decision. Rather, the court said, the Board must address each disciplinary matter on a case-by-case basis.

In upholding the Board's sanction, the court emphasized that the evidence showed that the psychiatrist had allowed a psychiatric patient to engage in sexual acting out during what were supposed to be therapeutic medication management sessions, that he continued to treat her after engaging in sexual relations with the patient, and that he threatened her with reprisals if she revealed his actions. The court determined that the Board's order revoking the psychiatrist's license was proportionate to the nature of the acts committed by him. Schechter v. Ohio State Med. Bd., No. 04AP-1115, 2005 WL 1869733 (Ohio Ct. App. Aug. 9, 2005).

Other Developments

IOM Report Focuses on Enhancing the Quality of Care Provided Individuals with Mental Health or Substance Abuse Problems

The Institute of Medicine (IOM) of the National Academies in 1999 issued a report entitled "To Err Is Human: Building a Safer Health System" that identified a large number of preventable medical errors. In 2001, the IOM issued a follow-up report, "Crossing the Quality Chasm: A New Health System for the 21st Century," which concluded that the health care system is in need of fundamental change and identified a framework and strategies for achieving improvements in the quality of health care. The IOM was then charged to explore whether similar failures were occurring in the field of mental health and addictive disorders and to identify how to achieve significant improvements. In response, the IOM has published a third volume entitled "Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series."

The report found that 33 million Americans use health care services for mental health or substance abuse problems and that millions more believe they need treatment but do not receive it. Related conditions were determined to be the leading cause of combined disability and death for women and the second highest for men. The report also found that effective treatments exist for these conditions, but deficiencies in care delivery prevent many from receiving appropriate treatments. In addition to serious personal consequences, it was concluded that ineffective, unsafe, or no treatment significantly impacts the workplace; the education, welfare, and justice systems; and the nation's economy as a whole.

The report determined that the field shares quality of care problems associated with health care generally, but also noted some distinctive characteristics that exacerbate these problems in this field. They included the greater stigma attached to related diagnoses, the more frequent coercion of patients into treatment, a less developed infrastructure for measuring and improving the quality of care, a greater number of linkages between the multiple clinicians, organizations, and systems providing care, less widespread use of information technology, greater variability in care providers' qualifications, a fractured and ineffective marketplace for the purchase and monitoring of services, and gaps in knowledge about how to provide effective treatment.

Among the recommendations generated were: (1) understanding the inherent interactions between the mind/brain and the rest of the body; (2) tailoring strategies to enhance the quality of care that reflect the distinct characteristics of these problems and illnesses; (3) promoting patient-centered care by supporting the decision-making abilities and preferences for treatment of persons with these problems and illnesses and avoiding coercion whenever possible; (4) identifying and distributing relevant evidence-based practices, in part by promoting means to more quickly produce scientific evidence and apply it to patient care; (5) coordinating multiple providers' care of a patient; (6) enhancing the informational infrastructure; (7) strengthening the quality and capacity of the relevant professional workforce, in part by producing national standards for the credentialing and licensure of care providers and by narrowing gaps in knowledge among professional groups; (8) enacting legislation that enhances benefit standardization among health plans and provides for parity in the coverage of mental health/substance use treatment; and (9) funding research and demonstrations aimed at improving the quality of care in this area. COMMITTEE ON CROSSING THE QUALITY CHASM, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, IMPROVING THE QUALITY OF HEALTH CARE FOR MENTAL AND SUBSTANCE-USE CONDITIONS (2006).

Program to Encourage Primary Care Physicians to Screen for Depression Launched

As the IOM report was issued, Aetna, one of the nation's largest insurers, announced that it was launching a new program to strengthen the identification and treatment of depression at the primary care physician level. Responding to concerns of employers who cite depression as a frequent cause of absenteeism and low productivity, Aetna will increase payments by 30-40% to selected primary care doctors in the District of Columbia, Maryland, New Jersey, Oklahoma, Pennsylvania, Virginia, and Texas when these physicians use a designated screening instrument for depression. The use of this instrument, which includes the Patient Health Questionnaire (PHQ-9), will add on average $15 to a doctor's $40 fee for a routine visit.

It has been noted that family care physicians are typically the first health care providers to whom depressed patients turn, in part because of the stigma that may be associated with seeing a mental health professional. But these patients may receive only cursory attention from family physicians, who nevertheless write an estimated 65-75% of the nation's prescriptions for antidepressants.

Other program features advertised by Aetna include providing primary care physicians with access to a network of mental health professionals who are on call, using case managers to track and follow-up with patients, and providing training in screening for depression to primary care physicians and their office staff. Aetna asserts that the additional costs of its program can often be offset by avoiding the larger financial costs associated with the disease and the higher medical expenses that often arise when other chronic conditions, such as diabetes and heart disease, are compounded by depression (e.g., when a depressed patient fails to take prescribed medications or adhere to recommended exercise and diets). Milt Freudenheim, *Aetna to Pay for Program to Manage Depression*, N.Y. TIMES (Nov. 2, 2005).

FDA Publicizes Steps Taken to Warn of Risks Associated with Pair of Drugs Used to Treat Psychiatric Disorders

On September 27, 2005, the Food and Drug Administration (FDA) posted on its Web site a warning that the popular antidepressant Paxil may increase the risk of birth defects if pregnant women take it during the first trimester. The FDA acted after the manufacturer of the drug, GlaxoSmithKline, sent the agency a letter citing evidence from a new study and stating that it had changed the drug's label to reflect the possibility of the risk. The study involved 3,581 pregnant women and found a 4% incidence of birth defects in those taking Paxil during the first trimester, versus a 2% incidence in those taking other antidepressants, with the most common malformation being ventricular septal defects (i.e., holes or other flaws in the wall between two of the heart's chambers). The company reported that the risk in the general population is 3%. Benedict Carey, *Paxil Alert for Pregnant Women,* N.Y. TIMES (Sept. 29, 2005).

On September 29, the FDA warned that Strattera, a drug commonly prescribed for attention deficit hyperactivity disorder (ADHD) as an alternative to stimulants may increase suicidal thinking in children and adolescents. The warning stemmed from a large-scale government study to examine whether psychiatric drugs have previously unrecognized side effects. Manufactured by Eli Lilly, the drug will carry a prominent "black box" warning, the FDA's most serious alert, on its label. An official at the agency said the evidence of suicide risk was not strong enough for doctors to change the way they prescribe the drug, but reflected a judgment that it was important to inform parents whose children are taking the drug or might take it. The drug is reported to help about one in four people who take it, but about one in 270 reported suicidal thinking. Strattera is the only nonstimulant drug approved for the treatment

of ADHD. It is reportedly typically prescribed to individuals who refuse to take stimulants, who react badly to them, or who have anxiety along with attention deficit problems, with some 3.4 million children and adults having taken it. The data indicated that 0.4% of 2,208 children and adolescents taking the drug had suicidal thoughts serious enough to report to their doctor, with one child having attempted suicide, while none of 851 minors taking a placebo reported suicidal thinking or attempted suicide. Benedict Carey, *F.D.A. Orders New Warning on an Attention-Deficit Drug*, N.Y. TIMES (Sept. 30, 2005).

APA Task Force Report Addresses Psychologists' Ethical Obligations in Investigations Related to National Security

The American Psychological Association (APA) released a task force report addressing psychologists' ethical obligations during investigations related to national security. The report follows accounts that mental health professionals participated in interrogations of detainees at the Guantanamo Bay naval station. The report states that "it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts."

The report also notes, however that "the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities." The report and its recommendations can be found at http://www.apa.org/releases/PENSTaskForce ReportFinal.pdf.

National Survey Finds High Prevalence, Low Treatment of Mental Illness

A survey of the nation's mental health found that one-quarter of all Americans met the criteria for a mental illness within the past year and at least 6% are so seriously affected that they cannot perform even routine activities for periods averaging three months. This survey found that half of those who are diagnosed with a mental disorder show signs of the disorder by age fourteen and three-quarters by the age of twenty-four, and that half of all Americans meet the criteria for a mental illness at some point in their lives.

The survey found that less than half of those in need of care get treated, only one-third receive even "minimally adequate" care, and those who seek treatment typically do so after ten years or more of delays, during which time additional problems develop. Reasons for why individuals do not get help are inattention to early warning signs, inadequate health insurance, and the stigma that surrounds mental illness. The study is described in four reports in the June issue of the Archives of General Psychiatry. Rick Weiss, *Study: U.S. Leads in Mental Illness, Lags in Treatment*, WASH. POST (June 7, 2005).

Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics regarding mental health law. The reading audience typically has legal or mental health training but not necessarily both. We seek articles that are of interest to this diverse audience.

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Amnesia and the Determination of Competency to Stand Trial*

By James E. Tysse** and Thomas L. Hafemeister***

I. Introduction

The relationship between amnesia and competence to stand trial ("CST") is often summed up in a single blunt phrase: amnesia for the time of the crime does not, by itself, preclude a finding of competence.[1] Although some scholars argue that amnesia is a legitimate basis for routinely finding criminal defendants incompetent to stand trial ("IST") when their amnesia impairs their ability to consult with counsel and assist in their defense, virtually every American court that has considered the issue has concluded that amnesia is not a *per se* (i.e., automatic) bar to the prosecution of an otherwise competent defendant.[2] While a number of different justifications have been articulated for this conclusion, including reasons that are both doctrinal (e.g., a defendant's memory for the period of time when the crime occurred is not a requirement for a fair trial) and practical (e.g., amnesia is extremely difficult to assess),[3] American courts have been

Also in This Issue:

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* This article represents the first author's continuing work on this subject, with an earlier version of this article published as James E. Tysse, *The Right to an "Imperfect" Trial – Amnesia, Malingering, and Competency to Stand Trial*, 32 WM. MITCHELL L. REV. 353 (2005).

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[1] *See* GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 124 (2d ed. 1999).

[2] *See, e.g.,* United States v. Stevens, 461 F.2d 317, 320 (7th Cir. 1972).

[3] Ronald Roesch & Stephen L. Golding, *Amnesia and Competency to Stand Trial: A Review of Legal and Clinical Issues,* 4 BEHAV. SCI. & L. 87, 87 (1986).

described as "unanimous in refusing to equate amnesia with incompetency."[4]

This is a pivotal determination as a large number of defendants claim partial or total amnesia for the period surrounding their alleged crimes. As many as a third of the defendants accused of violent crimes make such claims.[5] Indeed, recent studies are relatively consistent in finding that 25-40% of defendants found guilty of homicide claim amnesia for their crime.[6] Claims of amnesia, however, are not limited to cases involving charges of homicide but are raised in a wide range of cases.[7]

Various traits are commonly correlated with claimants of amnesia, including being older, lower IQ, alcohol abuse, manipulative behavior, and depressed mood.[8] The amnesia may be associated with concurrent drug and alcohol use, an underlying medical condition, or be the equivalent of a post-traumatic stress disorder.[9] But because genuine amnesia is thought to be relatively rare, malingering, as will be discussed, probably accounts for many if not most of these claims.[10] In fact, the fear that a defendant is malingering appears to be the chief rationale for why amnesia has not been

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[4] *See* MELTON ET AL., *supra* note 1, at 124. *See also* S.D. Parwatikar et al., *The Detection of Malingered Amnesia in Accused Murderers*, 13 BULL. AM. ACAD. PSYCHIATRY & L. 97, 102 (1985).

[5] Maaike Cima et al., *I Can't Remember Your Honor: Offenders Who Claim Amnesia*, 5 GERMAN J. PSYCHIATRY 24, 25 (2002) (finding that "[a]s a rule of thumb, 20 to 30% of offenders of violent crimes claim amnesia for their crime"). *See also* Roesch & Golding, *supra* note 3, at 93 (noting researchers have found "evidence that the incidence of claimed amnesia is higher when the charges are more serious, such as homicide").

[6] Maaike Cima et al., *Claims of Crime-related Amnesia in Forensic Patients*, 27 INT'L J. L. & PSYCHIATRY 215, 215 (2004). *See also* Cima et al., *supra* note 5, at 24; Parwatikar et al., *supra* note 4, at 97.

[7] Cima et al., *supra* note 5, at 25 (including cases involving sexual offenses, domestic violence, and fraud). Although these researchers assert that claims of amnesia "regularly occur" with other types of crimes, the vast majority of reported cases and literature deal with amnesia in the violent crime context. *See id.*

[8] *See* Cima et al., *supra* note 6, at 216; Cima et al., *supra* note 5, at 27.

[9] *See* Cima et al., *supra* note 5, at 26-32.

[10] *See* Marko Jelicic et al., *Symptom Validity Testing of Feigned Crime-Related Amnesia: A Simulation Study*, 5 J. CREDIBILITY ASSESSMENT & WITNESS PSYCHOL. 1, 7 (2004).

recognized as a *per se* bar to competency.[11] This makes a certain amount of sense because of the apparently high rate of malingered amnesia, the skepticism of society and the courts about such claims, and the high stakes associated with a determination of IST. Still, the judicial reluctance to find even admittedly amnesic defendants IST appears anomalous for a serious psychological problem that raises questions about the defendants' CST and their ability to receive a fair trial.

This article will critically examine how courts have addressed CST issues in conjunction with claims of amnesia. The article will conclude that (1) courts should consider amnesia claims relevant, though not necessarily dispositive, (2) such claims should be examined on a case-by-case basis designed to preserve the constitutional rights of defendants, and (3) when amnesia claims are found to be genuine and to interfere with the ability of defendants to assist in their own defense (especially in cases based on circumstantial evidence or without a clear motive for the crime), such defendants should be found IST.

II. Background

Amnesia is characterized by a disturbance in memory that is manifested either by an inability to recall previously learned information or past events (retrograde amnesia) or, less relevant here, an inability to learn and retain new information (anterograde amnesia).[12] Amnesia is complex and varied, but because amnesia is relatively easily feigned and can be advantageous to the person claiming amnesia, it is likely that many amnesia claims are fabricated.[13]

The American Psychiatric Association ("APA") recognizes two different types of genuine amnesia: amnestic disorder and dissociative amnesia. The APA defines amnestic disorder (more commonly known as "organic" amnesia) as "characterized by a disturbance in memory that is either due to the direct physiological effects of a general medical condition or due to the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure)."[14] This type of amnesia is said to arise from a physical defect that "may be structural (e.g., epilepsy, brain trauma), but it may also be momentary such as in the case of alcohol or drug intoxication."[15] Most instances of claimed amnesia in the criminal context appear to be organic—for example, intoxication at the time of the crime, brain trauma resulting from a car crash or gunshot wound, or an underlying medical condition, such as Korsakoff syndrome.[16]

In contrast, the APA defines the essential feature of dissociative amnesia (variously referred to in the literature as "psychogenic" or "functional" amnesia) as "an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness."[17] Dissociative amnesia is said

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[11] *See* MELTON ET AL., *supra* note 1, at 124 (finding that the principle that amnesia alone is not a bar to competency "appears to be predicated primarily on judicial distrust of the authenticity of such claims"). *See also* Dennis Koson & Ames Robey, *Amnesia and Competency to Stand Trial,* 130 AM. J. PSYCHIATRY 588, 588 (1973) (noting that while "[t]here is ample authority to the effect that competency to stand trial generally includes the faculty of memory," courts have not consistently reasoned this way because then "any amnesic defendant would have to found incompetent").

[12] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: FOURTH EDITION, TEXT REVISION 172 (2000); Elizabeth W. Rubinsky & Jason Brandt, *Amnesia and Criminal Law: A Clinical Overview*, 4 BEHAV. SCI. & L. 27, 33 (1986). Anterograde amnesia can form the basis for a finding of IST, but is not the type of amnestic claim generally made by criminal defendants and thus will not be the focus of this article.

[13] MELTON ET AL., *supra* note 1, at 52.

[14] AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 12, at 172.

[15] Cima et al., *supra* note 5, at 25.

[16] *See* Parwatikar et al., *supra* note 4, at 97 ("A significant number of murderers referred for pretrial psychiatric examination claim amnesia and attribute it either to alcohol, drug abuse, or an emotional difficulty in recalling the alleged crime.").

[17] *See* AMERICAN PSYCHIATRIC ASSOCIATION, *supra*

to arise from an event that is so traumatic or stressful, or from a period of such high arousal, that the defendant loses or fails to form any memory of the event in question.[18] But because eyewitnesses of violent acts rarely claim amnesia for those events, the theory that the presence of strong emotions leads to amnesia is "very controversial."[19] In any event, dissociative amnesia is believed to be quite rare.[20]

Many criminal defendants likely malinger (or feign) amnesia for a variety of reasons, including attempts to avoid criminal responsibility or to obstruct police investigations.[21] These efforts may seek to take advantage of the apparently strong perception among the public that amnesia is a common and plausible reaction to a traumatic event, especially when alcohol or drugs are involved.[22] The number of offenders who feign amnesia is unknown, but is presumed to be at least 20% of all claimed cases,[23] and it may be much higher.[24] One scholar cited various studies of base rates of malingered amnesia, and found that between 30 and 40% of amnesia claims were feigned, and these percentages increased in cases where individuals were charged with criminal offenses.[25] In fact, malingered amnesia may be the "most common cause for perpetrators' failure to 'remember' the crime incident."[26]

III. Arguments that Amnesia Should Be an Automatic Bar to a Finding of Competency[27]

As noted, a large number of criminal defendants assert a lack of memory for the time period when the criminal incident

note 12, at 520.

[18] *See id.* Less relevant here, the amnesia can also be manifested as a memory that cannot be retrieved in a verbal fashion. *Id.*

[19] Cima et al., *supra* note 5, at 27.

[20] *See id.*

[21] Cima et al., *supra* note 5, at 26. *See also* Sven-Ake Christianson & Susanna Bylin, *Does Simulating Amnesia Mediate Genuine Forgetting for a Crime Event?,* 13 APPLIED COGNITIVE PSYCHOL. 495, 495 (1999) (suggesting that, save for cases of genuine amnesia, the suspect ultimately is trying to avoid conviction by avoiding answering questions based on a claim of poor memory); Richard Rogers & J. L. Cavanaugh, *Nothing But the Truth . . . : A Re-examination of Malingering*, 11 J. PSYCHIATRY & L. 443, 446 (1983) (arguing that offenders simulate amnesia out of a combination of "coping strategies, good judgment, and survival"); Roesch & Golding, *supra* note 3, at 93 (noting an additional motivation to feign amnesia when the death penalty is involved).

[22] Cima et al., *supra* note 5, at 24-25 (describing a simulation study in which more than 70% of those studied found "highly plausible" an expert witness' testimony about an offender who developed complete amnesia for a crime involving drugs and high emotions). *But see* Roesch & Golding, *supra* note 3, at 93 ("[T]he courts and society in general view a defendant's claim of amnesia with great suspicion.").

[23] Cima et al., *supra* note 5, at 26, 27 (noting that as many as 20% of closed head injury patients pursuing financial compensation have been found to exaggerate their symptoms).

[24] *Id.* at 26, 27-28. *See also* Cima et al., *supra* note 6, at 220 (noting also the higher incidence of claimed amnesia among suspects who have been arrested previously, and suggesting that "offenders who are familiar with the penal system have had more opportunities experiencing the advantages of claiming (partial) amnesia for their crime").

[25] *See* Robert D. Miller, People v. Palmer: *Amnesia and Competency to Proceed Revisited*, 31 J. PSYCHIATRY L. 165, 169 (2003) (citing studies).

[26] Christianson & Bylin, *supra* note 21, at 496 (citations omitted). *But see* Christianson & Bylin, *supra* note 21, at 496 (noting the correlation between genuine amnesia and crimes committed under emotional stress in combination with drug or alcohol abuse).

[27] Amnesia is also relevant to other aspects of criminal law besides competency to stand trial, such as sentencing, mitigation, and, perhaps most importantly, criminal responsibility. The relationship between criminal responsibility and amnesia is beyond the scope of the present article. Briefly, however, criminal responsibility looks back to the defendant's mental state at the time of the offense as part of a determination of the defendant's culpability, while competency to stand trial focuses on the defendant's current mental status as part of an examination of whether a lack of functional capability undercuts the defendant's ability to receive a fair trial. With regard to criminal responsibility, a claim of amnesia is most likely to be raised in conjunction with an automatism defense, where a defendant may assert that because of amnesia (typically anterograde amnesia) the defendant did not have the requisite control or knowledge of his or her behavior and thus should be found not guilty. *See* Rubinsky & Brandt, *supra* note 12, at 29-32.

occurred. Most forensic mental health experts and many courts consider the decision by the District of Columbia Circuit of the United States Court of Appeals in *Wilson v. United States*[28] to be the guiding (though not controlling[29]) and most comprehensive standard for determining the role a defendant's claim of amnesia plays in the assessment of the defendant's CST.[30] However, as will be discussed, while the *Wilson* approach is very valuable, it fails to adequately address the conceptual underpinnings of the competency determination—most importantly, the defendant's right to due process as guaranteed by the Sixth Amendment. Thus, before turning to *Wilson*, an exploration of the CST standard will be provided.

The United States Supreme Court has held that it is unconstitutional to convict a defendant who is IST.[31] The Court has defined the requisite test in a pair of rulings that barred the trial of defendants who could not understand the proceedings or adequately defend themselves.[32]

In the first case, *Dusky v. United States*, the Court held that to be judged competent to stand trial, a criminal defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and . . . a rational as well as factual understanding of the proceedings against him."[33] In the second, *Drope v. Missouri*, the Court held that "a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial."[34] Although state lawmakers may require a higher level of competence, these holdings represent the constitutional minimum and reflect the standard in many states.[35] Thus, based on *Dusky* and *Drope*, two elements must be satisfied for all criminal defendants: they must have (1) a rational and factual understanding of the proceedings, and (2) the capacity to assist in preparing their defense.

Scholars have argued that genuine amnesia that results in a loss of memory for the period of time associated with a charged crime should inherently render defendants IST. Typically, they advance a broad reading of the "assist in preparing their defense" element[36] to support their assertion that amnesia necessarily renders criminal defendants IST because it fundamentally interferes with their ability to assist with their defense and consult with counsel.[37] The *Dusky* opinion itself seemed to

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[28] 391 F.2d 460 (D.C. Cir. 1968).

[29] Although courts in other jurisdictions may (and occasionally do) find the *Wilson* reasoning persuasive, as a decision of the District of Columbia Circuit of the United States Court of Appeals, it is not controlling outside that jurisdiction.

[30] *See* MELTON ET AL., *supra* note 1, at 124.

[31] Pate v. Robinson, 383 U.S. 372 (1966).

[32] *See* Kim Cocklin, *Amnesia: The Forgotten Justification for Finding an Accused Incompetent to Stand Trial*, 20 WASHBURN L.J. 289 (1980-81).

[33] 362 U.S. 402, 402 (1960).

[34] 420 U.S. 162, 171 (1975).

[35] *See, e.g.*, COLO. REV. STAT. ANN. § 16-8-102(3) (West 2006) ("incapable of understanding the nature and course of the proceedings against him or of participating or assisting in his defense or cooperating with his defense counsel"); VA. CODE ANN. § 19.2-169.1(A) (West 2006) ("lacks substantial capacity to understand the proceedings against him or to assist his attorney in his own defense").

[36] It is difficult to argue that retrograde amnesia interferes with a defendant's present ability to understand the proceedings because the amnesia is only for the period of the crime, not the current trial. Although severe anterograde amnesia may render a defendant presently unable to understand the proceedings because it results in an inability to form new memories, the few cases where such claims have been made have not been responsive to this assertion. *See, e.g.*, United States v. Villegas, 899 F.2d 1324, 1341 (2d Cir. 1990); United States v. Barreto, 57 M.J. 127 (C.A.A.F. 2002).

[37] Cocklin, *supra* note 32, at 301; Abraham L. Halpern, *Use and Misuse of Psychiatric Competency Examinations on Criminal Defendants*, 5 PSYCHIATRIC ANNALS 123, 141 (1975); Miller, *supra* note 25, at 177; Rubinsky & Brandt, *supra* note 12, at 29. *See also* Stephen J. Morse, *Why Amnesia and the Law Is Not a Useful Topic*, 4 BEHAV. SCI. & LAW 99, 99-100 (1986) ("[T]the incompetence to stand trial criteria can, as a normative matter, be interpreted narrowly or

suggest that memory ought to be an important consideration in the competency determination, both because the defendant in *Dusky* for whom a new CST hearing was ordered claimed to suffer from amnesia and because the Supreme Court in *Dusky* agreed with the Solicitor General that "it is not enough for the district judge to find that 'the defendant [is] oriented to time and place and [has] *some recollection of events.*'"[38] Some scholars have taken this statement to suggest that an important aspect of the competency determination is whether the defendant has the ability to remember the crime incident and describe it to his or her attorney.[39]

A few judges have made similar arguments. The Alaska Supreme Court noted that "partial amnesia would undeniably have impaired the appellant's ability to assist in his defense."[40] Although a majority of the Pennsylvania Supreme Court concluded that "amnesia is no defense at all" at trial, one dissenting judge argued that "the constitutional right to counsel would be a sham" if, due to the defendant's asserted amnesia, "defense counsel were not able to prepare a proper defense."[41]

In the early (pre-*Dusky*) case of *United States v. Sermon,* a federal district court judge asserted that "[b]roadly speaking, one cannot properly assist in his own defense unless he can advise his counsel concerning the facts of the case as known to him and unless, if necessary, he can testify on his own behalf in the cause concerning those facts."[42] The court continued that, although defendants are not expected to be able to "assist in their own defense by telling their lawyers what motions to file or how a particular witness should be examined, or cross-examined," they should be able to participate in "such phases of a defense as a defendant usually assists in, such as accounts of the facts [which are in legitimate dispute], names of witnesses, etc."[43]

The situation where amnesia most clearly implicates the ability of criminal defendants to consult with counsel and assist in their own defense is when some extenuating circumstances or a defense to the crime exists that the defendant cannot raise because of the amnesia, such as an alibi, an excuse, or a justification.[44] One court noted a hundred years ago that memory is vital to competency "because there may be circumstances lying in [the defendant's] private knowledge which would prove him innocent or [establish] his legal irresponsibility, of which he can have no

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broadly. . . . A broader interpretation would find such a defendant incompetent because it is surely arguable that a defendant who does not remember the crucial events has substantially impaired ability to assist his counsel in preparing an adequate defense.").

[38] 362 U.S. at 402 (quoting the Solicitor General) (emphasis added).

[39] Christopher Slobogin, *Estelle v. Smith: The Constitutional Contours of the Forensic Evaluation*, 31 EMORY L.J. 71, 81 n.45 (1982).

[40] Fajeriak v. State, 520 P.2d 795, 801 (Alaska 1974) (addressing a defendant's disruption of memory alleged to have been caused by head injuries). *See also* Youtsey v. United States, 97 F. 937, 940 (6th Cir. 1899) (holding that a "sound memory" is a prerequisite to competency); Wieter v. Settle, 193 F. Supp. 318, 322 (W.D. Mo. 1961) (noting that the defendant must have the capacity "to tell his lawyer the circumstances, to the best of his mental ability, (whether colored or not by mental aberration) the facts surrounding him at the time and place where the law violation is alleged to have been committed)"; People v. Angelillo, 432 N.Y.S.2d 127, 131 (Suffolk County Ct. 1980) (stating that one of the competency factors is "whether [the defendant] has some recollection of the events involved in the crime").

[41] Commonwealth *ex rel.* Cummins v. Price, 421 Pa. 396, 407 (1966) (Cohen, J., dissenting) (adding that the majority's refusal in this case to grant a continuance to see if the defendant's temporary amnesia had abated "completely prevents the presentation of any defense which would dispel the conclusions arrived at from the circumstances").

[42] United States v. Sermon, 228 F. Supp. 972, 977 (D. Mo. 1964).

[43] *Id.* at 978 (internal quotation marks omitted) (*quoting* Lyles v. United States, 254 F.2d 725, 729-30 (D.C. Cir. 1957)). But note that despite the broad language, the court in *Sermon* ultimately found the defendant competent to stand trial after a review of all the circumstances. *Id.* at 981-84.

[44] Comment, *Criminal Law—Ability to Stand Trial—Amnesia*, 52 IOWA L. REV. 339, 341-42 (1966).

advantage, because they are not known to persons who undertake his defense."[45]

The following account demonstrates the pejorative impact amnesia may have on a criminal defendant. The defendant was charged with sexual assault and capital murder, but claimed amnesia for the events in question. Only after several sessions with psychologists was he able to recall some of the details of his crime and assert that a sexual assault had not taken place, but that he had instead paid the victim for sex and murdered her after an argument in which the victim had tried to extort extra money from him. The police later verified his recollection with the discovery of corroborating evidence. As a result, the sexual assault charge was dropped, he pled guilty to second degree murder, and he did not have to face the death penalty. The recall of this information quite possibly saved his life.[46] Situations such as these, where the defendant is unable to challenge false or misleading evidence, emphasize the potential relevance of amnesia to competency.[47]

However, for amnesia to be recognized as routinely interfering with a defendant's ability to "assist with his defense" under *Dusky-Drope,* the standard would have to be read relatively broadly, certainly more broadly than is typically the case in this context.[48] Indeed, no American court has ever found amnesia alone to be a bar to competency.[49] The typical response to a broad reading of *Dusky-Drope* is that the *Dusky* test only requires a "sufficient *present* ability to consult with his lawyer with a reasonable degree of rational understanding"[50] and thus "[a] competency evaluation should focus on the defendant's present mental condition" and ability to participate *during trial* (i.e., communicate with his or her attorney, discuss trial strategy, and choose possible defenses).[51] The pervasive narrow reading of *Dusky/Drope* caused one scholar to lament that "[a]n examination of how amnesia and brain-injured cases are handled, in which the defendant can truly be said to fall short of the *Dusky* standard and yet in almost every case is indeed required to stand trial, reveals the utter absurdity of the law with respect to the competency issue."[52]

IV. The Two Primary Judicial Approaches to Amnesia Claims

The general unwillingness of the courts to read the *Dusky-Drope* standard to automatically render amnesic criminal defendants IST does not mean that all courts have completely ignored such claims.[53] Rather, modern courts have split between those that believe that amnesia is irrelevant and can never be an adequate ground for a finding of IST and those that think that amnesia must be considered as

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[45] United States v. Chisolm, 149 F. 284, 287 (S.D. Ala. 1906).

[46] Roesch & Golding, *supra* note 3, at 95.

[47] Koson & Robey, *supra* note 11, at 588.

[48] *See* Roesch & Golding, *supra* note 3, at 92 (recognizing that despite circumstances where a defendant's amnesia should arguably lead to a finding of incompetency, "[m]ost courts have used a strict interpretation of *Dusky*").

[49] *See, e.g.,* United States v. Sullivan, 406 F.2d 180, 185-86 (2d Cir. 1969) ("If in fact he had developed an amnesia preventing his recollection of the events of the day in question, this would not in itself be a complete defense to the charges. . . . [The defendant] was capable of understanding the charges and assist [sic] in the conduct of the trial."). *See* Parwatikar et al., *supra* note 4, at 102; Rubinsky & Brandt, *supra* note 12, at 29 ("[there remains] no appellate decision [where] amnesia, in and of itself, renders a defendant incompetent to stand trial"); Case Note, *Capacity to Stand Trial: The Amnesic Criminal Defendant*, 27 MD. L. REV. 182, 188 (1967) (concluding that no American or English court has found a defendant to be incompetent on the sole basis of amnesia); Miller, *supra* note 25, at 168-69 & n.9 (citing cases from nearly every circuit and state holding that amnesia *per se* will not render a defendant incompetent to stand trial).

[50] 362 U.S. 402, 402 (1960) (emphasis added).

[51] *See* Slobogin, *supra* note 39, at 81.

[52] *See* Halpern, *supra* note 37, at 141.

[53] *See* Donald H. J. Hermann, *Criminal Defenses and Pleas in Mitigation Based on Amnesia,* 4 BEHAV. SCI. & L. 5, 21 (1986); MELTON ET AL., *supra* note 1, at 124 (remarking on the sensitivity courts have shown "to the threat amnesia poses to accurate adjudication" while noting that "courts have been unanimous in refusing to equate amnesia with incompetency").

part of a fact-specific inquiry into a defendant's CST.[54]

A. Amnesia Irrelevant to the Competency Determination

Courts employing the first approach have ruled that amnesia can never be a bar to competency because amnesia is simply irrelevant to the competency determination. A federal district court summed up its views in the following way:

> [W]hile amnesia may be relevant as a symptom evidencing a present infirmity in the defendant's reasoning capacity, if the defendant has the present ability to understand the proceedings against him, to communicate with his lawyer and generally to conduct his defense in a rational manner, memory or the want thereof is irrelevant to the issue of competence.[55]

Courts that take this position have concluded that trials are imperfect venues in which all parties, including the defendant, suffer from lost or unavailable evidence, with amnesia being another form of "lost" evidence.[56] Alternatively, they may assert that memory is ephemeral for everyone—that everyone is amnesic to some degree because everyone forgets names, details, and places.[57] Courts of this view also tend to express their suspicion that the defendant is feigning amnesia.[58] Concern may be raised that the criminal justice system would be unable to function if trials were suspended or terminated because of a defendant's claimed amnesia.[59] Usually it is suggested that the defendant has alternative means of generating needed information and evidence.[60]

This judicial failure to find the trial of amnesic defendants unfair is deeply troubling to many scholars, who feel that courts do not take amnesia claims seriously enough. They argue that amnesia claims seem to be taken less seriously than other major mental abnormalities (such as depression and schizophrenia), to such an extent that many courts are dismissive or even flippant regarding amnesia claims.[61] The belief that amnesia is tantamount to simply having a bad memory is, according to some scholars, a "widespread misconception" that "runs

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[54] *See* Hermann, *supra* note 53, at 21.

[55] United States *ex rel.* Parson v. Anderson, 354 F. Supp. 1060, 1071 (D. Del. 1972) (citations omitted).

[56] *See* Reagon v. State, 251 N.E.2d 829, 831 (Ind. 1970) ("Many times . . . evidence is lost, a material witness dies, or, as in this case, the defendant has amnesia as to certain events or a time."); *United States* ex rel. *Parson*, 354 F. Supp. at 1072 ("extrinsic evidence far more valuable to the defense than the defendant's own testimony may be lost by reason of death, destruction or other fortuity prior to trial"). *See also* Comment, *Amnesia: A Case Study in the Limits of Particular Justice*, 71 YALE L.J. 109, 136 (1961).

[57] *See* Morrow v. Maryland, 443 A.2d 108, 113 (1982); *United States* ex rel. *Parson*, 354 F. Supp. at 1072 ("the memory of any defendant "fades" to some degree. The innocent defendant who is arrested several months after the alleged crime and cannot recall where he was on the night in question is not in a dissimilar circumstance").

[58] Case Note, *supra* note 49, at 188. Other rationales noted include "a feeling (especially in cases of alleged alcoholic or hysterical amnesia) that the defendant has only himself to blame for his loss of memory; and . . . the judicial apprehension that to hold that amnesia protects the defendant from trial "would be tantamount to a holding that amnesia negated criminal responsibility as an original proposition."). *Id.* (footnotes omitted).

[59] Reagon v. State, 251 N.E.2d 829, 831 (Ind. 1970) ("[S]uch handicaps . . . cannot prevent a trial from taking place eventually. Rarely would we find a case in which a defendant could not contend that he was deprived of some evidence and therefore he ought not to be tried"). *See also* Comment, *supra* note 56, at 136.

[60] *See United States* ex rel. *Parson*, 354 F. Supp. at 1072 ("Most importantly, we know that the defendant's recollection is only one of many sources of evidence which may permit the reconstruction of a past event.").

[61] *See* United States v. Borum, 464 F.2d 896, 900 n.3 (10th Cir. 1972) (joking that "[u]ndoubtedly there are instances in which defense counsel may wish that their clients would have amnesia"). *See also* Roesch & Golding, *supra* note 3, at 95 (noting that "at least one court has held that amnesia does not even entitle a defendant to an evaluation of competency") (*citing* Kirby v. Texas, 668 S.W.2d 448 (Tex. 1984)).

throughout court decisions."[62] They note that amnesia is defined as a lack of memory that is too extensive to be explained by ordinary forgetfulness, such that "the statement that 'all people are amnesic to some extent' is, by definition, incorrect."[63] Genuine amnesia, as clinically defined, is different from normal forgetting in its nature and in its magnitude, such that the analogy to "normal forgetting" is misplaced. By critical analogy, most courts would presumably never assert that clinical depression—which, by itself, has been found to render defendants IST[64]—is actually akin to "being sad," and thus "everyone is depressed at some point." Clinical depression is of a different order and magnitude and, like efforts to link amnesia with "forgetting," neither should be marginalized or rationalized away.[65]

B. The *Wilson* Case-by-Case Approach

The second approach, on the other hand, concedes that while amnesia is not a bar to competency *per se*, the courts should examine whether the defendant's amnesia in light of the particular facts of the case rendered the defendant incompetent.[66] The best known American decision on the relationship between amnesia and CST is *Wilson v. United States*, which provides a comprehensive example of this functional, case-by-case approach.[67] The defendant in *Wilson* robbed a bank and, after a high-speed chase from the police, severely injured his head in a violent crash.[68] Upon waking from a lengthy coma, he claimed to have no knowledge of the period from several hours before the robbery to when he awoke three weeks later.[69] Under these circumstances, the government conceded the usually "hotly contested" claim of his permanent amnesia at trial.[70] Thus, because malingering was not a concern, *Wilson* became an ideal case for exploring the extent to which amnesia affects a criminal defendant's ability to receive a fair trial and its relevance to CST determinations.

In its decision, a majority of the court emphasized that the defendant must be able to perform the functions that are essential to the fairness and accuracy of a criminal trial, embraced a case-by-case determination of the effect of amnesia on the ability to receive a fair trial, and established six specific factors to be considered in making this determination.[71] The six listed factors were:

> (1) The extent to which the amnesia affected the defendant's ability to consult with and assist his lawyer; (2) The extent to which the amnesia affected the defendant's ability to testify on his own behalf; (3) The extent to which the evidence . . . could be extrinsically reconstructed in view of the defendant's amnesia. . . . ; (4) The extent to which the Government assisted the defendant and his counsel in that reconstruction; (5) The strength of the prosecution's case. Most important here will be whether the Government's case is such as to negate all reasonable hypotheses of innocence. If there is any substantial possibility that the accused could, but for his amnesia, establish an alibi or other defense, it should be presumed that he would have been able to do so; (6) Any other facts and circumstances which would indicate whether or not the defendant had a fair trial.[72]

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[62] Rubinsky & Brandt, *supra* note 12, at 32.
[63] *Id.* at 33.
[64] *See, e.g.*, Loyd v. Smith, 899 F.2d 1416, 1419 (5th Cir. 1990) (recognizing defendant as incompetent after his doctors "found that [his] depression rendered him unable to understand the charges and proceedings against him and that he could not effectively participate or assist in his defense").
[65] *See* Miller, *supra* note 25, at 177.
[66] *See, e.g.*, United States v. Sermon, 228 F. Supp. 972, 976 (D. Mo. 1964); State v. McClendon, 419 P.2d 69, 72 (Ariz. 1966). *See* Rubinsky & Brandt, *supra* note 12, at 29.
[67] 391 F.2d 460, 463 (D.C. Cir. 1968).
[68] *Id.* at 461.
[69] *Id.*
[70] *Id.*
[71] *Id.* at 463-64.
[72] *Id.* (citations omitted).

Although, as argued below, this ruling placed undue emphasis on the question of the defendant's guilt rather than his due process rights, the court's functional approach was for the most part well-considered and many scholars have praised the *Wilson* decision for its practical and sensible treatment of the issue.[73] But although several courts have also employed case-by-case approaches,[74] the *Wilson* multi-factor approach has unfortunately not received universal acclaim—indeed, "[o]nly a few courts [have] explicitly discussed the *Wilson* criteria" at all.[75]

V. Amnesia and Judicial Pragmatism

From a theoretical perspective, whether amnesia should sometimes prove a bar to competency is a close question with strong arguments on both sides. But the dearth of cases that have actually found amnesia dispositive seems quite surprising in light of the high number of such claims and the academic support it has received. Perhaps the explanation is that pragmatic reasons for discounting amnesia claims tip the scales. Indeed, many courts seem preoccupied with practical fears, such as the consequences of finding amnesic defendants incompetent and the difficulty of detecting malingered amnesia.

A. The Problem of Finding Amnesic Defendants IST

Many courts have expressed reluctance to find defendants IST because of amnesia in part because of the possible consequences of finding these defendants incompetent.[76] Because the United States Supreme Court ruling in *Jackson v. Indiana* prohibits holding an unrestorably incompetent defendant indefinitely without trial,[77] "[i]f the amnesia is permanent, a finding of incompetency would be tantamount to a dismissal of charges" and permit the defendant to avoid prosecution.[78] This has resulted in a judicial "fear that amnesia might provide a 'ready-made' defense to all criminals."[79] The Pennsylvania Supreme Court noted:

> If in fact the condition of amnesia Is permanent, defendant's contention (1) would require Courts to hold that such amnesia will permanently, completely and absolutely Negate all criminal responsibility and (2) will turn over the determination of crime and criminal liability to psychiatrists, whose opinions are usually based in large part upon defendant's self-serving statements, instead of to Courts and juries, and (3) will greatly jeopardize the safety and security of law-abiding citizens and render the protection of Society from crime and criminals far more difficult than ever before in modern history. . . . Unless an accused is legally insane, the law is not and should not be so unrealistic and foolish as to Permanently free, without acquittal by a Judge or a jury, a person against whom a prima facie case of murder is made out.[80]

But this judicial fear is at least somewhat misplaced. The same concern applies to any mental disorder that would lead to a finding of IST, yet courts following the constitutional mandate recognized by the United States Supreme Court have been (at least selectively) vigilant in refusing to permit the prosecution of criminal defendants with other mental disorders that functionally impair their right to a fair trial, notwithstanding that such defendants may ultimately avoid prosecution. Granted,

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[73] *See, e.g.*, Koson & Robey, *supra* note 11, at 591.

[74] *See, e.g.*, United States v. Villegas, 899 F.2d 1324, 1341 (2d Cir. 1990); United States v. Swanson, 572 F.2d 523, 526 (5th Cir. 1978); Aldridge v. State, 247 Ga. 142 (Ga. 1980).

[75] Miller, *supra* note 25, at 168-69. Miller argues that one appellate court's conclusion that a majority of courts had adopted the *Wilson* court's multifactor approach was "simply incorrect." *Id.*

[76] Roesch & Golding, *supra* note 3, at 92.

[77] 406 U.S. 715 (1972).

[78] Roesch & Golding, *supra* note 3, at 92, 96.

[79] John M. W. Bradford & Selwyn M. Smith, *Amnesia and Homicide: The Padola Case and a Study of Thirty Cases*, 7 BULL. AM. ACAD. PSYCHIATRY & L. 219, 230 (1979).

[80] Commonwealth *ex rel.* Cummins v. Price, 218 A.2d 758, 763 (Pa. 1966).

amnesia claims may be more prevalent and less treatable than other mental disorders; but, as will be discussed, improved techniques to detect malingered amnesia are available, and the treatment of genuine amnesia has improved.[81] Further, competency has traditionally (and sensibly) been evaluated without regard to the possible obstacle it poses to securing a guilty verdict.[82]

Some courts have temporarily stayed criminal proceedings in the hopes that the amnesiac would eventually recover some memory.[83] But if it is unfair to try a defendant who is currently experiencing amnesia, there is no principled explanation for how it somehow *becomes* fair, after a stay without memory improvement, to try the defendant anyway. As one scholar points out, "appellate decisions . . . seem to be made on the practical basis that an adjudication of a *permanently* amnesic defendant as incompetent precludes forever the possibility of his returning to trial."[84] The desire to obtain a guilty verdict should not trump the consistent and principled application of the standards for adjudicating CST.

B. The Problem of Malingered Amnesia

Of seemingly greater concern to many courts than the practical consequences of holding amnesiacs incompetent is the special problem of malingered amnesia. Malingering is indeed a widespread problem, and it is the first issue that forensic mental health experts and courts must address when confronted with an amnesia claim.[85] Courts are understandably cautious with claims of amnesia, due to both the high rate of such claims and the perceived ease of malingering.[86] Indeed, courts have consistently pointed to the supposed ease and likelihood of feigning amnesia, as well as the difficulty of detecting it, as justification for finding allegedly amnesic defendants CST.[87] For example, the Supreme Court of Alaska held that "[t]he potential for fraudulent allegations of memory loss is so great that we would for this reason alone be reluctant to follow [sic] amnesia as a ground for a finding of incompetency even if we were otherwise inclined to do so."[88] Potentially exacerbating this problem is the fact that some expert testimony is based on patient interviews alone, which makes it very difficult to determine whether the amnesia claims are malingered.[89]

Undoubtedly, the practical problem of discerning real from feigned amnesia is a key obstacle to recognizing amnesia's potential relevance to determinations of CST. However,

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[81] *See, e.g.,* Haruo Kashima et al., *Current Trends in Cognitive Rehabilitation for Memory Disorders*, 48 KEIO J. MED. 79 (1999); David F. Rose et al., *Virtual Reality in Brain Damage Rehabilitation: Review*, 8 CYBERPSYCHOLOGY & BEHAV. 241 (2005).

[82] *See Wilson,* 391 F.2d at 467 (Fahy, J., dissenting).

[83] *See* State v. McClendon, 437 P.2d 421, 423 (Ariz. 1966).

[84] Koson & Robey, *supra* note 11, at 588.

[85] *See* MELTON ET AL., *supra* note 1, at 52.

[86] *See* Miller, *supra* note 25, at 169; Parwatikar et al., *supra* note 4, at 97; Stephen Porter et al., *Memory for Murder: A Psychological Perspective on Dissociative Amnesia in Legal Contexts,* 24 INT'L J. L. & PSYCHIATRY 23, 25-26; Rubinsky & Brandt, *supra* note 12, at 32.

[87] *See McClendon*, 437 P.2d at 424 ("The concern of the courts in this area is the very real danger that amnesia can be feigned easily and that discovery and proof of feigning and malingering is difficult, especially when the defendant refuses to take the stand."); Comment, *supra* note 56, at 123, 124-25 ("[A]n attempt to verify all but the most patently phony claims of amnesia is at best a difficult and time-consuming task; at worst it is a hopeless one."); Rubinsky & Brandt, *supra* note 12, at 42 (arguing that part of the reluctance of courts to believe amnesia claims may be based on the lack of reliable procedures for discriminating between real and malingered amnesia).

[88] Fajeriak v. State, 520 P.2d 795, 802 (Alaska 1974). *See also* State v. Pugh, 283 A.2d 537, 542 (N.J. Super. Ct. App. Div. 1971); *McClendon*, 437 P.2d at 425.

[89] Cima et al., *supra* note 5, at 27 ("For the expert witness, it is very difficult to differentiate between dissociative, organic or feigned amnesia on the basis of interviews with the defendant. This has to do with the fact that simulators can give a compelling imitation of someone with a dissociative or organic amnesia. . . . Nevertheless, our impression is that mental health professionals acting as experts in cases of amnesia often use interviews with the defendant as the sole source for making their diagnostic judgments.").

if this practical consideration is the primary basis for precluding amnesia as a basis for a finding of IST, then the focus should be on generating greater understanding of the differences between genuine and feigned claims and better mechanisms to distinguish them, rather than automatically excluding all claims of amnesia from consideration.[90]

VI. Distinguishing Genuine from Malingered Amnesia Claims

Efforts are ongoing to better distinguish genuine from malingered amnesia. The following provides a brief description of a few of these efforts.

A. Detecting Malingering in Cases of Claimed Organic Amnesia

Organic amnesia that involves traumatic brain injury asserted to be preventing the defendant from recalling events immediately before or after the injury is more often conceded at trial because the related amnesia tends to follow a fairly predictable course of injury and memory recovery known as Ribot's Law.[91] Organic amnesia under these circumstances is relatively unproblematic for the courts compared to dissociative amnesia, in part because the typical course of organic amnesia makes it much harder for defendants to simulate.[92]

When physical evidence of brain trauma or events likely to have induced this trauma (such as a severe blow to the head) exists, courts tend to consider amnesia claims more plausible. The consideration of amnesia in this context is generally less controversial.[93]

For example, in *Wilson v. United States*, the defendant's car accident and subsequent three-week coma following his bank robbery spurred the prosecution's decision to concede his amnesia for the crime.[94] Other cases follow a similar pattern where a defendant shoots someone before turning the gun on him or herself, and yet somehow manages to survive.[95] In these cases, because one of the common resultant brain symptoms of such events is amnesia, the defendant's amnesia is rarely disputed.

B. Detecting Malingering in Cases of Claimed Dissociative Amnesia

Cases of dissociative amnesia, on the other hand, are relatively rare and harder to detect, and thus more fraught with the danger of malingering.[96] One group of scholars determined that both lay persons and expert witnesses tend to significantly overestimate the occurrence of dissociative amnesia and "view dissociative amnesia as the rule and feigned amnesia as the exception."[97] Their

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[90] *See* Comment, *supra* note 44, at 342; Parwatikar et al., *supra* note 4, at 97, 102 ("If a method to detect malingered amnesia was developed, the legal policy concerning it could be changed to benefit those with true amnesia.").

[91] *See* Cima et al., *supra* note 5, at 29 ("organic amnesia requires the specific sequence of trauma, loss of consciousness, [Post Traumatic Amnesia], memory loss relating to recent rather than old memories, and memory recovery in such a way that older memories come back more readily than more recent ones").

[92] *Id.* Although this article does not focus on the potential relevance of amnesia to issues of criminal responsibility, the presence of symptoms conforming to Ribot's Law could be used by a defendant to argue that the defendant acted in self-defense following a traumatic brain injury induced by the purported victim. *Id.*

[93] *Id.* Although far more controversial and less frequent, for claimed organic amnesia based on extreme intoxication ("alcohol blackout"), the claimed amnesia may be conceded by the prosecution following supporting blood alcohol or toxicology tests. *See id.* at 28.

[94] 391 F.2d 460, 466 (D.C. Cir. 1968).

[95] *See, e.g.*, State v. McLendon, 437 P.2d 421, 422 (Ariz. 1968).

[96] *See* Cima et al., *supra* note 5, at 27-28 (discussing three reasons to suspect claims of dissociative amnesia, namely, that those who make such claims tend to fit a psychological profile, including a tendency to engage in manipulative behavior; the absence of dissociation in individuals not charged with crimes but who have experienced or witnessed similarly horrifying or violent events; and research that shows that a substantial proportion of individuals in general tends to feign symptoms and confabulate stories if it serves their interests).

[97] *Id.* at 27.

literature review, however, led them to conclude that "it would be wise to reverse these probability estimates."[98] Indeed, legal commentators have confidently asserted the impossibility of detecting malingered amnesia for decades.[99]

Traditional forensic interviews are generally unhelpful and unproductive because the person being interviewed can simply claim to have no memory of the events in question and because a simulator can give a compelling imitation of someone with amnesia.[100] It has been noted that forensic evaluators, unfortunately, often use interviews with the defendant as the sole source of information for their opinions on whether a claim of amnesia is genuine or malingered.[101] It has been asserted that "[i]t is only on the basis of psychological tests and tasks, that an expert will be able to identify simulators,"[102] and thus "experts who at the request of the court have to evaluate a case in which crime-related amnesia is claimed can and should do more than just interview the defendant."[103]

C. Clinical Research on Amnesia Malingering Detection

In fact, researchers in several recent studies have attempted to detect the presence of malingered amnesia in clinical and forensic settings, but with varying degrees of success.[104] For example, some found that it is difficult to detect malingering with confidence in the absence of external verification.[105] Still, several techniques have proven useful in distinguishing real from feigned cases of amnesia.[106] One promising group of studies describes a series of recently developed self-report instruments that have made great strides in detecting malingering in clinical settings, and have begun to test them in forensic settings as well. Two techniques deserve specific mention.[107]

The first is an instrument known as Symptom Validity Testing (SVT), where "the defendant is asked a series of dichotomous (true-false) questions about the crime and the circumstances under which it took place."[108] When providing purely random responses, the defendant's answers should be correct about 50% of the time. Performance significantly below chance indicates that the individual is avoiding correct alternatives, which in turn indicates that they know which are the correct answers and are feigning memory impairment.[109] Several studies have been reported in which suspected or confirmed malingerers, including individuals within a forensic setting, showed a response score significantly below chance.[110] The test procedure was found to be relatively robust, to be easy to administer and relatively easy to interpret, and to function well even when the number of test items was as few as ten, although a greater number was recommended to permit the use of a "runs" test to better detect simulation.[111]

Another promising method that forensic evaluators can use to detect malingering are self-report questionnaires that capitalize on the tendency of malingerers to exaggerate their amnesia.[112] The Structured Inventory of Malingered Symptomatology (SIMS) is a questionnaire that consists of seventy-five dichotomous (true-false) items that asks defendants to answer questions about how they experience amnesia. It is based on the

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[98] *Id.*
[99] Comment, *supra* note 56, at 123.
[100] Cima et al., *supra* note 5, at 27.
[101] *Id.*
[102] *Id.*
[103] *Id.* at 31.
[104] *See, e.g.,* Miller, *supra* note 25, at 169-72 (citing various studies).
[105] Steven P. Cercy et al., *Simulated Amnesia and the Pseudo-memory Phenomenon, in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION (Richard Rogers ed., 1997).
[106] *See* Cima et al., *supra* note 5, at 29-32.
[107] *See id.*
[108] *Id.* at 29-30.
[109] *Id.* at 30.
[110] *See id.*
[111] *Id.* at 30-31.
[112] *Id.* at 31.

assumption "that malingerers will exaggerate and so will endorse bizarre, unrealistic, and atypical symptoms."[113] There are five subscales, with subscales corresponding to symptoms domains that are sensitive to malingering and include low intelligence (LI), affective disorder (AF), neurological impairment (N), psychosis (P), and amnestic disorder (AM).[114]

Like the SVT, studies with SIMS have reported excellent results, identifying in a controlled setting more than 90% of malingerers and more than 90% of "honest" control subjects.[115] Similarly promising results were found in forensic settings, with the instrument demonstrating both high sensitivity (identifying malingers correctly) and high specificity (classifying non-malingerers correctly).[116]

Other studies have analyzed the relative success of using hypnotism, sodium amytal ("truth serum"), or state-dependant recall to test for malingering, as well as to revive "lost" or inaccessible memories.[117] The underlying theory of these approaches is that techniques that reduce the anxiety associated with unavailable memories may make the memories available again.[118] Courts in general have been skeptical about these techniques and their use has been controversial.[119] It has been concluded that the validity of these techniques to establish the presence or absence of malingering has not been established.[120] However, it has been suggested that they may have value because "they frequently elicit 'fuller' disclosures because the average defendant *believes* that they will discover deception."[121]

[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] For an overview of these studies, see Miller, *supra* note 25, at 172-76.
[118] *Id.* at 172.
[119] *Id.* at 173-74.
[120] Roesch & Golding, *supra* note 3, at 94.
[121] *Id.* (emphasis in the original).

VII. A Better Approach for Amnesia Claims

It is true that criminal defendants are "entitled to a fair trial, not a perfect trial," as courts are fond of saying in the amnesia context,[122] but to prevent the rights to receive the assistance of an attorney and to receive a fair trial from being empty rights, courts should closely consider the purpose of a competency determination when a claim of amnesia is raised. Because some of the practical concerns have been reduced as better techniques have been developed for detecting malingered amnesia, courts should consider how the problems posed by the amnesic criminal defendant can be better addressed.

As a first step, for the reasons outlined above, no court should automatically dismiss amnesia claims as irrelevant to the competency inquiry. Rather than categorically rejecting such claims, courts should use the case-by-case approach that scholars favor,[123] and that some courts already employ—most prominently in *Wilson v. United States*.[124] Particularly when the existence of amnesia is conceded or competent experts agree on its existence, courts should follow the lead of *Wilson* and sincerely consider on a case-by-case basis the possibility that the amnesia may render the defendant IST and unable to obtain a fair trial.

Second, when conducting this case-by-case approach, the focus should not be on the likely guilt or innocence of the accused, but rather on whether the amnesia, if established to be genuine, will result in an inability to consult

[122] McKenzie v. Risley, 842 F.2d 1525, 1550 (9th Cir. 1988) (citing Delaware v. Van Arsdall, 175 U.S. 673 (1986)). *See also* State v. McClendon, 437 P.2d 421, 425 (Ariz. 1968); People v. Amador, 246 Cal. Rptr. 605 (Ct. App. 1988); People v. Palmer, 31 P.3d 863, 870 (Colo. 2001).
[123] *See* Roesch & Golding, *supra* note 3, at 96 (describing the *Wilson* case and others as employing "the kind of functional, case by case assessment which we have proposed be used in all determinations of competency"); *see also* Patricia A. Zapf & Ronald Roesch, *Mental Competency Evaluations: Guidelines for Judges and Attorneys*, 37 CT. REV. 28, 31-34 (2000).
[124] 391 F.2d 460 (D.C. Cir. 1968).

with counsel and to assist in preparing his or her defense. Courts should assess the functional limitations posed by the amnesia for the exercise of these rights.[125] The six factors identified in *Wilson* are a good starting point for this assessment, with their examination of whether the amnesia interferes with the defendant's ability to testify and to consult with counsel; whether the evidence can be extrinsically reconstructed and the extent to which the government can and has aided in that reconstruction; the strength of the prosecution's case; and any additional facts or circumstances that indicate whether the defendant can and will receive a fair trial.

However, the concurring judge in *Wilson* described the "nub" of the majority's opinion as being that for brain-damaged, non-malingering amnesiacs, the judge and jury must "make a fact finding that there is no reasonable doubt of guilt."[126] But competency determinations should not and are not limited to defendants who are possibly not guilty, but afford protections to which all incompetent defendants are entitled. As the dissenting judge vigorously argued in *Wilson*:

> Determination of guilt is not the test of the validity of a criminal conviction under our system of law. Though such a determination is essential, it must be reached at a trial which conforms to the requirements of the Bill of Rights. Ascertainment of guilt even to a scientific or mathematical certainty does not alone suffice.[127]

Any other approach undermines the dignity and the integrity of the judicial process.

Thus, the *Wilson* approach should be modified to not focus on the strength of the prosecution's case, but to determine the extent to which the amnesia, when reliably established or conceded by the prosecution, impairs the defendant's right to a fair trial. Thus, courts should look at (1) whether the amnesia interferes with the ability of the accused to testify on his or her own behalf, (2) whether the amnesia interferes with the ability of the defendant to consult with counsel, and (3) the extent to which the incident and surrounding circumstances can be reconstructed through extrinsic evidence (including through mandated sharing of information held by the prosecution).

Two other issues should also be taken into account by courts presiding over these cases. First, the court should examine whether the evidence indicates that the amnesia is likely to be temporary or permanent in nature. The determination should <u>not</u> be made, as some courts have done, to refuse to issue a finding of IST for defendants with permanent amnesia because it may not be possible to bring such defendants to trial under *Jackson.* Such defendants retain their right to be CST even though ultimately they should be afforded the same right that is given to all defendants under *Jackson* who are found to be permanently IST, namely, that they not languish indefinitely in the custody of the state when restoration of competency is not reasonably to be expected.[128] When the loss of memory appears to be temporary, however, the state should be entitled to maintain custody of the defendant for a reasonable period of time so that reasonable efforts can be made to restore competency.

Second, the functional, case-by-case approach should examine whether any affirmative defenses or mitigation claims are likely to be relevant in the case under consideration. When a defendant reasonably could be expected to make an affirmative

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[125] *See* Roesch & Golding, *supra* note 3, at 95-96.
[126] *Id.* at 465-66 (Leventhal, J., concurring). *See also* United States v. Sullivan, 406 F.2d 180, 187 (2d Cir. 1969) (implying that a court's treatment of the amnesic defendant will turn, in part, on the sufficiency of the evidence presented).
[127] 391 F.2d at 466-67 (Fahy, J., dissenting).
[128] *See* Parwatikar et al., *supra* note 4, at 102-03 (noting that even if the defendant is able to convince the court that amnesia is genuine, it may be "a Pyrrhic victory for the true amnesiac, unless such matters as automatic commitment to a state hospital and the dismissal of charges against the 'permanently incompetent' are resolved").

representation on his or her own behalf, a more proactive role by the defendant may be required and the mere ability to testify and consult with an attorney may not suffice. If an affirmative defense or mitigation claim is likely and the amnesia is established to be genuine, the court should determine whether the amnesia is likely to impose a significant impediment to the defendant's ability to pursue the affirmative defense or mitigation claim. If so, this may provide an additional basis for finding a defendant IST.

VIII. Conclusion

Courts should continue to treat amnesia claims skeptically, but should not discount them altogether. Although many—perhaps most—claims of amnesia are not genuine, improved understanding of amnesia and more reliable techniques to detect malingering mean amnesia claims pose less of a practical problem for courts and permit a more nuanced judicial response. Just as experts "can and should do more than just interview the defendant,"[129] courts should do more than simply dismiss these claims. Practical difficulties associated with distinguishing genuine from malingered cases of amnesia will continue to challenge the courts, but competence to stand trial is such a fundamental predicate of the right to a fair trial that justice demands that claims of amnesia be heard and evaluated based on an individualized, functional analysis of the impact of any established amnesia on the defendant's competence to stand trial.

[129] *See* Cima et al., *supra* note 5, at 31.

Reforming (purportedly) Non-Punitive Responses to Sexual Offending

By Adam Shajnfeld* and Richard B. Krueger**

I. Introduction

Clovis Claxton, who was developmentally disabled and wheelchair-bound after contracting meningitis and encephalitis as a child, was twenty-four years old and living with his family in Washington state in 1991 when he exposed himself to the nine-year-old daughter of a caregiver.[1] Although he had the mental capacity of a ten- to twelve-year-old child, he was charged with first-degree child molestation and served twenty-seven months in prison.[2] When his family moved to Florida in 2000, Claxton was listed as a sexual offender on the Florida Department of Law Enforcement website, but the website inaccurately indicated he had been charged with the rape of a child.[3] Claxton had not been charged with any other offense since his release from prison, but sheriff's deputies in Florida did take him into custody at least five times for threatening suicide.[4]

In 2005, brightly-colored fliers were dropped into mailboxes and pinned to trees around Claxton's neighborhood, where he lived in an apartment adjoining his parents' house.[5] A short time before, a county commissioner had urged that warning signs be posted in neighborhoods where convicted sex offenders live.[6] The fliers displayed Claxton's picture and address, downloaded from the Florida website, and the words "child rapist."

Claxton, distraught and fearing for his life, called the sheriff's office and said he wanted to kill himself.[7] He was taken for an overnight psychiatric assessment, but released the next day.[8] The following morning he was found dead, an apparent suicide, with one of the fliers lying next to him.[9]

Alan Groome was eighteen years old when he was convicted of a sex offense.[10] He was paroled after serving a number of years behind bars in the state of Washington. Upon his release, he moved in with his mother, but they were evicted from their apartment when residents learned of his past. They then moved in with his grandmother, but Groome was forced to leave when police officers knocked on the doors of 700 neighbors, handing out fliers with his address and photo.

Groome became homeless, begging for money. "I got the feeling no one cares about me, so why should I care about myself and what I do?" said Groome. One detective described Groome as "a man without a

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[1] Cara Buckley, *Town Torn Over Molester's Suicide*, MIAMI HERALD, Apr. 23, 2005, at 1; Daniel Ruth, *Who Was the Real Threat to the Town?* TAMPA TRIB., Apr. 27, 2005, at 2.

[2] Buckley, *supra* note 1, at 1.

[3] *Id.*

[4] *Id.*; Ruth, *supra* note 1, at 2.

[5] Buckley, *supra* note 1, at 1; Ruth, *supra* note 1, at 2.

[6] Buckley, *supra* note 1, at 1.

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] The quotes and facts in this paragraph are taken from Daniel Golden, *Sex-Cons*, BOSTON GLOBE, Apr. 4, 1993, at 12. This article does not address the many issues surrounding juvenile sex offenders. For a treatment of these issues, see Elizabeth Garfinkle, *Coming of Age in America: The Misapplication of Sex-Offender Registration and Community-Notification Laws to Juveniles*, 91 CAL. L. REV. 163 (2003).

country." His parole officer loaned him money because he believed Groome had "a lot of potential." A little over two years after being released from prison, Groome had not been re-arrested but was living in a homeless shelter, looking for employment.[11]

As will be discussed, the United States Supreme Court has distinguished between society's punitive and non-punitive responses to sexual offenders, granting society more discretion and affording sexual offenders few protections in conjunction with non-punitive responses. Although all agree that sexual offenses should generally result in punitive sanctions, including prison sentences, the so-called non-punitive responses to sex offenders currently employed by society are not only very punitive in nature, but they are also largely unhelpful in curbing and may even be increasing sexual offending. Sex offender registration and notification requirements, for example, place offenders in physical danger, force offenders out of their homes and cause them to lose their jobs, and create public hysteria.[12]

These requirements often bear little relation to the risk posed by the offender. The label "sex offender" can refer to anyone from a child rapist to an adult involved in a consensual, albeit incestuous, relationship with another adult. These requirements are typically insensitive to differences in motivation and intent, the nature of the offense and its impact on the victim, and the likelihood of recidivism and risk to society. Further, these regimes rarely allow sex offenders who successfully undergo treatment or who can be demonstrated to be highly unlikely to reoffend to be relieved of these requirements before at least many years have passed, if at all.

Legal and societal responses should take better account of what is currently known about sex offenders and be changed accordingly. This Article describes the characteristics of sex offenders (Part II), discusses various registration and notification requirements (Part III), explores Constitutional challenges to registration and notification laws (Part IV), addresses the civil commitment of sex offenders (Part V), analyzes the various problems with current responses to sex offenders (Part VI), reports current options for treating sex offenders (Part VII), provides various recommendations for implementing a more appropriate societal response to sex offenders (Part VIII), and offers some concluding remarks (Part IX).

II. Characteristics of Sex Offenders

"Sex offender" is a legal, not a psychological term.[13] There is no uniform definition of a sex offender. One who engages or attempts to engage in a sexual act with a minor, or who commits or attempts to commit aggravated sexual battery against a person of any age, is widely considered to be a sex offender.[14] In

[11] *Turning Point with Barbara Walters* (ABC News television broadcast Sept. 21, 1994), transcript available on LexisNexis ("Interview with Alan Groome, Transcript #131").

[12] Although this article mainly addresses three particular so-called non-punitive responses: civil commitment, registration, and community notification, there are others, including restrictions on where a sex offender can reside and work. In Virginia, for example, a person convicted of various sex offenses involving children is permanently prohibited from loitering within 100 feet of a primary, secondary, or high school or a child day program (VA. CODE § 18.2-370.2 (2006)), residing within 500 feet of any child day center, or primary, secondary, or high school (VA. CODE § 18.2-370.3 (2006)), or working or engaging in any volunteer activity on property that is part of a public or private elementary or secondary school or child day center (VA. CODE § 18.2-370.4 (2006)).

[13] Richard B. Krueger & Meg S. Kaplan, *The Paraphilic and Hypersexual Disorders: An Overview*, 7 J. PSYCHIATRIC PRAC. 391, 393 (Nov. 2001).

[14] The federal enactment establishing the Jacob Wetterling, Megan Nicole Kanka, and Pam Lychner Sex Offender Registration and Notification Program Act defines "sex offender" as "an individual who was convicted of a sex offense" and defines "sex offense" generally as a criminal offense that has an element involving a sexual act or sexual contact with another, various listed criminal offenses against a minor, or an attempt or conspiracy to commit these offenses. Adam Walsh Child Protection and Safety Act of 2006, Pub. L. No. 109-248, § 111 (2006). Many state statutes are more specific. *See, e.g.,* VA. CODE ANN. § 9.1-

many states, persons who have been convicted of possessing child pornography are also classified as sex offenders,[15] as are adults engaged in consensual incest,[16] persons who indecently expose themselves,[17] and statutory rapists (for instance, a twenty-two year old who has sex with her sixteen year-old boyfriend).[18] The legal definition of a sex offender includes a very wide range of offenders. From a psychological perspective, though, sex offenders are extremely diverse. The psychological profiles, recidivism rates, and effective treatment modalities of such offenders vary greatly. To appropriately respond to these individuals, a better understanding of these variations is needed.

For example, it is important to distinguish between paraphilic sex offenders and non-paraphilic sex offenders. Paraphilias are psychiatric disorders defined as

> recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months.[19]

To be diagnosed as having a paraphilia, depending on the type of paraphilia,[20] the person must also either have acted on the urge or there must be resulting clinically significant distress or impairment in important areas of functioning.[21] Those who develop paraphilias tend to lack social skills and suffer from depression, substance abuse, or other co-occurring psychiatric disorders.[22] Far more men than women develop paraphilias.[23]

Paraphilias need not involve illegal behavior. Transvestic fetishism, where a heterosexual male engages in cross-dressing, is not a crime. Further, not all sex offenders suffer from paraphilias. For example, many rapists commit sex offenses out of anger and desire for domination, not for sexual gratification.[24] In one study involving thirty-six convicted male sex offenders, only 58% could be diagnosed with a paraphilia.[25]

Regardless of these variations, as of 2006, there were roughly 566,700 registered sex offenders in the United States.[26] This figure,

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902 (2006); WASH. REV. CODE § 9A.44.130(9) (2006).

[15] FLA. STAT. §§ 775.21(4)(a)1b, 827.071(5) (2006); BURNS IND. CODE ANN. § 35-42-4-4(c) (2006). An Indiana appellate court left open the question of whether that state's statute could be applied to virtual child pornography. Logan v. State, 836 N.E.2d 467, 472 (Ind. Ct. App. 2005). The federal law governing sex offender registration and notification was recently expanded to include possession, production, or distribution of child pornography. Adam Walsh Child Protection and Safety Act of 2006 § 111(7)(G).

[16] LA. REV. STAT. ANN. § 14:78 (2006). The statute includes within the definition of incest an uncle and niece either marrying or having sexual intercourse with one another, regardless of how old they are. *Id.*

[17] TEX. PENAL CODE § 21.08 (2006). Under Texas law, a person can be guilty of indecent exposure even if no one else actually sees the defendant's genitals. Boyles v. State, No. 05-94-01727-CR, 1996 WL 403992, at *8 (Tex. App. July 12, 1996).

[18] N.Y. PENAL LAW § 130.25(2) (Consol. 2006).

[19] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: FOURTH EDITION, TEXT REVISION 566 (2000) [hereinafter DSM-IV-TR].

[20] The various types of paraphilia include Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, Voyeurism, and Paraphilia Not Otherwise Specified. *See id.* at 569-76.

[21] *Id.* at 566.

[22] SIMON LEVAY & SHARON M. VALENTE, HUMAN SEXUALITY 469 (2002); Krueger & Kaplan, *supra* note 13, at 399-400.

[23] THE MERCK MANUAL OF DIAGNOSIS AND THERAPY, § 15, Ch. 192 (1999-2005), *available at* http://www.merck.com/mrkshared/mmanual/section15/chapter192/192d.jsp.

[24] KAREN J. TERRY, SEXUAL OFFENSES AND OFFENDERS: THEORY, PRACTICE, AND POLICY 92 (2006).

[25] Krueger & Kaplan, *supra* note 13, at 393 (citing Susan L. McElroy et al., *Psychiatric Features of 36 Men Convicted of Sexual Offenses*, 60 J. CLINICAL PSYCHIATRY 414, 416 (1999)).

[26] National Center for Missing and Exploited Children, *Registered Sex Offenders in the United*

however, is not a reliable measure of the actual number of sex offenders, as sex offenses are extremely underreported.[27] At the same time, this number can be mistakenly read to indicate the number of current active sex offenders in this country, a conclusion that fails to take into account the effects of treatment and monitoring, and the fact that many of these offenders are relatively unlikely to reoffend.

One of the most complicated and contested issues regarding sex offenders is that of recidivism.[28] Calculating their rate of recidivism is difficult for a number of reasons. First, as noted, sex offenses are underreported.[29] Second, sex offenders may continue to re-offend for many years, and thus recidivism rates differ depending on the length of time considered.[30] Third, recidivism differs substantially depending on the type of sex offender in question.[31] For instance, sex offenders who molest a family member (i.e., those who commit incest) are less likely to re-offend than those who molest non-family members.[32] Similarly, one study found recidivism rates for rapists and child molesters to be 18.9% and 12.7%, respectively, over an average four to five year follow-up period.[33] Collapsing all sex offenders together into a single category and making generalizations about this diverse range of offenders using this aggregate determination is likely to result in substantial mischaracterizations regarding the risk of re-offending for many of these individuals.

Even though lumping the recidivism rates of all sex offenders together is unhelpful in assessing the risk posed by these offenders, it does shed light on the dubiety of popular claims about sex offender recidivism. One meta-analysis of recidivism studies of over 23,000 sex offenders found the rate of recidivism to be 13.4% on average for a four to five year follow-up period.[34] Another study, from the United States Department of Justice, found recidivism for sex offenders released from prison to be 5.3% for a three-year follow-up period.[35] In contrast, a Department of Justice report of recidivism rates for nearly 300,000 released prisoners found that 13.4% of those imprisoned for robbery were rearrested for robbery after release, and 22% of those imprisoned for assault were rearrested for assault following release, all within a three-year follow-up period.[36] Thus, while recidivism rates are difficult to measure and reported results vary, and there are numerous factors that make recidivism for a particular individual more or less likely,[37] the recidivism of sex offenders is neither inevitable[38] nor nearly as high as popularly believed.[39]

States (Mar. 6, 2006), *at* http://www.missingkids.com/en_US/documents/sex-offender-map.pdf.

[27] TERRY, *supra* note 24, at 7, 10.

[28] For a good review of the recidivism issue, including the results of many studies, see CENTER FOR SEX OFFENDER MANAGEMENT (PRINCIPAL AUTHOR TIM BYNUM), RECIDIVISM OF SEX OFFENDERS (May 2001), http://www.csom.org/pubs/recidsexof.pdf.

[29] TERRY, *supra* note 24, at 7, 10.

[30] Lucy Berliner, *Sex Offenders: Policy and Practice*, 92 Nw. U. L. Rev. 1203, 1209 (1998) (citing R. Karl Hanson et al., *Long Term Recidivism of Child Molesters*, 61 J. CONSULTING & CLINICAL PSYCHOL. 646 (1993)).

[31] *Id.*

[32] Hanson et al., *supra* note 30, at 646.

[33] R. Karl Hanson & Monique T. Bussière, *Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies*, 66 J. CONSULTING & CLINICAL PSYCHOL. 348, 351 (1998).

[34] *Id.* at 357. The meta-analysis included studies that measured recidivism in terms of re-conviction, re-arrest, and offenders' self-reports. *Id.* at 350.

[35] PATRICK A. LANGAN ET AL., RECIDIVISM OF SEX OFFENDERS RELEASED FROM PRISON IN 1994, 1 (2003), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/rsorp94.pdf.

[36] PATRICK A. LANGAN & DAVID J. LEVIN, U.S. DEP'T OF JUSTICE, RECIDIVISM OF PRISONERS RELEASED IN 1994, NCJ 193427, at 9 (2002), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/rpr94.pdf.

[37] LEVAY & VALENTE, *supra* note 22, at 467.

[38] Hanson & Bussière, *supra* note 33, at 357.

[39] ROBERT ALAN PRENTKY & ANN WOLBERT BURGESS, FORENSIC MANAGEMENT OF SEXUAL OFFENDERS 237 (2000). *See also* SARAH BROWN, TREATING SEX OFFENDERS: AN INTRODUCTION TO SEX OFFENDER TREATMENT PROGRAMS 8 (2005).

A number of studies have reported higher recidivism rates for sex offenders, most prominently the so-called "Abel study" where 561 non-incarcerated paraphiliacs reported that they had committed a total of 291,737 "paraphilic acts" against 195,407 victims.[40] The Abel study suffers from a number of serious problems. First, "paraphilic acts" are defined very broadly, including fetishism, homosexuality, sadism, and masochism.[41] These behaviors, though, are not illegal when they involve a consenting adult, and homosexuality is no longer considered a paraphilia. In fact, the Abel study hints at this confusion, at one point using the term "victim/partner."[42] Thus, it is doubtful that the high rate of recidivism is reflective of what is currently thought to be a sex offense. Second, the median values of the number of victims per paraphiliac are significantly lower than the mean (average) values, which indicate that a small percentage of paraphiliacs are responsible for a disproportionately large amount of the sex offenses.[43] Broad generalizations from a study such as this one fuel panic, but do not accurately reflect the fact that, although there are outliers who are extreme offenders, recidivism rates are low for most sex offenders.

III. Registration and Notification Laws

In 1994, Congress passed the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act.[44] While not imposing mandatory obligations on the states, the Wetterling Act was a significant milestone because it provided significant financial incentives for the states to adopt various provisions pertaining to sex offenders.[45] For example, it required sex offenders to register for at least ten years with authorities following release from prison or placement on parole, supervised release, or probation.[46] Further, state officials were expected to collect and maintain information about offenders, such as their name, home address, photograph, fingerprints, offense history, and documentation of any treatment received for mental abnormality or personality disorder.[47] In 1996, the Wetterling Act was amended to include a notification provision, known as "Megan's Law," which allows states to disclose information collected through registration for "any purpose permitted under the laws of the State."[48] Megan's Law, like many other broad sex offender laws, was enacted in the politically and emotionally charged aftermath of a brutal act against a child.[49] Currently, all fifty states have enacted some type of Megan's Law.[50]

Recently, Congress passed a new version of the Wetterling Act as part of the Adam Walsh Child Protection and Safety Act of 2006.[51] The bill expands the sex offender registration and notification requirements previously imposed on the states. First, it broadens the definition of sex offender, divides sex offenders into three tiers (tier III being the most serious) based on the severity of the crime for which the offender was convicted, and requires that all sex offender registries include the offender's name (including any

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[40] Gene G. Abel et al., *Self-Reported Sex Crimes of Nonincarcerated Paraphiliacs*, 2 J. INTERPERSONAL VIOLENCE 3, 19 (1987).

[41] *Id.* at 18.

[42] *Id.* at 17.

[43] *See id.*

[44] 42 U.S.C. 14071 (2006). As will be discussed, this law was recently amended. *See* Adam Walsh Child Protection and Safety Act of 2006, Pub. L. No. 109-248 (2006).

[45] *Id.* at (g), (i). States that do not comply face a reduction of 10% of funds allocated under § 42 U.S.C. 3751 for criminal justice projects.

[46] *Id.* at (b)(6).

[47] *Id.* at (b)(1)(A)(iv), (b)(1)(B).

[48] Pub. L. No. 104-145 (1996) (codified as 42 U.S.C. § 14071(e) (2006)).

[49] *See* Michele L. Earl-Hubbard, *Comment: The Child Sex Offender Registration Laws: The Punishment, Liberty Deprivation, and Unintended Results Associated with the Scarlet Letter Laws of the 1990s*, 90 NW. U.L. REV. 788, 813 (1996); TERRY, *supra* note 24, at 184.

[50] Doron Teichman, *Sex, Shame, and the Law: An Economic Perspective on Megan's Laws,* 42 HARV. J. LEGIS. 355, 357 (2005).

[51] Adam Walsh Child Protection and Safety Act of 2006, Pub. L. No. 109-248 (2006).

alias), physical description, current photograph, Social Security number, residential address, vehicle and license plate number, DNA sample, fingerprints, criminal offense, and criminal history; the name and address of any employer; and the name and address of any school that is being attended.[52]

Second, it requires all jurisdictions to make virtually all sex offender registry information publicly accessible via the Internet and creates a national sex offender website.[53] This generally forces states to broadly disseminate information on every registered sex offender, not just those who pose the greatest risk of re-offending.[54]

A few items cannot be posted, including the identity of any victim, the Social Security number of the sex offender, and any reference to arrests that did not result in conviction, and a few items are left to the discretion of the state, including any information about a tier I sex offender convicted of an offense other than a specified offense against a minor, the name of the employer of the sex offender, and the name of an educational institution where the sex offender is a student.[55]

Third, the bill imposes a registration and Internet notification requirement of fifteen years for a tier I sex offender (with a reduction of five years if a "clean record" is maintained), of twenty-five years for a tier II sex offender, and of life-long duration for a tier III offender.[56] A tier I offender is required to re-register in person at least once a year, a tier II offender every six months, and a tier III offender every three months.[57]

For purposes of comparison, the following are some existing examples of state registration and notification regimes. In Washington, a sex offender can be relieved of the requirement to register ten years after the offender has either been released from confinement, or, if there was no confinement, ten years from entry of judgment and sentence.[58] In Florida, the earliest a sex offender who offended as an adult can be relieved of the requirement to register is twenty years after the offender has been released from sanction, supervision, or confinement, whichever is later.[59] To be relieved of this requirement after twenty years, the offender cannot have been arrested for any felony or misdemeanor (not just a sexual or related offense) since his release,[60] and a court must grant the offender's petition for relief.[61] In Washington and Florida, even if a sex offender no longer poses a risk of re-offending, he must still register as a sex offender until at least either ten or twenty years, respectively, have passed.[62]

Registration, though, did not necessarily mean that the community would be notified about the sex offender. Under the previous Wetterling Act, states were required to notify the community of certain offenders, while notification for others remained optional.[63]

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[52] *Id.* at §§ 111, 114.

[53] *Id.* at §§ 118, 120.

[54] Some states had already begun to take this step. In Virginia, for example, the General Assembly in 2006 expanded dissemination via the Internet from individuals "convicted of murder of a minor and violent sex offenders" to individuals "convicted of an offense for which registration is required." *See* VA. CODE § 9.1-913 (2006).

[55] Adam Walsh Child Protection and Safety Act of 2006 § 118.

[56] *Id.* at § 115.

[57] *Id.* at § 116.

[58] WASH. REV. CODE § 9A.44.140(1)(c) (2006).

[59] FLA. STAT. § 943.0435(11)(a) (2006).

[60] *Id.* at 11(a).

[61] *Id.* at 11.

[62] In these states, an offender who was a physically castrated quadriplegic suffering from dementia would still have to register for this entire period of time.

[63] *See* 42 U.S.C. 14071(e)(2) (2006), which requires that states release information to the community when "necessary to protect the public concerning a specific person required to register under this section." The Department of Justice has interpreted this provision to require release of information to the community about the most dangerous offenders, but permits a state to choose not to release information regarding sex offenders it deems are not a threat to public safety. U.S.

State-sponsored Internet sites were routinely used as a means to provide this notification.[64] Many states, however, made information regarding *all* sex offenders accessible via the Internet as well.[65] The amount of information available on a particular offender varied from state to state, but all states included the offender's name, offense, physical characteristics, and age.[66] Florida's Internet sex offender database also included the offender's photograph and last known address.[67]

Some states employed risk-tiers, with offenders classified by their risk of re-offending. For example, Rhode Island law provided for three risk-tiers: low risk, moderate risk, and high risk.[68] The level of community notification, if any, depended on the offender's classification.[69] Law enforcement agents were notified of low risk offenders.[70] For moderate and high risk offenders, Internet notification was permitted.[71]

While community notification today is typically provided via the Internet, this need not be the exclusive means. Louisiana, in addition to having a searchable Internet database of sex offenders,[72] also has perhaps the strictest and most comprehensive notification requirements of any state.[73] Upon release from confinement, a sex offender must supply his name, address, crime information, and photograph to all residences and businesses within a one-mile radius in a rural area, or 3/10 mile radius in an urban area, of the offender's residence. The offender must also notify all adults also residing in his place of residence and the superintendent of the school district in which he resides of his status.[74] A court may even require the offender to wear special clothing indicating that he is a sex offender.[75]

IV. Constitutionality of Registration and Notification Laws

The Supreme Court has issued two major rulings on the constitutionality of sex offender registration and notification laws, both in 2003.

A. Procedural Due Process: *Connecticut Department of Public Safety v. Doe*[76]

In 1999, a person (referred to as John Doe) required to register as a sex offender under Connecticut law,[77] filed a federal lawsuit under 42 U.S.C. § 1983[78] against the Connecticut agencies responsible for administering the State's sex offender registry. Connecticut's law required certain classes of sex offenders to register, and provided for community notification of the presence of these offenders without regard to the registrant's degree of

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DEP'T OF JUSTICE, MEGAN'S LAW; FINAL GUIDELINES FOR THE JACOB WETTERLING CRIMES AGAINST CHILDREN AND SEXUALLY VIOLENT OFFENDER REGISTRATION ACT, AS AMENDED, No. RIN 1105-AA56, 582 (1997).

[64] Of the fifty states, only Rhode Island provides no information about sex offenders on an Internet site. *See* http://www.klaaskids.org/pg-legmeg.htm (last visited July 17, 2006).

[65] For example, Florida provides a searchable Internet database generally listing all convicted sex offenders available at http://www3.fdle.state.fl.us/sexual_predators/ (last visited July 17, 2006).

[66] Teichman, *supra* 50, at 381.

[67] *See* http://www3.fdle.state.fl.us/sexual_predators/search.asp?sopu=true&PSessionId=819208581& (last visited July 18, 2006).

[68] R.I. GEN. LAWS § 11-37.1-12 (2006).

[69] *Id.*

[70] *Id.* at (b).

[71] *Id.*

[72] *See* http://lasocpr1.lsp.org/ (last visited July 18, 2006).

[73] *See* LA. REV. STAT. ANN. § 15:542 (2006).

[74] *Id.* at § 15:542(B)(1)(a)-(c).

[75] *Id.* at § 15:542(B)(3) ("Give any other notice deemed appropriate by the court in which the defendant was convicted of the offense . . . including but not limited to signs, handbills, bumper stickers, or clothing labeled to that effect.").

[76] 538 U.S. 1 (2003).

[77] CONN. GEN. STAT. § 54-250-261 (2001).

[78] This section allows a person to sue, in federal court, for a state's violation of his or her civil rights.

dangerousness to the community.[79] Instead, the registration requirement was linked to whether they had been convicted of certain specified sex offenses.[80]

Doe asserted that this registration requirement harmed his reputation and altered his status under state law. Doe alleged, *inter alia*, that the failure to provide him with a pre-registration hearing to determine if he was dangerous violated his procedural due process rights under the Fourteenth Amendment because he was deprived of his liberty interests without a hearing.

The Supreme Court found no violation of procedural due process.[81] The Court reasoned that procedural due process only requires a hearing on the existence of a particular fact (or facts) when such fact is relevant under a state statute.[82] Here, as the statute did not claim that the list was comprised of dangerous sex offenders, but instead merely claimed to be a list of sex offenders regardless of level of danger, Doe was not entitled to a hearing to determine his dangerousness.

In *dicta*, the Court noted that one could still challenge the State's law on substantive due process grounds, an issue not brought up nor addressed in the case.[83]

[79] *Connecticut Department of Public Safety v. Doe*, 538 U.S. at 4-5, 7.
[80] CONN. GEN. STAT. § 54-258a (2001).
[81] *Connecticut Department of Public Safety v. Doe*, 538 U.S. at 1.
[82] *Id.* at 7.
[83] *Id.* at 8. A substantive due process claim asserts that the claimant has a fundamental right to some constitutionally-protected interest that is being infringed by the law/action in question, and that the government has to justify abridging that fundamental right. If a fundamental right is implicated, a court strictly scrutinizes the law/action, and a very strong justification is required to overcome a presumption of unconstitutionality. Less strict standards of review are applicable to abridgments of quasi- or non-fundamental rights. *See* Gunderson v. Hvass, 339 F.3d 639, 643-44 (8th Cir. 2003).

B. Ex Post Facto: *Smith v. Doe*[84]

The Ex Post Facto Clause of the Constitution[85] prohibits the government from imposing punishment for an act that was not a crime at the time it was committed, and from imposing more punishment for an offense than was prescribed by law at the time the crime was committed.[86]

In 1994, Alaska passed its Sex Offender Registration Act (SORA).[87] SORA contains a registration requirement and provides for community notification.[88] Alaska makes much of the information it gathers available on the Internet.[89] Of primary relevance to this lawsuit, however, was that SORA was made retroactive, thereby encompassing sex offenders who committed their crimes before SORA was enacted.[90] Respondents John Doe I and John Doe II, both convicted of sex offenses before passage of SORA and then, after the passage of SORA, required to register under it, brought an action under 42 U.S.C. § 1983 challenging SORA as it applied to them as a violation of the Ex Post Facto Clause. The Supreme Court found no violation of the Ex Post Facto Clause.[91]

The primary question as far as the Court was concerned was whether SORA imposed additional punishment after the fact (i.e., after the crime was committed). The Court determined that if the legislature intended to impose punishment through its legislation, then its retroactive application was indeed a violation of the Ex Post Facto Clause.[92] If the legislature intended to enact a civil (non-punitive) regulatory scheme through its

[84] 538 U.S. 84 (2003).
[85] U.S. CONST. art. I, § 9, cl 3.
[86] Cummings v. Missouri, 71 U.S. 277, 325-26 (1867).
[87] *See* 1994 Alaska Sess. Laws page no. 41 (codified at ALASKA STAT. §§ 12.63, 18.65.087 (1994)).
[88] *See id.*
[89] *Smith v. Doe*, 538 U.S. at 91.
[90] 1994 Alaska Sess. Laws page no. 41, § 12.
[91] *Smith v. Doe*, 538 U.S. at 84.
[92] *Id.* at 92.

legislation, however, there was an Ex Post Facto violation only if the statutory scheme was so punitive in its effect as to negate the legislature's stated intent.[93] The Court stated that it was required to be deferential to the legislature's stated intent,[94] requiring the "clearest proof" of punitiveness to overcome a presumption that the legislature had accurately depicted the nature of its legislation.[95]

In the case before it, the Court noted that the Alaska legislature had stated that its intent in enacting SORA was to protect public safety.[96] As a result, the Court found that the stated intent of the legislature was not to impose punishment on sex offenders with the registration requirement.[97] The Court then proceeded to determine whether the legislation had sufficient punitive effect to undercut this characterization.

The Court discussed five of seven factors previously established,[98] which, while not "exhaustive or dispositive,"[99] provided "useful guideposts" in determining if a law is sufficiently punitive in effect to overcome the stated intent of the legislation.[100] The factors were whether the regulatory scheme: (1) has been historically/traditionally regarded as punishment, (2) serves the traditional aims of punishment, (3) imposes an affirmative restraint or disability on the offender, (4) has an alternative (non-punitive) purpose to which it may be rationally connected, and (5) is excessive in relation to the alternative purpose.[101]

Under this analysis, the Court found no punitive effect sufficient to overcome the legislature's stated intent.[102] First, while SORA might resemble colonial shaming punishments—in which the offender was held up before others, forced to confront them face-to-face, and sometimes expelled from the community—SORA was substantively different, as public shaming often involved corporal punishment and, even when it did not, involved more than mere dissemination of information.[103] Second, the Court found that SORA imposed no physical restraint on the offender, nor did it restrain the activities sex offenders may pursue, such as employment.[104] Third, while the statute might deter crimes, the mere presence of a deterrent effect did not render legislation criminal.[105] Fourth, SORA was determined to have a legitimate, non-punitive purpose, namely, that of promoting and ensuring public safety, and its execution was rationally connected to this purpose.[106] Fifth, SORA was not considered to exceed its non-punitive purpose, even though it was potentially over-inclusive by failing to mandate individual determinations of dangerousness, because Alaska could rationally conclude that a conviction for a sex offense provided evidence of a substantial risk of recidivism.[107]

C. Other Potential Constitutional Challenges

By casting Megan's Law statutes as non-punitive (i.e., they do not impose punishment on sex offenders), the Court has also precluded a constitutional challenge based on an Eighth Amendment "cruel and unusual

[93] *Id.* at 92 (citing United States v. Ward, 448 U.S. 242, 248-49 (1980)).
[94] *Id.* at 92 (citing Kansas v. Hendricks, 521 U.S. 346, 361 (1997)).
[95] *Id.* at 92 (quoting Hudson v. United States, 522 U.S. 93, 100, 139 (1997) (quoting Ward, 448 U.S. at 249)).
[96] *Id.* at 93.
[97] *Id.* at 96.
[98] Kennedy v. Mendoza-Martinez, 372 U.S. 144, 168-69 (1963).
[99] *Smith v. Doe*, 538 U.S. at 96 (quoting Ward, 448 U.S. at 249).
[100] *Id.* at 96 (quoting Hudson, 522 U.S. at 99).
[101] *Mendoza-Martinez*, 372 U.S. at 168-69.
[102] *Doe*, 538 U.S. at 105.
[103] *Id.* at 98.
[104] *Id.* at 100.
[105] *Id.* at 102 (citing Hudson, 522 U.S. at 105).
[106] *Id.* at 102-03.
[107] *Id.* at 104.

punishment" theory.[108] In addition, although the Supreme Court has yet to address these issues, federal courts of appeals have generally rejected attacks against registration and notification statutes based on purported violations of substantive due process,[109] privacy,[110] and equal protection.[111] In light of the Court's unwillingness to strike down sex offender registration and notification laws in the two cases it considered, sex offenders would likely face an uphill battle pursuing these other challenges before the Supreme Court.

V. Civil Commitment

Another means widely thought to limit the danger posed by sex offenders is to impose on them civil commitment through "sexually violent predator" (SVP) laws.[112] Under this approach, sex offenders are confined to a treatment facility, typically following the completion of their prison term, based on a finding that "because of a mental abnormality or personality disorder, [the person] finds it difficult to control his predatory behavior, which makes him likely to engage in sexually violent acts."[113] "Mental abnormality" or "personality disorder" is frequently defined to mean "a congenital or acquired condition that affects a person's emotional or volitional capacity and renders the person so likely to commit sexually violent offenses that he constitutes a menace to the health and safety of others."[114] This approach employs the civil, rather than the criminal, process and allows a person to be involuntarily hospitalized if, following a hearing, that person is found to pose a risk of self-harm or harm to others.[115] This approach permits the state to confine the person until he or she no longer poses a danger to society.[116]

In *Kansas v. Hendricks*, the United States Supreme Court upheld a Kansas statute that allowed the involuntary civil commitment of a sex offender who, due to a "mental abnormality or personality disorder," is likely to engage in "predatory acts of sexual violence."[117] In *Hendricks*, the respondent was a convicted sex offender whose pedophilia was considered to constitute the requisite "mental abnormality."[118]

Five years later, the Court issued a second ruling that clarified that *Hendricks* does not require that the state prove that sex offenders are completely incapable of controlling themselves before the state may commit them.[119] In *Kansas v. Crane*, the Court established that the state is only required to prove that it would be "difficult" for the person to control his or her dangerous behavior as a predicate to civil commitment.[120]

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[108] *See id.* at 102-03.

[109] Gunderson v. Hvass, 339 F.3d 639, 643-44 (8th Cir. 2003), *cert. denied* 540 U.S. 1124 (2003) (holding that no fundamental right is implicated by such a statute, and that the statute is rationally related to a legitimate government purpose). *See also In re* W.M., 851 A.2d 431, 450 (D.C. Cir. 2004), *cert. denied* 125 S. Ct. 885 (2005) (holding that Alaska's SORA statute does not implicate a fundamental right).

[110] A.A. v. New Jersey, 341 F.3d 206 (3d Cir. 2003) (stating that any privacy right of a sex offender is outweighed by the state's compelling interest in protecting public safety (citing Paul P. v. Farmer, 227 F.3d 98, 107 (3d Cir. 2000))).

[111] Doe v. Moore, 410 F.3d 1337, 1346-49 (11th Cir. 2005), *cert. denied*, 126 S. Ct. 624 (2005) (finding no equal protection violation).

[112] *See* JOHN Q. LA FOND, PREVENTING SEXUAL VIOLENCE: HOW SOCIETY SHOULD COPE WITH SEX OFFENDERS 128 (2005).

[113] VA. CODE ANN. § 37.2-900 (2006).

[114] *Id.*

[115] ANDREW J. HARRIS, CIVIL COMMITMENT OF SEXUAL PREDATORS: A STUDY IN POLICY IMPLEMENTATION xiii (2005); John Kirwin, *One Arrow in the Quiver--Using Civil Commitment as One Component of a State's Response to Sexual Violence*, 29 WM. MITCHELL L. REV. 1135, 1137 (2003).

[116] *See, e.g.*, FLA. STAT. § 394.917(2) (2005).

[117] Kansas v. Hendricks, 521 U.S. 346, 350 (1997) (quoting KAN. STAT. ANN. § 59-29a01 (1994)). The phrase "predatory acts of sexual violence" has since been replaced with "repeat acts of sexual violence." KAN. STAT. ANN. § 59-29a01 (2005).

[118] *Kansas v. Hendricks*, 521 U.S. at 360.

[119] Kansas v. Crane, 534 U.S. 407, 411 (2002).

[120] *Id.* at 411.

As of 2006, nineteen states had civil commitment statutes for certain sex offenders.[121] After an initial rapid proliferation of such laws, enthusiasm for additional enactments has waned. In the decade of the 1990s, fifteen state programs were passed; since 2000, only four states have enacted such programs. Reasons for this vary, but prohibitive cost, lack of ability to control costs, better alternative uses of funds and resources, lack of release back into the community resulting in an ever increasing number of individuals committed, and lack of demonstrated efficacy are all cited.[122] As of December 2004, 3,943 people had been confined under these laws, with only 427 of them having been conditionally released (most of them) or discharged.[123]

Civil commitment is arguably the most draconian of the so-called non-punitive sex offender legislation in that it confines, for an indeterminate and potentially life-long period of time, offenders who have already served their criminal sentences. It confines these offenders essentially because of crimes they might commit in the future. Civil commitment should be used as a last resort and only for offenders whose dangerousness has been established on a case-by-case basis.

VI. Problems with the Current Responses to Sexual Offending

Current sex offender legislation regarding community notification in particular needs to be more focused. The broad range of offenders encompassed by these laws detracts attention and resources away from those offenders that need the greatest attention, monitoring, and supervision, namely, offenders who pose the highest risk of recidivism. As discussed, individuals who commit incest or statutory rape, or who possess child pornography, are often considered to be sex offenders for purposes of community notification. While the putative reason for sex offender legislation is a regulatory one–protecting citizens[124]–notification regimes are not risk-discriminating. For instance, adult relatives who engage in consensual sexual intercourse with one another pose little, if any, risk to the community, yet they can be subject to registration and notification requirements. This broad scope needlessly scares community members by overstating the presence of what are perceived to be dangerous offenders, places burdens on offenders who pose little or no risk of harming anyone, and drains financial, law enforcement, and administrative resources.

Notification also makes it difficult for offenders to obtain housing and employment. In a study involving thirty convicted sex offenders subjected to community notification, 83% reported that they had been excluded from a residence and 57% reported that they had lost employment as a result of their status as sex offenders.[125] In another study, 300 employers were surveyed as to whether they would hire ex-convicts, including offenders who had committed sexual crimes against children or sexual assault against adults.[126] The overwhelming majority of employers surveyed stated that they would not hire the sex offenders.[127] Job stability, however, significantly reduces the likelihood that a sex

[121] Susan Broderick, *Innovative Legislative Strategies for Dealing with Sexual Offenders*, 18(10) AMERICAN PROSECUTORS RESEARCH INSTITUTE UPDATE 1 (2006), http://www.ndaa-apri.org/publications/newsletters/update_vol_18_number_10_2006.pdf.

[122] John Q. La Fond & Bruce J. Winick, *Doing More Than Their Time* (op-ed), N.Y. TIMES, May 21, 2006, at sec. 14, p. 13.

[123] *Id.*

[124] *See, e.g.*, N.Y. CORRECT. LAW Art. 6-C Note (2005).

[125] Richard G. Zevitz & Mary Ann Farkas, *Sex Offender Community Notification: Managing High Risk Criminals or Exacting Further Vengeance?* 18 BEHAV. SCI. & L. 375, 383 (2000).

[126] Shelley Albright & Furjen Denq, *Employer Attitudes Toward Hiring Ex-Offenders*, 76(2) PRISON J. 118, 124-25 (1996).

[127] *Id.* at 129-31.

offender will re-offend,[128] making notification counterproductive in this respect.

Given that landlords are reluctant to house sex offenders, not surprisingly many are homeless.[129] Ironically, this makes monitoring them more difficult. In addition, with sex offenders forced to move from place to place, even state to state, it becomes harder for offenders to maintain needed ongoing relationships with mental health professionals and family members, friends, or community members and organizations that can provide support services, which in turn may enhance the likelihood of recidivism.[130]

Vigilantism has also been associated with community notification laws. When communities are notified about the presence of a sex offender, some community members may harass, intimidate, or even violently attack the offenders. In one instance, a teenage offender received death threats and found his dog decapitated on his step.[131] In another instance, arsonists burned down the home where a released sex offender was supposed to live.[132] One study found that amongst 942 sex offenders in Washington state subject to community notification, there were thirty-three reported incidents of harassment of some form against the offender or his family.[133] While this number may seem low, one must keep in mind that such incidents may be underreported, as offenders may not want to call further attention to themselves or their families, and that even the possibility of such vigilantism can cause significant worry amongst offenders and their families and hamper treatment efforts.

Another common result of notification is isolation. Social ostracism that the sex offender experiences may push him farther from integrating with society, decrease social skills, and make re-offense more likely.[134]

While community notification increases public anxiety,[135] an article published in October 2005 noted that in the ten years that such laws have been in place, there has not been a single study that has shown reduced recidivism of sexual violence attributable to notification.[136] In December of that same year, a report from the Washington Institute of Public Policy did find that sex offenses had decreased in the years since Washington's passage of sex offender legislation that

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[128] Candace Kruttschnitt et al., *Predictors of Desistance among Sex Offenders: The Interaction of Formal and Informal Social Controls*, 17 JUST. Q. 61, 80 (2000).

[129] *See, e.g.*, Monica Davey, *Iowa's Residency Rules Drives Sex Offenders Underground*, N.Y. TIMES, Mar. 15, 2006, at A1.

[130] Further exacerbating this dislocation, a number of communities and states prohibit convicted sex offenders from living within a certain distance of designated locations such as schools or child-care centers. *See, e.g.*, IOWA CODE § 692A.2A (2005). These restrictions have had the effect of virtually excluding convicted sex offenders from urban areas, as well as preventing them from living with family members. Davey, *supra* note 129. Interestingly, the Iowa County Attorney's Association, an organization of Iowa prosecutors, has criticized such legislation as being counterproductive, asserting that it causes homelessness and is too broad, and that no research shows that such a restriction reduces sex offenses. IOWA COUNTY ATTORNEYS ASSOCIATION, STATEMENT ON SEX OFFENDER RESIDENCY RESTRICTIONS IN IOWA (Jan. 2006), http://spd.iowa.gov/filemgmt_data/files/SexOffender.pdf.

[131] Jan Hoffman, *New Law Is Urged on Freed Sex Offenders*, N.Y. TIMES, Aug. 4, 1994, at B1.

[132] Joshua Wolf Shenk, *Do 'Megan's Laws' Make a Difference?* U.S. NEWS & WORLD REP., Mar. 9, 1998, at 27.

[133] SCOTT MATSON & ROXANNE LIEB, WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY, COMMUNITY NOTIFICATION IN WASHINGTON STATE: 1996 SURVEY OF LAW ENFORCEMENT, Executive Summary, Doc. No. 96-11-1101 (Nov. 1996), *available at* http://www.wsipp.wa.gov/rptfiles/sle.pdf.

[134] TERRY, *supra* note 24, at 196.

[135] Mary Bolding, *California's Registration and Community Notification Statute: Does It Protect the Public from Convicted Sex Offenders?*, 25 W. ST. U.L. REV. 81, 81 (1997).

[136] EXECUTIVE BOARD OF DIRECTORS, ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS, THE REGISTRATION AND COMMUNITY NOTIFICATION OF ADULT SEXUAL OFFENDERS (Oct. 5, 2005), http://www.atsa.com/ppnotify.html.

contained registration and notification provisions.[137]

There are a number of problems with drawing conclusions from this decrease, however. First, as the report acknowledges, Washington has increased the length of incarceration for sex offenders during this period.[138] If offenders are incarcerated for longer periods of time, they have less opportunity to offend. Thus, the decrease in recidivism could be attributable to increased length of incarceration. Second, even if one ignores the incarceration issue, the notification regime in Washington is risk-discriminating in that it provides for community notification only for moderate and high risk offenders,[139] thus obviating some, but not all, of the inefficiencies and counterproductive components of notification regimes. Those notification regimes that are not risk-discriminating and that are not accompanied by treatment, employment, and housing for offenders are unjust and inefficient. Third, it is notable that with fifty states having enacted community notification laws, this is the only study that we have located that suggests some effect in terms of reducing recidivism. Clearly, more research on the impact of these laws is needed.

Civil commitment as a mechanism for responding to sexual offenders also carries a heavy price. First, a general right to be free from physical restraint and various liberty interests are afforded by the Constitution.[140] There are of course situations where these important guarantees can be tempered, but such restrictions should be limited.[141] Second, civil commitment is very expensive. The cost of housing and treating a civilly committed person for one year in Washington is $138,000.[142] Overall, the cost of operating special facilities for the commitment of sex offenders at the national level is estimated to be $224 million per year.[143] Thus, if there are cheaper or less restrictive ways to achieve the goals of civil commitment, namely, protect public safety and promote rehabilitation, they should be pursued.

VII. Treatment Options

While there is no known cure for inappropriate sexual thoughts and behavior,[144] there are treatments that can significantly reduce their strength and occurrence. Treatments include non-biological therapies such as cognitive behavioral therapy, and biological therapies such as surgical castration and pharmacological (drug) therapy.

Among the non-biological treatments for sex offenders, cognitive-behavioral therapy is the most common.[145] During cognitive-behavioral therapy, offenders may obtain social skills training, sex education, cognitive restructuring, aversive conditioning, and victim empathy therapy.[146]

Social skills training attempts to provide the offender with social competency, so that the individual may pursue appropriate social interactions; sex education informs the offender of the risks and practice of sexual

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[137] ROBERT BARNOSKI, WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY, SEX OFFENDER SENTENCING IN WASHINGTON STATE: HAS COMMUNITY NOTIFICATION REDUCED RECIDIVISM? Doc. No. 05-12-1202 (Dec. 2005), http://www.wsipp.wa.gov/rptfiles/05-12-1202.pdf.

[138] *Id.*

[139] WASH. REV. CODE § 4.24.550 (2006).

[140] *See Kansas v. Hendricks*, 521 U.S. at 356.

[141] *Id.*

[142] TERRY, *supra* note 24, at 211.

[143] ROXANNE LIEB & KATHY GOOKIN, WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY, INVOLUNTARY COMMITMENT OF SEXUALLY VIOLENT PREDATORS: COMPARING STATE LAWS, Doc. No. 05-03-1101 (2005), *available at* http://www.wsipp.wa.gov/rptfiles/05-03-1101.pdf. On the other hand, the average cost per year of housing an inmate in state prison is $22,650. JAMES STEPHAN, U.S. DEP'T OF JUSTICE, STATE PRISON EXPENDITURES, 2001, SPECIAL REPORT, NCJ 202949 (June 2004), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf.

[144] TERRY, *supra* note 24, at 139.

[145] *Id.* at 154.

[146] Richard B. Krueger & Meg S. Kaplan, *Behavioral and Psychological Treatment of the Paraphilic and Hypersexual Disorders*, 8 J. PSYCHIATRIC PRAC. 24-25 (2002).

behavior; cognitive restructuring helps the offender avoid cognitive distortions that may have provided the offender with a justification for his behavior; aversive conditioning pairs painful, annoying, or unpleasant experiences, such as a bad smell, with an offender's inappropriate sexual fantasy; and victim empathy therapy helps offenders understand the harm they have caused to the victim and that the victim is also a person with feelings.[147] Offenders may also undergo relapse prevention therapy, a type of cognitive-behavioral therapy, where they learn how to identify problematic thoughts and behaviors and stop their progression.[148]

Cognitive behavioral therapy, while often successful in reducing recidivism amongst sex offenders,[149] does not always work, either completely or at all.[150] Thus, it is very important for a mental health professional to determine when cognitive-behavioral therapy is appropriate, and to monitor its effectiveness.

Surgical castration[151] involves removal of the testes, which has the effect of significantly reducing circulating testosterone.[152] While surgical castration does decrease sex drive,[153] it does not always do so completely.[154]

Further, many view surgical castration, which they associate with the eugenics movement that sought to sterilize those with undesirable traits thought to be hereditary,[155] with fear and skepticism. Additionally, the reduction of sex drive achieved through surgical castration can be overcome with the use of exogenous androgens, such as testosterone,[156] which may be obtained surreptitiously. Nevertheless, some authorities believe that surgical castration may become more common, as it has achieved the lowest recidivism rate of any treatment.[157]

Pharmacological therapy,[158] however, is a viable option for many, particularly those with paraphilias. One of the most noteworthy studies on pharmacological therapy for sex offenders tested the efficacy of triptorelin, a drug that reduces male testosterone levels, in decreasing the deviant sexual desire and behavior of thirty men.[159] All of the men suffered from paraphilias, with twenty-five of them suffering specifically from pedophilia.[160] Before triptorelin use, the men reported an average of forty-eight deviant sexual fantasies per week (with a standard deviation of ten) and five incidents of abnormal sexual behavior per month (with a standard deviation of two).[161]

During treatment, which involved monthly intramuscular injections of triptorelin,

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[147] *Id.*

[148] THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS, REDUCING SEXUAL ABUSE THROUGH REATMENT AND INTERVENTION WITH ABUSERS (1996), http://www.atsa.com/pptreatment.html [hereinafter ATSA].

[149] Polizzi et al., *What Works in Adult Sex-Offender Treatment? A Review of Prison- and Non-Prison Based Treatment Programs*, 43 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 357, 371 (1999).

[150] See ATSA, *supra* note 148.

[151] Surgical castration is also referred to as physical castration or orcheictomy.

[152] Kurt Freund, *Therapeutic Sex Drive Reduction*, 62 (Supp. 287) ACTA PSYCHIATRICA SCANDINAVICA 5, 15 (1980). For an updated review of surgical castration, see Richard B. Krueger et al., Orchiectomy (in preparation).

[153] Richard Wille & Klaus M. Beier, *Castration in Germany*, 2 ANNALS SEX RESEARCH 103, 129 (1989).

[154] TERRY, *supra* note 24, at 154.

[155] *See* Charles Scott & Trent Holmberg, *Castration of Sex Offenders: Prisoners' Rights Versus Public Safety*, 31 J. AM. ACAD. PSYCHIATRY L. 502, 502 (2003).

[156] J. Michael Bailey & Aaron S. Greenberg, *The Science and Ethics of Castration: Lessons from the Morse Case*, 92 NW. U.L. REV. 1225, 1235 (1998).

[157] Ariel Rosler & Eliezer Witztum, *Pharmacotherapy of Paraphilias in the Next Millennium*, 18 BEHAV. SCI. & L. 43, 44 (2000).

[158] Pharmacological therapy is also referred to as drug therapy or chemical castration.

[159] Ariel Rosler & Eliezer Witztum, *Treatment of Men with Paraphilia with a Long-Acting Analogue of Gonadotropin-Releasing Hormone*, 338 NEW ENG. J. MED. 416 (1998).

[160] *Id.* at 417.

[161] *Id.* The study did not include a control group "because the men might have continued to offend while receiving a placebo." *Id.*

supplemented with regular supportive psychotherapy (one to four sessions a month), all of the men had a prompt reduction in paraphilic activities, with the maximal reduction in the intensity of their sexual desire and symptoms occurring after three to ten months with the exception of one man in whom it was achieved after two years.[162] All of the men reported that their sexual desire decreased considerably, that their sexual behavior became easily controllable, that their deviant sexual fantasies and urges disappeared completely, and that there were no incidents of abnormal sexual behavior during therapy.[163] Once the maximal effects of treatment were achieved, there were no sexual offenses reported by the men, by their relatives, or by a probation officer.[164] Symptoms returned among those men who stopped treatment, including three who reported intolerable side effects. Further, for three of these men who were subsequently given an alternative medication (cyproterone acetate), two were subsequently prosecuted and received prison sentences for sex crimes.[165] Case studies of another testosterone-reducing drug, leuprolide acetate (brand name Lupron), reported successful results similar to those of triptorelin.[166]

Currently, medroxyprogesterone acetate (MPA)[167] is the drug most commonly used to reduce serum testosterone levels.[168] MPA is given by injection and need only be administered once every three months.[169] Each injection costs about $30 to $75.[170] Gonadotropin releasing hormone agonists, such as depot-leuprolide acetate, though, are gaining a foothold[171] because they have fewer adverse side-effects[172] and are considered more effective[173] than MPA. Although leuprolide acetate is significantly more expensive than MPA,[174] considering its treatment potential, it may well be worth the cost.

Pharmacological therapies are generally given to those with paraphilias, as they have stronger and more intense deviant sexual desires than other sex offenders.[175] As noted, however, pharmacological therapies may induce unpleasant or harmful side effects or

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[162] *Id.* at 418.
[163] *Id.*
[164] *Id.* at 418-19.
[165] *Id.* 419.
[166] Richard B. Krueger & Meg S. Kaplan, *Depot-Leuprolide Acetate for Treatment of Paraphilias: A Report of Twelve Cases*, 30(4) ARCHIVES SEXUAL BEHAV. 409 (2001). *See also* Peer Briken et al., *Treatment of Paraphilia with Luteinizing Hormone-Releasing Hormone Agonists*, 27 J. SEX & MARITAL THERAPY 45, 52 (2001); Richard B. Krueger & Meg S. Kaplan, *Chemical Castration: Treatment for Pedophilia*, *in* 2 DSM-IV-TR CASEBOOK 309, 309 (Michael B. First et al. eds., 2006).
[167] Available under the brand name Depo-Provera.
[168] TERRY, *supra* note 24, at 153.
[169] MPA can also be given orally. Luk Gijs & Louis Gooren, *Hormonal and Psychopharmalogical Interventions in the Treatment of Paraphilias: An Update*, 33(4) J. SEX RESEARCH 273, 275 (1996).
[170] JENNIFER JOHNSEN, PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., IS THE SHOT RIGHT FOR YOU? (2006), http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/birthcontrol/pub-depo-provera.xml.
[171] Fabian M. Saleh & Laurie L. Guidry, *Psychosocial and Biological Treatment Considerations for the Paraphilic and Nonparaphilic Sex Offender*, 31 J. AM. ACAD. PSYCHIATRY & L. 486, 490 (2003).
[172] Krueger & Kaplan, *supra* note 166, at 418 (citing Smith et al., *Clinical Effects of Gonadotrophin-releasing Hormone Analogue in Metastatic Carcinoma of Prostate*, 25 UROLOGY 106 (1985)). Side effects of MPA include hyperglycemia, nightmares, weight gain, and lethargy. Rosler & Witztum, *supra* note 159, at 420. Side effects of leuprolide acetate include hot flashes and decreases in bone density, which can be countered by administering, among other things, alendronate, vitamin D, and calcium. *Id.* at 419-20; Richard B. Krueger et al., *Prescription of Medroxyprogesterone Acetate to a Patient with Pedophilia, Resulting in Cushing's Syndrome and Adrenal Insufficiency*, SEXUAL ABUSE: J. RES. & TREATMENT (forthcoming 2006).
[173] *Id.* at 420-21.
[174] Although costs vary, the cost of one four-month dose has been set at $2,660. WALGREENS, LUPRON DEPOT 30MG INJ, http://www.walgreens.com/library/finddrug/druginfo1.jsp?particularDrug=Lupron&id=15887) (last visited July 19, 2006).
[175] TERRY, *supra* note 24, at 153.

for other reasons may be resisted by sex offenders. While the testosterone-reducing effects of drugs like MPA and leuprolide acetate may be overcome by taking exogenous androgens, standard laboratory analyses of blood and urine can be used to test for the presence of such androgens.[176] It is also important to note that pharmacological therapies need not be life-long; these therapies may be employed for short-term treatment that allows offenders to obtain some measure of control over their sexual impulses and enables other forms of treatment, such as behavioral therapy, to become effective.[177]

However, pharmacological therapies have their limits. For instance, drugs that reduce testosterone levels, like leuprolide acetate and MPA, may not have any effect on nonsexual violence.[178] Thus, for offenders without paraphilias or whose primary problems are non-sexual, or for offenders with paraphilias and nonsexual violence problems, behavioral therapies, either alone or in conjunction with pharmacological therapies, are necessary.

VIII. Recommendations

Before better means to reduce the occurrence of sexual offenses can be established, the potent obstacle of the political process must be recognized. In a representative democracy, elected legislators are responsible to and dependent upon the support of their constituents. Considering the significant inaccuracies in, and overall frenetic nature of, popularly held beliefs and attitudes regarding sex offenders, it is not surprising that legislators often feel they must adopt measures driven by fear rather than sound science or public policy.

In this vein, a Police Chief in Des Moines, Iowa, arguing for the repeal of an Iowa law placing residency restrictions on certain sex offenders that increased their homelessness and subsequently decreased the ability to monitor their whereabouts, worried that state legislators would not re-work the counterproductive statute out of political cowardice.[179] This fear needs to be overcome and the following recommendations implemented.

(1) Current medical practice has embraced "evidence-based medicine," which is "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[180] This approach integrates "individual clinical expertise with the best available external clinical evidence [drawn] from systematic research."[181] There is a similar need for "evidence-based legislation." Although recidivism rates are frequently bandied about in the course of legislative debates over proposed sex offender legislation, there is a need for more accurate and precise information on risk and treatment that will enable more appropriate decisions to be made. In general, educational and training programs regarding sex offenders should be made available to legislators and their staff to inform their decision-making.

(2) Sex offender legislation should be preceded by careful study and a projected cost-benefit analysis, rather than rely on speculation and public fears. In addition, any legislation that is enacted should always include a provision mandating and funding a cost-benefit analysis of the legislation and its effects. Building "sunset" provisions into this

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[176] *See* Bailey & Greenberg, *supra* note 156, at 1236. For instance, anabolic steroids such as testosterone cypionate, which may help increase sex-drive, are easily detectible, even months after use. Lorenz C. Hofbauer & Armin E. Heufelder, *Endocrine Implications of Human Immunodeficiency Virus Infection*, 75 MED. 262, 271 (1996); Morris B. Mellion, *Anabolic Steroids in Athletics*, 30 AM. FAM. PHYSICIAN 113, 118 (1984).
[177] Krueger & Kaplan, *supra* note 166, at 419.
[178] *Id.*
[179] Lee Rood, *New Data Shows Twice as Many Sex Offenders Missing*, DES MOINES REG. & TRIB., Jan. 23, 2006, at 1A.
[180] David L. Sackett et al., *Evidence Based Medicine: What It Is and What It Isn't*, 312 BRITISH MED. J. 71, 71 (1996).
[181] *Id.*

legislation can provide an opportunity for a systematic review of the cost-benefit analysis and the impact of the legislation, and can be considered in determining whether to modify the legislation.[182]

(3) Sexual offending is a complex behavior and understanding and redressing it is a difficult challenge. Accordingly, proposals to reduce this criminal behavior should be carefully considered and studied. To promote this effort, multidisciplinary commissions should be formed with governmental support and charged to fully evaluate the effects and integration of sex offender-related legislation. These commissions should include mental health professionals, lawyers, criminologists, judges, and legislators. Such commissions should address sex abuse as both a criminal justice and a public health problem. The Centers for Disease Control and Prevention and the World Health Assembly (the decision-making body for the World Health Organization) have declared violence to be a public health priority, and The Association for the Treatment of Sexual Abusers has suggested that this framework be extended to sexual violence.[183] The public health model is used to complement the criminal justice approach and strives to prevent the occurrence of crimes through the identification of risk factors and the development of interventions to address these factors.[184] A public health approach can develop not only appropriate post-offense responses, but also generate broader, more systematic, long-term changes that can help prevent the occurrence of sexual abuse and the development of sex offenders.

(4) Risk level classifications should be incorporated into society's responses to sex offenders, particularly with regard to their community notification systems, and a graduated response employed that limits the use of the most "punitive" mechanisms to those offenders that have been shown to pose the greatest risk. This would enable offenders who pose minimal risk and are unlikely to re-offend to reintegrate into society, as well as motivate all offenders to seek and comply with needed treatment programs to obtain this level of classification. Mental health professionals can now identify factors that are related to recidivism and, using sophisticated, empirically-validated instruments, accurately assess the likelihood of future risk.[185] These instruments should be used, for example, to determine what level of community notification is employed for various categories of sex offenders. Community notification should be tailored to the risk these offenders present.

(5) Legislative responses to sex offending should incorporate incentives that reward offenders who undergo, comply with, and maintain treatment, such as relieving these offenders of some of the obligations and hardships they would otherwise face. As noted, the strictest measures should be

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[182] A "sunset" provision provides that the legislation, unless renewed, will expire after a specified period of time or upon a given date.

[183] *See, e.g.,* THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS, SEXUAL ABUSE AS A PUBLIC HEALTH PROBLEM (2001), http://www.atsa.com/pppublichealth.html.

[184] *Id.*

[185] While there are a number of instruments used to predict the likelihood of recidivism, the Static-99 is the most common and most validated. R. KARL HANSON, PUBLIC SAFETY AND EMERGENCY PREPAREDNESS CANADA, THE VALIDITY OF STATIC-99 WITH OLDER SEXUAL OFFENDERS (2005), http://ww2.psepc-sppcc.gc.ca/publications/Corrections/20050630_e.asp. The Static-99 considers ten static factors about an offender, such as the offender's gender and prior sexual offenses, and assigns a score to an offender based on the answers to questions related to these factors. *See* TERRENCE W. CAMPBELL, ASSESSING SEX OFFENDERS 83-84 (2004). Static-99 shows "moderate predictive accuracy." R. Karl Hanson & David Thornton, *Improving Risk Assessments for Sex Offenders: A Comparison of Three Actuarial Scales*, 24 L. & HUM. BEHAV. 119, 129 (2000). Static-99 has its critics. *See, e.g.,* CAMPBELL, *supra*, at 83-97. It is properly used as a starting point, both in practice and as a springboard for further research. A more comprehensive view of risk would involve considering both static and dynamic (such as current employment stability) factors. Further research is necessary, but risk assessment instruments have experienced steady improvement, improvement that will continue with new research and testing.

reserved for those offenders who pose the greatest, most difficult-to-reduce risk of re-offending, thereby targeting scarce resources and focusing attention in a more efficient and productive manner. Such incentives will further motivate offenders to seek and comply with needed treatment programs.

(6) Less restrictive alternatives (including both behavioral and pharmacological treatment) should be considered before civilly committing a sex offender and, where appropriate, be offered to the offender.[186] Such treatment should be provided free of charge or at least at an affordable rate. The successful employment of these alternatives can avoid the huge costs associated with civil commitment, while enhancing the likelihood that an offender becomes a productive member of society. At the same time, the availability of civil commitment or other mechanisms can help ensure treatment compliance.

(7) Government supported opportunities for offenders to obtain employment, housing, treatment, and support services should be enhanced. Offenders cannot reintegrate into society and develop healthy living habits if they have no income, shelter, treatment, or support. Enhancing the likelihood that offenders must or will continually relocate because they lack these opportunities not only virtually ensures that offenders will not improve and exhibit appropriate behavior, but also makes it more difficult to monitor the offender to enhance public safety.

(8) Resources available to treat potential offenders should receive more publicity. Existing state-sponsored websites, publications, and education programs appropriately highlight the resources available to victims, as well as how people can identify and locate sex offenders. There is little or no attention given to advertising how and where a person with a sexual disorder can obtain competent and confidential treatment that will prevent inappropriate behavior from occurring. Governmental funding should be provided to enhance awareness of these services.[187] Additionally, governmental support should be supplied to ensure that people can obtain these resources even when they lack the ability to pay for these services.

(9) Drug and mental health courts have been successfully implemented in some locations.[188] These courts hear mostly or exclusively drug cases or relatively minor criminal cases involving defendants with a mental disorder, respectively, and have thus developed significant experience and expertise in such matters. Sex offense courts may be a viable mechanism in which judges and parole or probation officers are knowledgeable about sex offenders, the treatment modalities specifically designed for sex offenders, the appropriate mechanisms to prevent recidivism, and how best to monitor and supervise offenders to ensure public safety.

However, there is much debate regarding specialized courts in the literature, and thus the matter needs further study.[189] Regardless

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[186] Involuntary pharmacological therapy is not addressed here, as it raises numerous constitutional and ethical concerns that merit a separate, thorough analysis.

[187] Examples of organizations that provide referrals to mental health professionals and programs that treat sex offenders include: The Safer Society Foundation, P.O. Box 340, Brandon, VT, 05733-0340, (802) 247-5141, www.safersociety.org; The Association for the Treatment of Sexual Abusers (ATSA), 4900 S.W. Griffith Dr., Suite 274, Beaverton, OR, 97005, (503) 643-1023, www.atsa.com, atsa@atsa.com.

[188] *See, e.g.,* Jonathan E. Fielding et al., *Los Angeles County Drug Court Programs: Initial Results*, 23 J. SUBSTANCE ABUSE TREATMENT 217, 223 (2002).

[189] The issue of specialized sex courts is not a simple one. Scholars have long debated the merits and drawbacks of specialized courts as compared to courts of general jurisdiction. Proponents see specialization as beneficial insofar as the courts can develop significant expertise in the area of specialization and produce efficiencies such as those that economists have noted flow from specialization in the production of goods and services. Opponents worry that specialization can render these courts more susceptible to special

of whether such specialized courts are implemented, educational and training programs regarding sex offenders should be made available to judges, as well as probation and parole officers, to inform their decision-making.

(10) Because of the limited knowledge and understanding of sex offending, funding and support for research to enhance this understanding is essential. Further research should focus on improving the collection and analysis of recidivism data; studying the effects on recidivism of existing non-punitive responses to sex offenders and possible alternatives; and examining, evaluating, and improving the efficacy of non-biological and biological treatment.

IX. Conclusion

Crafting appropriate responses for sex offenders is no easy task. As they are some of the most hated and reviled members of society, legislators (even those who are well-intentioned) fear opposing legislation targeting these offenders, regardless of how misguided the legislation may be. In the long run, however, well-informed and carefully crafted measures will prove more effective than impulsive, ill-conceived responses in reducing sex offenses.

Four principles should guide the development of these responses. First, sex offenders should be recognized to be a heterogeneous group, distinguishable by offense type and risk of re-offense. Second, the law should take into account new pharmacological therapies, such as testosterone-suppressing drugs, as well as other innovations and therapeutic approaches as a means of reducing the likelihood of future offenses.[190] Third, greater efforts should be made to promote offender reintegration into society, thereby improving their chances for successful treatment and diminishing the likelihood that they will reoffend. Fourth, it is critical to assess the effects of such legislation and to invest in research into the causes, treatment, and prevention of sexual violence.

By integrating law and therapeutic efforts, responses can be formulated that prevent future offenses and victimization, offer offenders and potential offenders the optimal opportunity to lead healthy, productive lives, and decrease the cost of sexual offending to society. By implementing the recommendations described above, society can move one step closer to these goals.

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interests and bias, and that the monotony (hearing the same cases over and over) and lack of prestige of a specialized judgeship might attract a lower-quality judiciary than a generalized judgeship would. For an excellent review of these issues, consult Jeffrey Stempel, *Two Cheers for Specialization*, 61 BROOK. L. REV. 67 (1995).

[190] These therapies are not cure-alls. They must be used appropriately, as discussed in this article and in the medical literature.

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4/13: *Risk Assessment for Sex Offenders*, Charlottesville, VA

4/19: *Confidentiality of Medical Records*, Leesburg, VA

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Developments in the United States Supreme Court

Supreme Court Upholds Arizona's Ability to (1) Limit the Scope of the Insanity Defense and (2) Preclude the Use of Mental Health Expert Testimony in Conjunction with a *Mens Rea* Determination

In its recently completed term that began October 3, 2005, and ended June 29, 2006, the United States Supreme Court decided sixty-nine cases with a signed opinion. After an unprecedented eleven years without a change in its membership, these opinions were closely watched to see whether the Court's direction would change with the addition of Chief Justice John G. Roberts, Jr., and Samuel A. Alito, Jr. For many mental health professionals, the case of greatest interest, *Clark v. Arizona*, was issued on the final day of the term.

Although the Court in its ruling demonstrated some skepticism about mental health evidence, it indicated that this evidence must be allowed to play some role in adjudicating criminal responsibility. However, the Court gave states the option of channeling and restricting the use of this evidence in this context to either an insanity defense or a *mens rea* determination.

Two issues were raised by this case: (1) whether Arizona's relatively narrow insanity defense violated due process because it excuses a defendant from criminal responsibility only when a defendant was suffering, at the time of the offense, from a mental disorder of such severity that the defendant could not distinguish right from wrong; and (2) whether Arizona violated due process when it precluded the use of expert testimony to establish a defendant lacked the requisite state of mind associated with the charged crime (known in legal shorthand as *mens rea*). This case was of particular interest because the Supreme Court has said little about the insanity defense, *mens rea* in conjunction with mental disorders, and the use of mental health testimony in these criminal proceedings.

The case involved Eric Clark, who shot and killed a police officer when he was seventeen-years old. It was undisputed that he suffered from paranoid schizophrenia at the time of the incident. He had demonstrated increasingly bizarre behavior over the year before the shooting and testimony established that he thought the town where he lived was populated with aliens, some of the aliens were impersonating government agents, the aliens were trying to kill him, and bullets were the only way to stop them. In the early hours of June 21, 2000, Clark had been circling a residential block in his pickup truck with loud music blaring. A psychiatrist for the prosecution testified that these actions were an attempt to lure the police to intervene. After a responding officer pulled Clark over, Clark shot the officer and ran away on foot.

Insanity Defense. At trial, Clark raised an insanity defense. When Arizona first codified its insanity rule in 1978, it adopted the full *M'Naghten* rule (first established in 1843 in England's *M'Naghten's Case*). This rule established two means whereby a criminal defendant could obtain a verdict of not guilty by reason of insanity, namely, by showing that he or she suffered from a mental disorder that caused (1) impaired cognitive capacity that left the defendant unable to understand what he or she was doing, or (2) impaired moral capacity that left the defendant unable to understand that his or her action was wrong. In 1993, the Arizona legislature deleted the cognitive capacity aspect from its insanity test.

As a result, Clark could only be adjudged insane if he showed that at the time of the offense "[he] was afflicted with a mental disease or defect of such severity that [he] did not know the criminal act was wrong." During the trial, the prosecution argued that Clark's actions, which included telling some people a few weeks before the incident that he wanted

to shoot police officers, intentionally luring an officer to the scene to kill him, evading the police after the shooting, and hiding the gun, showed that despite his paranoid schizophrenia he did appreciate the wrongfulness of his conduct. The defense argued that Clark was suffering from delusions about aliens when he killed the officer and was incapable of luring the officer or understanding right from wrong at the time. Clark's insanity defense was ultimately unsuccessful and he was found guilty of first-degree murder and given a sentence of life imprisonment.

On appeal, Clark argued that both prongs of the *M'Naghten* test (impaired moral and cognitive capacity) were required when the government recognizes an insanity defense. A majority of the Supreme Court rejected Clark's argument. The Court concluded that Arizona's elimination of the cognitive capacity aspect did not violate due process because its exclusion did not (1) offend a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundament" nor (2) shortchange some constitutional minimum.

The Court determined that the *M'Naghten* test has not historically been deferred to. Rather, a wide range of variations have been employed by the states in their formulations of the insanity defense, including four states that have no affirmative insanity defense. (It should be noted that the Court did not address the constitutionality of not providing an insanity defense). It found that no particular formulation of the insanity defense formed a baseline for due process and thus the articulation of the insanity defense is substantially open to state choice, just as the conceptualization of criminal offenses is generally left to the discretion of each state.

The Court commented that this flux in legal standards was legitimate in light of their interplay with the medical concepts of mental abnormality that influence the expert opinion testimony commonly used in these cases, and which are similarly subject to flux and disagreement. In light of this "reasonable debate" about what the legal and medical tests should be, the Court concluded that due process did not impose a single formulation of legal insanity.

The Court added that Arizona's focus on the moral capacity prong (i.e., the ability to tell right from wrong), did not necessarily preclude evidence regarding a defendant's cognitive capacity (i.e., the ability to appreciate the nature and quality of his or her actions) from being considered, and asserted that cognitive incapacity could be used to demonstrate moral incapacity. For example, the Court pointed out, if Clark did not know what he was doing when he acted, he could not have known that he was performing a wrongful act. The Court therefore concluded that the narrowing of Arizona's insanity test also did not have any practical impact on Clark's ability to pursue an insanity defense, and thus did not shortchange him of his right to due process.

Mens Rea. Turning to the *mens rea* issue, the Court noted that the existing rule in Arizona permits a psychiatrist or psychologist to testify regarding an insanity defense, but they can not testify about a defendant's *mens rea* (i.e., whether the defendant had the requisite mental state, such as the necessary intent or understanding, to commit the charged crime). In reviewing this rule, the majority asserted that there are three categories of evidence with a potential bearing on *mens rea*.

The first was characterized as "observation evidence." The majority opinion described this as testimony from individuals who observed what the defendant did and who heard what the defendant said. According to the majority, this evidence can be introduced through either lay or expert testimony. If introduced through an expert, this testimony could include the expert's views about the defendant's behavioral characteristics and tendency to think in a certain way (e.g., what was on Clark's mind when he fired the gun).

The second category was depicted as "mental-disease evidence," which describes whether the defendant suffered from a mental disease with certain features (e.g., that Clark was psychotic at the time, with a condition that fell within the category of schizophrenia). The majority asserted this evidence is usually provided by an expert witness based in part on an examination of the defendant.

The third category was characterized as "capacity evidence." The majority described this as expert testimony that addresses a defendant's capacity for cognition, moral judgment, and *mens rea* (e.g., that the effect of Clark's schizophrenia was that he was unable to appreciate the nature of his action and to tell that it was wrong).

The majority asserted that the Arizona rule did not exclude the first category of evidence, only the other two, and this first category, which could include testimony from psychologists or psychiatrists, could be used to rebut the prosecution's evidence of *mens rea*. The Court concluded that Arizona's decision to limit the second and third categories of evidence, including expert testimony regarding typical behavior associated with mental disease, to the insanity defense was permissible.

In supporting its ruling that Arizona could prevent the defense from using "mental-disease evidence" and "capacity evidence" to rebut the prosecution's case regarding the presence of the requisite *mens rea*, the Court ruled that this exclusion did not violate the principle that a criminal defendant is innocent unless and until the government proves beyond a reasonable doubt each element of the offense charged, including the mental element or *mens rea*, nor did it violate a defendant's due process right to present evidence favorable to the defendant on an element that must be proven to convict the defendant.

The Court acknowledged that this evidence could be relevant to rebut evidence that the defendant did in fact form the required *mens rea* at the time in question, but responded that the right to introduce relevant evidence can be curtailed if there is a good reason for excluding it. The Court asserted that it is well-established that evidence can be excluded if its probative value is outweighed by its unfair prejudice, its confusion of the issues, or its potential to mislead the jury. If such evidence can be excluded, the Court continued, clearly it can be subjected to a limitation similar to that imposed by Arizona, namely, channeling or restricting it to the insanity defense.

The Court then determined that there were sufficient reasons for this channeling or restricting of "mental-disease evidence" and "capacity evidence." First, the Court reasoned, because a State is entitled to limit the availability of the insanity defense by placing the burden of persuasion associated with this defense on the defendant, the State should also be free to deny a defendant the opportunity to displace the presumption of sanity by focusing instead on *mens rea*. The Court posited that this could occur if the defendant was given the opportunity to present expert testimony of mental disease and incapacity on the *mens rea* issue.

Second, the Court cited the controversial character of some categories of mental illness, the potential of "mental-disease evidence" to mislead, and the danger of according undue certainty to "capacity evidence."

For instance, the Court noted that an assigned diagnosis may mask vigorous debate within the profession about the very contours of the mental disorder itself. Although not condemning "mental-disease evidence" wholesale, the Court determined that this "professional ferment" provided a basis for general caution in treating psychological classifications as predicates for excusing otherwise criminal conduct.

The Court also asserted that this evidence can mislead jurors even when a diagnostic category is broadly accepted and the assignment of a defendant's behavior to that

category is uncontroversial. The Court was concerned that the classification may suggest something very significant about a defendant's capacity, when in fact the classification provides little or no information about the ability of the defendant to form *mens rea*. The Court referenced the conflicting conclusions drawn from Clark's diagnosis of schizophrenia and stated that "it is very easy to slide from evidence that an individual with a professionally recognized mental disease is very different, into doubting [incorrectly] that he has the capacity to form *mens rea*." Because mental-disease evidence on *mens rea* can easily mislead, the Court concluded it was not unreasonable to address that tendency by confining consideration of this evidence to the insanity defense.

In addition, the Court found particular risks inherent in this evidence because of its significant reliance on the experts' judgment. The Court noted that a defendant's state of mind at the crucial moment can be elusive no matter how conscientious the inquiry, and this uncertainty is compounded by the fact that the categories of psychology that govern the expert's professional judgment were designed for treatment and are not co-existent with the law's categories for determining criminal responsibility. The Court cited the trial testimony of Clark's expert who had asserted that no one knew exactly what was on his mind at the time of the shooting. Because of this uncertainty and the risk that the expert's judgment will be given an apparent authority that is not justified, the Court concluded that the State was entitled to channel such expert testimony to the insanity defense when the party seeking the benefit of this evidence has the burden of persuasion.

The Court added in a footnote (footnote 45) that a final reason for channeling this evidence to the insanity defense is because a successful insanity defense does not result in the defendant's acquittal (unlike the *mens rea* requirement), but permits the State to mandate commitment and treatment of a defendant who suffers from a mental disorder that makes the defendant dangerous until a judge orders release after an independent commitment proceeding. The Court closed by stating that not every State need make the judgment that Arizona had made, but that Arizona had "sensible reasons" to channel the evidence in this manner.

Dissenting Opinion. Three members of the Court, which did not include either of its newest members, filed a dissenting opinion. The dissent focused on the *mens rea* issue and expressed no opinion on the ruling regarding the insanity test. The dissent asserted the majority had crafted an unworkable, "restructured evidentiary universe" that lacked convincing authority to support it. Further, the dissent argued, the majority had denied Clark an opportunity to introduce critical and reliable evidence showing that he did not have the requisite intent or knowledge necessary for him to be convicted of the charged crime.

Among other things, the dissent objected that factual "observation evidence" regarding a defendant with a mental disorder made little sense and lacked needed credibility without a mental health professional being able to confirm the account given based on the professional's experience with people who have exhibited similar behaviors. For example, the dissent noted, the observation that people with schizophrenia often play radios loudly to drown out the voices in their heads is a fact regarding behavior that the majority would admit into evidence, but is only a relevant fact if testimony is also admitted that Clark had schizophrenia, which the majority permitted Arizona to exclude.

The dissent asserted that the central theme of Clark's defense was that his schizophrenia made him delusional and that these delusions were so dominant that he had no intent to shoot a police officer or knowledge that he was doing so, but Arizona's *per se* evidentiary rule that categorically excluded testimony regarding mental illness made it impossible for him to pursue this defense and thereby violated his due process rights. The dissent questioned that the risk of jury confusion

justified this rule (arguing that juries often are asked to address complex evidence), disputed that this evidence was inherently unreliable, asserted that this evidence was highly relevant and needed to clarify the issues in this case, and determined that there was no permissible rationale for restricting this evidence to the insanity defense. The dissent concluded that the majority's ruling forces juries to decide guilt in a "fictional world" where they hear evidence about "undefined and unexplained behaviors" without the guidance that would be provided by an understanding of mental illness. Clark v. Arizona, 126 S. Ct. 2709 (2006).

U.S. Attorney General's Effort to Block Oregon's Assisted Suicide Law Through Physician Registration Requirements Struck Down as Exceeding His Authority

Physician-assisted suicide was authorized in Oregon in 1994 following a state-wide voter referendum, and reaffirmed following a second referendum in 1997. The Oregon Death with Dignity Act permits an individual who has been diagnosed with a terminal illness that will lead to death in six months to obtain from a willing physician a prescription for a medication that will hasten death, although the individual must self-administer the medication.

The law requires that before a prescription can be issued an attending physician must: (1) determine the individual has made a voluntary request, (2) ensure the individual's choice is informed, and (3) refer the individual to counseling if he or she might be suffering from a psychological disorder or depression causing impaired judgment. A second "consulting" physician must examine the individual and the medical record and confirm the first physician's conclusions. In 2004, thirty-seven individuals ended their lives by ingesting a lethal dose of medication as authorized under the Oregon law.

Although the regulation of physician behavior is typically a responsibility of the state in which the physician practices, the federal government in 1970 enacted the Controlled Substances Act to combat drug abuse by controlling illegitimate trafficking by physicians of substances that also have a medical use. The law requires physicians who wish to prescribe medications to register with the United States Attorney General and empowers the Attorney General to deny, suspend, or revoke this registration if it would be "inconsistent with the public interest."

In 2001, then-Attorney General John Ashcroft issued an Interpretive Rule that asserted that this federal law permitted him to prohibit the use of controlled substances for physician-assisted suicide. Ashcroft asserted that dispensing medications to assist suicide is inconsistent with the public interest because it is not a "legitimate medical purpose" and was prepared to suspend or revoke the federal registration of a physician who provided medication for this purpose. As this would result in a physician losing the ability to prescribe medications for all of his or her patients, it was believed that this ruling would effectively block physician-assisted suicide in Oregon. The State of Oregon challenged this Interpretative Rule.

The United States Supreme Court, in a six-to-three opinion, held that the Attorney General had exceeded the authority delegated to him under the Controlled Substances Act and thus the Interpretative Rule was invalid. In reaching its conclusion, the Court noted that the regulation of the practice of medicine is generally reserved for the states and the Controlled Substances Act did not indicate that Congress had intended to regulate the practice of medicine generally. Because its reach was relatively narrow and intended only to regulate medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug trafficking, and because there was a lack of justification for construing prescriptions for assisted suicide as "drug abuse," the Court concluded that the Controlled Substances Act, as written, did not permit the Attorney General to bar the dispensing of controlled substances

for assisted suicide in the face of a state medical regime that permitted such conduct.

A dissenting opinion argued that "the prescription of drugs to produce death" was not a legitimate medical purpose and thus the issuance of the Interpretative Rule banning their prescription to assist suicide was within the Attorney General's delegated authority. Gonzalez v. Oregon, 126 S. Ct. 904 (2006).

Monetary Damages Can Be Recovered from a State Under the ADA When Disability Discrimination Also Violates the Constitution

Title II of the Americans with Disabilities Act of 1990 (ADA) places limits on the ability of public entities, including states, to exclude or deny benefits to an individual with a mental or physical disability. Although Title II authorizes private citizens to file lawsuits seeking to recover monetary damages from public entities that violate the ADA, the Eleventh Amendment of the federal Constitution recognizes the sovereign immunity of the states and generally provides them with immunity from such suits.

Two years ago in *Tennessee v. Lane*, 541 U.S. 509 (2004), the United States Supreme Court, in a five-to-four ruling, upheld the ADA's authorization of these suits with regard to a state's failure to make county courthouses accessible to people with disabilities. However, it cautioned that it was going to examine the application of Title II to states on a case-by-case basis that focuses on whether the act of discrimination impinges on "basic constitutional guarantees" and whether there is a significant history of official mistreatment of individuals with a disability in the context under review. Some commentators speculated that the Court would be reluctant to expand state liability under the ADA beyond the relatively narrow context in *Lane* where an individual with a disability was denied the ability to exercise the fundamental rights associated with being able to access a courthouse.

In its first subsequent application of Title II, a unanimous Court ruled that the ADA's abrogation of sovereign immunity also encompasses a lawsuit filed by a prison inmate who claimed that state prison officials denied his constitutional rights by deliberately refusing to accommodate his fundamental disability-related needs for mobility, hygiene, medical care, and participation in prison programs. The Court determined that if these allegations by a paraplegic inmate were established, they would constitute violations of the Eighth and Fourteenth Amendments and entitle the inmate to recover monetary damages from the State of Georgia under Title II of the ADA.

Left unanswered by the Court is whether monetary damages can be recovered from a state for actions that violate the provisions of the ADA but not the federal constitution. United States v. Georgia, 126 S. Ct. 877 (2006).

Supreme Court Upholds Authority of Police to Enter Home Without Warrant to Protect Occupant Objectively Believed to Be Seriously Injured or Imminently Threatened with Such Injury

In a unanimous ruling of potential relevance to individuals involved in an altercation or a heated dispute in their home or while visiting another individual in that person's home, the United States Supreme Court ruled that police may enter a home without a warrant when they have an objectively reasonable basis for believing that an occupant is seriously injured or imminently threatened with such injury.

In this case, police officers responding to a call regarding a loud party saw an altercation taking place in the kitchen of the home while they stood outside. Four adults were attempting with some difficulty to restrain a juvenile, who eventually broke free and punched one of the adults in the face, causing that person to spit blood into a sink while the other adults continued to try and restrain the juvenile. At this point, the police opened the door, announced their presence, and came in.

The altercation then ceased, but was followed by a series of arrests for contributing to the delinquency of a minor, disorderly conduct, and intoxication. At trial, the defendants filed a motion to suppress all evidence obtained after the officers entered the home, arguing that the warrantless entry violated the Fourth Amendment.

The Supreme Court granted that under the Fourth Amendment searches and seizures inside a home without a warrant are presumptively unreasonable and the evidence gathered is generally excluded, but noted that there are exceptions to the warrant requirement (e.g., a warrant is not required to enter private property to fight a fire and investigate its cause, to prevent the imminent destruction of evidence, or to engage in "hot pursuit" of a fleeing suspect).

Among these exceptions is that a warrant is not needed to render emergency assistance to an injured occupant or to protect an occupant from imminent injury. Further, the Court ruled, it did not matter if an officer entered the residence for some reason other than to assist persons who are seriously injured or threatened with such injury (e.g., to make arrests and gather evidence), provided the circumstances when viewed *objectively* met this requirement.

Here, the Court determined, the officers had an objectively reasonable basis for believing both that the injured adult might need help and that the violence in the kitchen was just beginning. The Court reasoned that the Fourth Amendment does not require a "peace officer" to wait until someone is rendered semi-conscious, unconscious, or worse before entering, to delay until first aid is needed, or to only intervene if the altercation becomes too one-sided.

The Court also ruled that the manner of the officers' entry in this case was reasonable when they opened the door, one of them yelled "police," and they then entered the kitchen when nobody heard this announcement "above the din." The officer's announcement of his presence under these circumstances, the Court concluded, was at least the equivalent of a knock on the door, which generally allows an officer to enter a home. Brigham City, Utah v. Stuart, 126 S. Ct. 1943 (2006).

Defendants Found Incompetent to Be Sentenced Also Entitled to *Sell's* Protections from Treatment over Objection; Ruling Not Disturbed

The United States Supreme Court, in *Sell v. United States*, 539 U.S. 166 (2003), held that governmental officials, under limited circumstances, can obtain a court order to administer over objection antipsychotic drugs to restore the competence of defendants found incompetent to stand trial, even though it had not been shown they were dangerous to themselves or others. Because it believed that most cases can and should be resolved by first focusing on the defendant's dangerousness to self or others, an independent basis for forcible medication established in *Washington v. Harper*, 494 U.S. 210 (1990), the Court indicated that it thought few *Sell* orders would be needed and that the protections it mandated would limit the imposition of what was acknowledged to be a significant invasion of a defendant's constitutionally protected liberty interest in avoiding the involuntary administration of these drugs and their side effects.

The Fourth Circuit has ruled that a similar requirement applies to defendants who have been found incompetent to be sentenced. Federal criminal procedure distinguishes between a defendant found incompetent to stand trial and a defendant who has been found incompetent to be sentenced (i.e., a defendant convicted of a crime but found to be incompetent while awaiting sentencing). Defendants found incompetent to be sentenced are committed to a suitable facility for care and treatment and can be detained there for up to the maximum term available for the offense for which the defendant was found guilty.

In the case before the Fourth Circuit, the defendant had been convicted of violating federal drug and firearms laws. Prior to sentencing, the defendant obtained a court-ordered transfer and evaluation to determine whether he was mentally competent to proceed with sentencing. After he was found to be incompetent, treatment staff obtained a court order authorizing involuntary medication. Following medication, the defendant's competence was judged to be restored and he received a ten-year sentence. The defendant subsequently argued that the requirements that permit involuntary medication with antipsychotic drugs had not been met and thus the sentence should be vacated.

On appeal, the Fourth Circuit agreed that it was not enough here for the government to simply show that medication was in the defendant's best interests. Unless the government demonstrated that the medication was necessary to prevent the defendant from harming himself or others, which it had not, the court concluded *Sell* also governed defendants found incompetent to be sentenced and as a result the government must further prove that (1) the medication is substantially likely to render the defendant competent, (2) the medication is substantially unlikely to have side effects that significantly interfere with the defendant's ability to assist counsel, and (3) involuntary medication is necessary to further the government's interest in prosecuting the defendant.

As these additional requirements had not been satisfied in the case before it, the Fourth Circuit ruled that the treatment over objection had been improperly ordered. However, the Fourth Circuit determined that a sentence should be vacated only if this error seriously affected the fairness, integrity, or public reputation of the judicial proceedings. The court ultimately concluded that this sentencing did not have that effect. First, the court noted that the defendant had already been medicated against his will and nothing it could do would reverse any harm that had been incurred. Second, the court reasoned that the defendant would potentially be worse off if the sentence was vacated because the maximum punishment for the crime with which he was charged was forty years and if medication was discontinued he could be committed for restorative services for up to four times longer than the ten-year sentence he had already received.

The United States Supreme Court declined to review this ruling. United States v. Baldovinos, 434 F.3d 233 (4th Cir. 2006), *cert. denied*, 126 S. Ct. 1407 (2006).

Sex Offenders Can Be Prohibited from Living Within 2,000 Feet of a School or Registered Child Care Facility; Ruling Not Disturbed

Every state has adopted legislation that imposes registration and community notification on certain sex offenders, and there is now an Internet-based (www.nsopr.gov) national repository that collects and makes available to the public the names and the home and work addresses of these offenders. In addition, nineteen states have passed sexual offender civil commitment statutes, several states have abolished the statute of limitations on felony child sex abuse charges (e.g., Alaska, Maine, Rhode Island), at least two states have enacted legislation to admit evidence of prior acts of child abuse at a trial where there are current charges of child sexual abuse (California and Michigan), many states have increased sentences for sex offenders (e.g., Florida), a number of states have extended or enhanced the supervision of sex offenders upon release from prison (e.g., Florida authorizes lifetime supervision), and eighteen states have established buffer zones that prohibit registered sex offenders from living near places where children congregate. Susan Broderick, *Innovative Legislative Strategies for Dealing with Sexual Offenders*, 18(10) AMERICAN PROSECUTORS RESEARCH INSTITUTE UPDATE 1 (2006).

Iowa enacted a law that prohibits persons convicted of certain sex offenses against minors from living within 2,000 feet of a school or a registered child care facility. The

restricted areas in many cities encompass the majority of the available housing in the city. One county reported that 77% of its 9,019 residential units would be unavailable as a result and those that were available were "mainly farmhouses." A lawsuit was filed that argued, among other things, that the law was unconstitutional because these limitations apply "regardless of whether a particular offender is a danger to the public" and that individual risk assessments were required before such restrictions could be implemented.

Although a federal district court ruled the law was unconstitutional, the Eighth Circuit of the United States Court of Appeals reversed this ruling and authorized its implementation. The Eighth Circuit held, in part, that these restrictions could be applied to all offenders who have been convicted of certain crimes against minors regardless of what an estimate of future dangerousness might show, and thus individualized hearings were not required. The court also rejected assertions that these restrictions implicated fundamental rights such as an asserted "right to privacy and choice in family matters," "right to travel," or "right to live where you want."

Notwithstanding the absence of a scientific study showing that this type of exclusion is likely to enhance the safety of children, the court determined that a state legislature is free to make judgments about the best means to protect the health and welfare of its citizens when precise statistical data are unavailable and human behavior is unpredictable. The court found that (1) this approach was not the effective equivalent of banishment, (2) convicted sex offenders are more likely to commit sex offenses against minors than the general population, and (3) the legislature appropriately intended to reduce the likelihood of reoffense by limiting the offender's temptation and opportunity to commit a new crime. The court concluded the federal constitution does not prevent a state from regulating the residency of sex offenders in this manner.

A dissenting opinion argued that this legislation (1) resembled banishment in its effect in that it excludes these individuals from virtually all of Iowa's cities and larger towns, (2) imposes a permanent stigma, and (3) is excessive in its life-time ban of all offenders, regardless of their type of crime, type of victim, or risk of re-offending.

The United States Supreme Court declined to review this ruling. Doe v. Miller, 405 F.3d 700 (8th Cir. 2005), *cert. denied*, 126 S. Ct. 757 (2005).

A follow-up report asserted that this law had the unintended consequence of driving many Iowa sex offenders underground. The report found that many towns had striven to even further restrict the residential options of sex offenders by adding parks, swimming pools, libraries, and bus stops to the lists of locations that sex offenders could not live near. Further, six neighboring states had enacted similar legislation because they feared that Iowa sex offenders might cross state lines to find a place to live.

The report found that the number of acceptable residences was so restricted that Iowa's largest cities, like Des Moines, were virtually off-limits. Some sex offenders were rendered homeless, others left sleeping in cars or trucks, and still others forced to cluster in rural motels and trailer parks, often distant from their families and potential support networks. Many others simply vanished from view, with law authorities reporting that nearly three times as many registered sex offenders were considered missing in the six months since the law took effect (with an increase from 140 to 400 registered sex offenders now listed as "whereabouts unconfirmed" or living in "non-structure locations" (i.e., tents, parking lots, or rest areas), out of 6,000 registered sex offenders in Iowa). Interviewed law enforcement officials said they would rather know where these individuals live than to have these residential restrictions. Monica Davey, *Iowa's Residency Rules Drive Sex Offenders Underground*, N.Y. TIMES (Mar. 15, 2006).

Police Officer Must Have Probable Cause to Handcuff Man Reported to Be Suicidal; Ruling Not Disturbed

When a dispatcher relays to a police officer a call for assistance, the information provided may include a "mental health code" designed to alert the responding officer that mental illness may play a role in the encounter. In a case from Ohio, two sheriff's deputies were told incorrectly that a man had his feet tied to a set of railroad tracks and they were dispatched pursuant to a "Code 58," which indicates a possible suicide. In actuality, a seventy-seven-year-old retired farmer had gone out to shoot groundhogs in a rural farming area, an activity in which he routinely engaged to help protect his neighbor's crops. The man had taken with him a folding chair, his rifle, and a tripod to steady his rifle, and positioned himself upon an elevated railroad grade on a neighbor's property roughly 250 yards from a rural road. A passerby had seen him and telephoned the Sheriff's Department. The responding deputies found the man seated in his folding chair. From the road, they used the speaker system in their cruiser to instruct the man to come toward them. The man stood up, gathered his belongings, and began walking along the railroad tracks towards the officers.

As he approached, the officers noticed that the man had a rifle slung over his shoulder. They drew their firearms, crouched behind the open doors of their vehicle, and ordered the man to lay down the rifle before coming any closer. Because the man appeared to be unable to hear their initial command, the officers repeated their instructions. Upon hearing their command at a distance of 200 yards, the man readily complied. For the next couple of minutes, with nothing in his hands, the man continued to walk in a normal fashion towards the officers and did not say or do anything out of the ordinary. Although it became apparent to the officers that he was an older gentleman, when he reached the road the officers directed the man to walk backwards toward them, which he did. After he reached them, still at gunpoint, the officers commanded the man to lay face down on the roadway and handcuffed his arms behind his back.

At this point the man went into cardiac arrest. After unsuccessfully attempting to stand the man on his feet, the officers left him handcuffed and lying on the ground while one of the officers retrieved the objects the man had placed on the ground. A few minutes later, another deputy arrived, as well as a woman who lived nearby. The woman, unable to attain the attention of the other deputies, informed the newly arrived deputy that the man had a heart condition. This deputy, observing the man's distressed state, removed his handcuffs, turned him on his back, and called for medical assistance. The man, however, was left permanently disabled as a result of the incident.

On appeal, the Sixth Circuit of the United States Court of Appeals ruled that the man could pursue a federal lawsuit against the deputies for violating his constitutional rights. The court held that, absent suspected criminal activity, a law enforcement official may not physically restrain an individual merely to assess his mental health. Further, to seize an individual believed to be suicidal, an officer must have probable cause to believe that the person is dangerous to himself or others. Although this does not require that the individual exhibit actual dangerous behavior, it does require a probability or substantial chance of dangerous behavior as judged from the perspective of a reasonable person in the position of the law enforcement official.

In this case, the Sixth Circuit concluded, the deputies could not demonstrate that they had probable cause to believe the man was a danger to himself or others. The court reasoned that the man's response to the deputies' instructions immediately revealed that he was not tied to the railroad tracks as reported and would have caused a reasonable officer to question the veracity of the attempted suicide report. The court added that when ordered to put down his rifle, the man had complied, and he had proceeded

towards them in a normal manner for an individual of his age. The court noted that the officers never questioned the man to determine if he might be depressed and attempting to commit suicide, and the man had never done anything that the officers considered to be suspicious or threatening. As a result, there was nothing from which a reasonable officer could have found a probability or substantial chance that the man posed a danger to himself or others at the time he was seized.

A dissenting opinion argued that the proper test in the case was whether the officers had "reasonable suspicion" rather than "probable cause" to believe the individual is a threat to self or others. However, the majority responded that the "reasonable suspicion" test only applies to investigatory stops and probable cause becomes the test when the seizure lasts more than the reasonably short period of time necessary to conduct the investigation or when force is applied.

Although here the encounter began as an investigatory stop incident to a suicide report, the majority determined that this was no longer an investigation after the man complied with the officers' orders, did not take any sudden, unpredictable, or threatening action toward the officers, appeared to be merely an elderly man hunting in a location where hunters are commonly found, and did not do anything that caused the officers concern once he laid down his rifle. Because the degree of force used exceeded what was required for an investigative stop, the majority concluded that the deputies violated the man's constitutional rights when they forced him at gun point to lay face-down on the ground and handcuffed him. In support of its ruling that the probable cause standard applies to mental health seizures of individuals by law enforcement officials, the majority cited decisions by the Second, Fourth, Fifth, Seventh, Eighth, and District of Columbia Circuits.

The dissenting opinion disagreed with the majority's characterization of the incident. Because the deputies had been told that a man was suicidal and sitting on railroad tracks with his feet tied to the tracks, and they found the man sitting on the railroad tracks and carrying a firearm, the dissent concluded the deputies could reasonably believe that the man was a danger to not only himself but also to others and were entitled to seize and restrain the man temporarily even if suicide is not a crime in that jurisdiction. Further, the deputies had additional reason to believe the man was a suicidal threat to himself or others as one of the responding officers was aware that a year earlier another individual had committed suicide by sitting on the tracks in that county.

The dissent added that the degree of force used was reasonable because the deputies could deduce that a suicidal individual might have little regard for the consequences of his actions and might turn his rifle or a hidden firearm on them. The dissent noted that the detention lasted only approximately five minutes and the handcuffs were removed once it became apparent that the man was physically distressed.

The United States Supreme Court declined to review this ruling. Fisher v. Harden, 398 F.3d 837 (6th Cir. 2005), *cert. denied*, 126 S. Ct. 828 (2005).

Developments in Virginia

Virginia Supreme Court

Court-Appointed Mental Health Evaluator Owes a Limited Duty of Care to the Person Being Examined

A health care provider typically owes a duty of care to an individual with whom a professional relationship has been established, including a duty to exercise reasonable care in diagnosing and treating the individual. Mental health professionals, however, are also often asked to provide court-ordered evaluations of litigants in civil proceedings or criminal defendants. The Virginia Supreme Court has indicated that mental health professionals in this context also owe a duty of care to these individuals, albeit a limited duty, and that they may be liable for damages if that duty is breached.

In the case before the court, a woman involved in an automobile accident had filed a lawsuit to recover damages resulting from the accident. Because the woman alleged she sustained a traumatic brain injury from the accident, the defendant was entitled under Virginia law to require her to undergo a medical exam to determine the nature and extent of her purported brain injury.

A licensed clinical psychologist with a subspecialty in neuropsychology conducted the exam. The woman claimed that during the course of the exam the psychologist verbally abused her, raised his voice to her, caused her to break down into tears, stated she was "putting on a show," and accused her of being a "faker and malingerer." She further asserted that the psychologist knew she had pre-existing mental and emotional conditions, which, in addition to her traumatic brain injury, included a medical history of nervous problems, post-traumatic stress disorder, and suicidality.

The woman subsequently filed a lawsuit against the psychologist for medical malpractice. She stated that her mental and physical health had drastically deteriorated as a result of the psychologist's abusive conduct.

The Virginia Supreme Court began by noting that the same rules apply regardless of whether it is a physician or some other health care provider that is involved in providing a statutorily mandated examination. Further, the court found that all states that have examined this question have imposed a duty of care on the health care provider conducting the exam (including California, Colorado, Kansas, Maryland, Michigan, Minnesota, Montana, New Jersey, New York, Ohio, Pennsylvania, Texas, Washington, and West Virginia). But the court also noted that because such examinations do not involve the traditional *consensual* relationship that serves as the focus of medical malpractice cases, the duty of care owed by the health care provider to the person being examined is more limited.

The court concluded that in Virginia a duty of care does exist between health care professionals and examinees because examinees place their physical person in the hands of another who holds that position solely because of their training and experience. As the relationship does not involve the full panoply of the health care provider's typical responsibilities to diagnose and treat, the scope of a cause of action for personal injury is limited, however.

Because the duty relates solely to the actual performance of the exam, there is no duty to diagnose or treat the examinee. For example, the health care provider is not liable for failing to diagnose and inform the examinee of a medical condition the health care provider discovered, or should have discovered, while conducting the exam. Further, no liability may arise from the health care provider's report or testimony regarding the exam.

Rather, the health care provider' duty is "solely to examine the patient without harming

her in the conduct of the examination." Thus, malpractice can accrue when the examining health care provider fails to follow the applicable standard of care in the conduct of the examination.

The court determined that liability should be limited because otherwise malpractice actions might be used to dissuade health care providers from undertaking court-ordered exams. Alternatively, they might be used in an effort to manipulate the outcome of the exam or to provide the bases for an endless stream of litigation where disappointed litigants seek to redeem the loss of the main action by suing the professionals whose adverse testimony is viewed as having brought about the adverse result.

In this case, the court determined that the woman who was examined asserted sufficient facts in her complaint to entitle her to a trial to determine their veracity, namely, whether the psychologist verbally abused her despite his prior knowledge of her fragile mental and emotional state, which in turn caused her to sustain severe psychological trauma and mental anguish affecting her mental and physical well-being. Harris v. Kreutzer, 624 S.E.2d 24 (Va. 2006).

Mental Health Provider Engaged in an "Inappropriate and Extraprofessional Relationship" with a Client Can Not Be Sued for Alienating the Client's Affections for a Spouse

When a mental health provider has become sexually involved with a client, the client may have a claim for malpractice. If this relationship results in discord between the client and the client's spouse, including divorce, the spouse may assert a similar right to sue the therapist.

At one time, if someone alienated the affections of a married person towards his or her spouse, the person responsible for the alienation could be subjected to a lawsuit for damages. However, most states, including Virginia, have abolished this cause of action for a number of reasons, including that they treat a spouse as the property of the other spouse, these suits were often motivated by the vindictiveness of a spouse whose marriage had failed, and the lawsuits seemed inconsistent with the adoption of no fault divorce and the decriminalization of adultery. As this cause of action became unavailable, alternative bases for a lawsuit were pursued, such as a tort action for intentional or negligent infliction of distress. However, courts have generally rejected them as mere disguises for an alienation claim.

Further, a client's spouse generally cannot file a claim against a therapist because professional duties are ordinarily owed only to the client. One possible exception to this rule is when the therapist provides professional services to both of the spouses and as a result owes a duty of care to both spouses.

In a Virginia case, a licensed clinical social worker provided psychotherapy for two years to a woman to address psychological problems associated with her marriage. The clinician then suggested that the marital relationship would improve if he were to also treat the husband. The clinician then began to separately see both the husband and the wife. The clinician asked the husband for intimate details concerning his relationship with his wife. The husband ultimately withdrew from treatment after concluding that both his emotional condition and his marriage were deteriorating under the clinician's care. At about the same time, his wife told him that she wished to terminate their marriage.

The husband alleged that he later discovered that the clinician maligned him while treating his wife, disclosed to her intimate details that the husband had disclosed to the clinician, and "engaged in an inappropriate and extraprofessional relationship" with his wife. Claiming that he had suffered severe damage to his emotional health, the husband filed a malpractice lawsuit against the clinician.

Reviewing this claim, the Supreme Court of Virginia noted that the same laws govern

professional malpractice actions against all health care providers, including clinical social workers as well as physicians. The court added that Virginia law does not permit lawsuits for alienation of affection, although it does allow a cause of action for intentional infliction of emotional distress.

The court determined that a substantial portion of the husband's claimed damages arose from the effect of the clinician's conduct upon the husband's marriage. Because it did not wish to support a revival of the abolished tort of alienation of affection asserted in the guise of an action for intentional infliction of emotional distress, the court ruled that the husband was only entitled to recover for breaches of the clinician's professional standard of care owed to the husband that would be compensable even if the husband were unmarried. This could include maligning him to a third person, administering improper treatment, or subjecting him to the humiliation and embarrassment of having his most intimate confidences disclosed to a third party without his authorization. However, no weight could be given to the effect of the clinician's conduct upon the husband's marriage. Doe v. Swelling, 620 S.E.2d 750 (Va. 2005).

Virginia Court of Appeals

Prison Sentence Imposed on Parents Who Hosted Teen Beer Party Is Upheld

Underage drinking has been recognized as a significant public health concern. For example, the annual social cost of underage drinking in the United States has been estimated at $53 billion, including $19 billion from traffic crashes and $29 billion from violent crime. In a 2005 nationwide survey of high school seniors, 47% reported consuming alcohol in the past month. A number of law-related efforts have been employed in an effort to curb this consumption, including imposing greater legal liability on parents who permit or promote this activity.

In a closely watched case, the Virginia Court of Appeals, sitting en banc, upheld the imposition of a pair of twenty-seven-month-long prison sentences on a now-divorced couple for providing alcohol at their home to minors attending the sixteenth birthday party of the woman's son.

A police officer had gone to the couple's home after police received reports of underage drinking there. After turning his car into the driveway of the home, he saw some activity in the backyard and a pair of what appeared to be teenagers holding beer bottles. When these individuals saw the officer, they yelled "cops," dropped the beer bottles, and began running towards some nearby woods. After parking his car in the driveway, the officer saw other teenagers running towards the woods and beer bottles strewn about the backyard. After entering through the backyard, the officer found the parents sitting at their kitchen table.

The parents were arrested and each charged with nineteen counts of contributing to the delinquency of a minor. The parents argued that the officer was unlawfully present on their property when he viewed the illegal activity and therefore his testimony should be suppressed and the convictions reversed.

The Virginia Court of Appeals ruled that unless property owners have made affirmative attempts (such as posting no trespassing or private property signs or erecting physical barriers such as gates or fences) to discourage members of the general public from approaching their residence or it is very late at night, there is implied consent that members of the general public, including the police, can enter upon the ordinary means of approaching their front door, which includes the driveway, front sidewalk, and front porch. While upon this "path," police officers do not need a warrant, probable cause, or exigent circumstances to justify their presence, and they are entitled to "keep their eyes open" and respond to any criminal activity they observe.

The court concluded that in this case the officer did not exceed the scope of the implied consent to enter the premises and approach

the front door of the home. Because he saw minors drinking in the backyard while on the "path" to the front door, the officer's presence and observations did not violate the Fourth Amendment.

Further, after observing minors drinking beer and fleeing into the woods, he was justified in entering the backyard because he had probable cause to believe that a crime was being committed. Also, exigent circumstances justified his entry into the backyard without a warrant because the officer could reasonably believe that multiple, underage individuals gathered at a party in the country who had consumed significant quantities of alcohol might attempt to drive home, placing both themselves and the general public at risk of significant harm, in addition to posing a risk that relevant evidence (specifically, their identities and blood alcohol levels) would be lost.

A pair of dissenting opinions rejected the majority's position that property owners impliedly consent to the police entering the path to their front door and concluded that the police officer's entry and search violated the Fourth Amendment. Robinson v. Commonwealth, 625 S.E.2d 651 (Va. Ct. App. 2006).

U.S. Court of Appeals, Fourth Circuit

Fourth Circuit Adopts Narrow Test for Determining Incompetence to Be Executed

Sitting en banc, the Fourth Circuit in a seven-to-six ruling held that the test for determining whether a criminal defendant is competent to be executed is limited to whether the condemned inmate is able to comprehend that he or she is sentenced to death and the reason why.

Percy Levar Walton, who received a death sentence after he pled guilty to murdering in 1996 three people in Danville, Virginia, had argued on appeal that (1) the trial court had applied the wrong legal standard in determining his competence to be executed, (2) the evidence showed he was incompetent to be executed, and (3) he was mentally retarded and thus under *Atkins v. Virginia*, 536 U.S. 304 (2002), was not subject to the death penalty.

In rejecting this appeal, the Fourth Circuit began by noting that a majority of the members of the U.S. Supreme Court in *Ford v. Wainwright*, 477 U.S. 399 (1986), agreed that the Eighth Amendment forbids the execution of the insane because the retributive value of execution is thwarted if the individual does not understand the reason for the execution. The Fourth Circuit concluded, however, that *Ford* established that an inmate is incompetent to be executed only when the inmate is unable to comprehend that he or she is to be executed as punishment for his crime. The Fourth Circuit added that this limited test has been widely recognized or adopted, citing rulings from the Fifth, Sixth, Eighth, and Ninth Circuits, enactments by Congress and the legislatures of Arizona, Georgia, Louisiana, Ohio, Utah, and Wyoming, and rulings by the high courts of Indiana and Tennessee.

The Fourth Circuit rejected Walton's argument that an inmate should also be found incompetent if the inmate is unable to assist his or her counsel during the competency determination process. The court reasoned that the "exhaustive" modern safeguards and procedures available to condemned inmates ensure that the outcome is not tainted because of a failure to discover a trial error that a competent inmate might have pointed out. Although the Fourth Circuit acknowledged that some states, including Mississippi, North Carolina, South Carolina, and Washington, specifically require that an inmate be able to assist counsel to be deemed competent to be executed, the court determined that this was not a Constitutional requirement and because Virginia has not adopted this standard, it was not applicable in this case.

The Fourth Circuit similarly rejected Walton's argument that the test should include an

examination of whether a condemned inmate has the capacity to prepare mentally and spiritually for his or her passing. The court noted a lack of precedent supporting this proposed test.

Where the majority primarily diverged from the dissent was in what was to be considered in determining whether inmates understand why they are being executed. The dissent asserted that inmates must have at least a rudimentary comprehension that execution will mean their death, defined as the end of their physical life. In other words, the dissent argued, the constitutional question "Do you understand that your execution will cause you to die?" cannot be meaningfully answered unless a condemned inmate understands what it means "to die."

The dissent stressed that this test did not shield inmates who because of their beliefs about an afterlife did not see the end of their physical life as a cause for concern. But it did require an ability to grasp the concept that execution will cause the heart to stop beating and brain activity to cease. Because there was some evidence that Walton had a childlike perception of death that saw death as temporary or more akin to sleep from which someone could awaken you, the dissent asserted that his case should be remanded to specifically determine whether Walton understood that execution will mean his death.

The majority, however, rejected both this interpretation of the competency test and the dissent's characterization of Walton's understanding of death. The majority emphasized that the question is not whether the inmate is mentally ill because that constitutes a different concept from whether an inmate is mentally incompetent to be executed. The majority acknowledged that many of Walton's beliefs about the "afterlife" might strike others as odd or unrealistic, including his belief that he would come back to life shortly after his execution and be able to resurrect his dead relatives. However, the majority concluded that Walton understood his existing life would end as the result of execution and thus he understood that he would die as punishment for his crimes, which was all that was required under the Constitution.

A concurring opinion rejected the dissent's definition of competence to be executed as inappropriately requiring an evaluation of an inmate's *Weltanschauung*, i.e., religious, poetic, or metaphysical views of death and the afterlife. Noting the contrasting views of Christians, Thornton Wilder, any number of Eastern religions, and the Solipsists, this judge concluded that courts are not required to evaluate the meaning of such understandings in making this determination.

The majority, without dispute from the dissent, also concluded that Walton was not mentally retarded as defined under Virginia law. The majority noted that the United States Supreme Court in *Atkins* ruled that each state is relatively free to define what constitutes mental retardation for purposes of imposing the death penalty and Virginia has established that an individual is deemed mentally retarded in this context only if the individual shows, among other requirements, that his or her intellectual function would have corresponded to an IQ score of seventy or less before he turned eighteen.

The majority asserted that, although this does not require that the individual submit a score of seventy or less from an IQ test taken before he turned eighteen, there must be some evidence that his intellectual function would have fallen below this standard before turning eighteen. Walton's position hinged primarily on (1) an IQ score of seventy-seven that he received when he was tested a few months after he turned eighteen, (2) an argument that this score should be reduced to a score of seventy-four because of the "Flynn Effect," which asserts that IQ scores increase over time and that IQ tests should be renormed to take into account rising IQ levels, and (3) an assertion that the "standard error of measurement" associated with IQ tests reduced his score to seventy or less.

The Fourth Circuit responded that, even if the "Flynn Effect" did exist, there was insufficient evidence that the standard error of measurement, which could lower *or raise* an IQ test score, actually lowered Walton's IQ score to the requisite degree. Walton v. Johnson, 440 F.3d 160 (4th Cir. 2006).

Federal District Court in Virginia

Applying *Sell v. United States*, Virginia Federal Court Judges Order Treatment over Objection of Criminal Defendants Found Incompetent to Stand Trial

A steady stream of judicial rulings continues to be issued that addresses the parameters of the United States Supreme Court's ruling in *Sell v. United States*, 539 U.S. 166 (2003), that under limited circumstances the government may treat over objection a criminal defendant in an effort to restore the defendant's competence to stand trial. These rulings, however, have tended to focus on different aspects of the *Sell* decision, as exemplified by the recent rulings of three federal district court judges in Virginia.

Western District of Virginia. In *United States v. Evans*, 404 F.3d 227 (4th Cir. 2005), the Fourth Circuit reversed an order by the United States District Court for the Western District of Virginia that had authorized such treatment. The Fourth Circuit held that the lower court had erred because the government had failed to articulate with sufficient particularity the medications it planned to administer to the defendant, the potential side effects specific to the defendant's medical condition, and a plan for responding to the onset of such side effects.

Following this ruling, the government developed a more extensive and detailed proposal for treating the defendant and submitted it to the district court for review. The district court, for the most part, found that this proposal met the requirements of *Sell* and, with minor modifications, authorized its implementation.

The defendant, Herbert G. Evans, is charged with forcibly interfering with a United States Department of Agriculture employee and threatening to murder a magistrate judge. He suffers from paranoid schizophrenia and has refused antipsychotic medication to restore his competence since 2003. Pursuant to the directions of the Fourth Circuit, the district court focused on the second and fourth prongs of the *Sell* test in evaluating the proposal, namely, whether the government had adequately demonstrated that its prosecutorial interest was significantly furthered by involuntary medication and whether involuntary medication was medically appropriate.

The district court found that the proposal set forth a carefully detailed treatment plan, a specific plan for monitoring and responding to side effects, and a literature review supportive of its position. The proposal provided a number of empirical studies indicating a substantial success rate following the involuntary medication of patients like the defendant and cited the 2004 guidelines of the American Psychiatric Association for treating schizophrenia (with its statistics related to the successful treatment of schizophrenia). Although the defendant countered with a report of his own that disputed these studies as applied to the defendant, the court generally found the government's report persuasive.

The court further determined that, although the burden of proof was on the government to show that the *Sell* criteria for treatment over objection were met by clear and convincing evidence, this burden had been met. The court ruled that the proposed involuntary medication was substantially likely to render the defendant competent to stand trial and substantially unlikely to produce side effects that would significantly interfere with the defendant's defense.

As for the side effects, the court acknowledged that troublesome side effects, mainly metabolic in nature, are common with second-generation antipsychotics, but

concluded that they are generally not so serious as to inhibit the defendant's assistance with his own defense.

The court also found that the proposed treatment was generally medically appropriate. Because the defendant had expressed his intention to refuse medication, the court found it appropriate for the government to choose a long-acting antipsychotic, risperidone, to reduce the necessity for forceful encounters in administering the medication. The court also supported the use of this second-generation antipsychotic to avoid the neuromuscular side effects the defendant had experienced previously with haloperidol and noted that risperidone is the only second-generation antipsychotic available in a long-lasting form.

The court authorized injections of this medication for between four and five months and, if the defendant did not respond within this time, authorized alternative antipsychotic medication for an additional four to five months. If risperidone was ineffective or caused intolerable side effects, the government was authorized to try, in order, long-acting haloperidol by injection, aripiprazole, and ziprasidone.

The government was required to monitor the defendant for side effects and, in particular, for side effects related to the defendant's diabetes and hypertension. It was ordered to cease treatment at any time when the defendant's diabetes reached a level requiring daily insulin injections. The government was also prohibited from using a nasogastric tube to administer test doses of the medication because of the risks of harm associated with using such a tube on an uncooperative patient and because risperidone is available in an orally soluble tablet form.

After ten months of treatment that failed to restore competence or the worsening of the defendant's diabetes to the point of requiring daily insulin shots, the government was required to cease treatment and to return to the court with a new proposal. United States v. Evans, 427 F. Supp. 2d 696 (W.D. Va. 2006).

Western District of Virginia. Perhaps because the judge's judgment had not previously been subjected to appellate review, an arguably more typical ruling was issued in conjunction with a defendant who had been arrested for carrying a handgun without a license.

The defendant was arrested after he approached law enforcement officers in Washington, D.C., asking for directions to Seattle, Washington. The man subsequently told the officers he was former President Gerald R. Ford's adopted son and wanted to go to President Ford's residence to pick up some old boxing tapes, and acknowledged that he had a gun and a knife in his possession.

After the defendant was found incompetent to stand trial (IST), committed to a federal facility, and refused to take psychotropic medications, the warden of the facility filed a motion seeking permission to forcibly medicate the defendant. The only evidence submitted was a forensic report generated by a staff psychologist and staff psychiatrist at the facility. The report asserted that the defendant had a delusional disorder, grandiose type, which rendered him IST but did not render him dangerous within the controlled environment of the facility.

The judge in this case began her analysis by examining whether the defendant was accused of a "serious" crime as required in *Sell* for treatment over objection of a non-dangerous defendant found IST. The test to determine this issue, the court ruled, was whether the defendant was charged with any offense for which the defendant may be sentenced to more than six months' imprisonment. Because carrying a handgun without a license is punishable by a term of imprisonment of up to five years, the court concluded the defendant was charged with a serious offense.

Although the judge acknowledged that *Sell* directed that a defendant's potential for future confinement in a mental health facility or prior lengthy confinement could be taken into account in determining the government's interest in prosecution, the judge determined without explanation that neither applied here.

Also without explanation, the judge further found that the other *Sell* factors were met, namely, that the recommended medication was substantially likely to render the defendant competent, was substantially unlikely to cause side effects that would interfere significantly with the defendant's ability to assist in his trial defense, that alternative, less intrusive treatments were unlikely to restore the defendant to competency, and the administration of this medication was medically appropriate.

Unlike *Evans*, further supporting details were not provided by the court in its ruling beyond the forensic report's assertion that (1) without antipsychotic medication the defendant was substantially unlikely to become competent to stand trial (CST), (2) such medication was likely to improve his mental status to a level where he would be CST, (3) the standard treatment of anyone with delusional disorder, grandiose type, involved the prescription of antipsychotic medication, (4) the recommended typical antipsychotic medication Prolixin would be medically appropriate, and, (5) although this medication could produce unwanted side effects, the defendant would be carefully monitored for side effects and medically managed if they occurred. United States v. Martin, No. 1:04mj00183, 2005 WL 1895110 (W.D. Va. Aug. 10, 2005).

Eastern District of Virginia. A third case focused on a defendant who had been charged with conspiracy to possess with the intent to distribute cocaine, found incompetent to stand trial, and not shown to be a danger to self or others. The judge ordered the involuntary administration of antidepressant and antipsychotic medication in an effort to render the defendant competent to stand trial. The court noted that under such circumstances *Sell* "requires an exacting focus on the personal characteristics of the individual defendant and the particular drugs the government seeks to administer."

The court's focus, however, was the delay in conducting a trial caused by the defendant's incompetence and the subsequent impact on the memories and availability of witnesses if medication was not administered. Similar to the ruling in *Martin*, without citing supporting facts or providing explanation, the judge determined that administration of medication was both medically and clinically appropriate.

Arguably providing a different twist to the directive in *Sell* that the likely placement of a defendant who refuses medication in a secure mental health facility undercuts the government's interest in treatment over objection, this judge was concerned that the defendant's depression and psychosis would only progressively worsen during an extended period of involuntary commitment. United States v. Hopkins, No. 3:04cr260 (E.D. Va. Apr. 10, 2006), 20 VA. LAW. WKLY. 1420 (Apr. 24, 2006).

Lawsuit Can Continue that Alleges Inadequate Mental Health Care Contributed to Suicide of Inmate in Virginia Maximum Security Prison

The United States Supreme Court, in *Estelle v. Gamble*, 429 U.S. 97 (1976), established that the Eighth Amendment is violated when prison officials are deliberately indifferent to an inmate's serious illness or injury. This ruling has been widely interpreted to encompass an inmate's serious mental health needs as well. When an inmate commits suicide, a lawsuit may be filed that asserts that the inmate's constitutional rights were violated because prison officials failed to provide the requisite adequate mental health services despite knowing of the inmate's mental health needs, and the absence of these services contributed to the inmate's suicide.

At Wallens Ridge State Prison, a "Supermax" facility (Security Level 5) in rural southwestern Virginia, an inmate died in his cell after hanging himself with a bed-sheet. The inmate had previously attempted to commit suicide on two occasions and intentionally injured himself on another occasion. In a lawsuit brought after the inmate's death, it was alleged that (1) correctional officials had been deliberately indifferent to the inmate's serious medical needs, (2) there had been inadequate related supervision and training of staff, and (3) a physician at the facility committed medical malpractice.

A federal district court judge in Western Virginia rejected a number of preliminary challenges to the lawsuit. First, the court refused to dismiss the case for a failure to previously exhaust various potential administrative remedies. In an effort to curb what was viewed as oftentimes spurious prison inmate litigation, Congress passed the Prison Litigation Reform Act in 1996. This law requires prison inmates to exhaust available administrative remedies before filing a federal lawsuit that asserts a constitutional violation.

The judge ruled, however, that this requirement only applies to lawsuits filed by prisoners and does not apply to lawsuits filed following an inmate's death. The court also noted that the requirement may not apply to cases filed by former prisoners.

Second, the court acknowledged that a claim under the Constitution that prison officials were deliberately indifferent to the serious medical needs of an inmate requires more than just a showing of negligence and necessitates proof that the officials actually appreciated the risk factors that were present. The court ruled, however, that this requirement could be met by showing that the defendants were aware that the inmate presented a suicide risk and was experiencing serious mental health problems (which in this case were potentially exacerbated by his erroneous impression that he was HIV positive), and deliberately refused to provide appropriate treatment and failed to protect the inmate from harm despite his requests to be treated in the facility's mental health unit.

The court added that prison doctors can be found to have been deliberately indifferent to an inmate's serious medical needs when they do not monitor an inmate to whom they have prescribed drugs for a psychotic episode and fail to make any subsequent inquiries into the inmate's condition.

Third, although the court cautioned that establishing supervisory liability will typically be difficult because it requires proof of more than a single incident or isolated incidents, the court determined that in this instance the allegations that (1) the defendants had created a policy and custom that sanctioned the providing of inadequate medical care to inmates and (2) this inaction caused the inmate's death were sufficient to permit the lawsuit to continue and to allow the plaintiff to conduct discovery in an effort to prove these allegations.

Finally, although under certain circumstances a state-employed prison physician may enjoy sovereign immunity that shields the physician from liability for the death of an inmate in a state prison, the court held that at this stage of the proceedings insufficient information was available as to the nature of the employment relationship between the Commonwealth and the physician involved to resolve this issue. Simmons v. Johnson, No. 7:05 CV 00053, 2005 WL 2671537 (W.D. Va. Oct. 20, 2005).

Governor of Virginia

Virginia Governor Orders Six-Month Delay of Execution to Determine Whether Inmate Competent to Be Executed

A little more than an hour before the scheduled execution of Percy Levar Walton, Virginia Governor Timothy M. Kaine delayed execution for at least six months until December 8, 2006, to enable an independent evaluation to be conducted on Walton's mental condition and competence. Walton, now age twenty-seven, received a death

sentence after he pled guilty in 1997 to the 1996 murder of three people in Danville, Virginia. The statement issued by Gov. Kaine noted that state and federal courts had consistently upheld this conviction.

Indeed, the United States Court of Appeals for the Fourth Circuit, sitting en banc, in *Walton v. Johnson*, 440 F.3d 160 (4th Cir. 2006), had rejected arguments in March of 2006 that Walton (1) was mentally incompetent to be executed and (2) was mentally retarded and thus not subject to the death penalty. Further, although a federal judge in Norfolk had halted the execution pending a United States Supreme Court decision about the constitutionality of lethal injection the day before the scheduled execution, the Fourth Circuit in Richmond vacated that stay and ninety minutes before the scheduled execution the Supreme Court denied without comment an appeal for a stay based on the lethal injection question.

Nevertheless, Gov. Kaine's statement noted that it is unconstitutional to execute a person who is mentally incompetent because the Supreme Court has held that a person must have sufficient mental capacity to understand the punishment he or she is about to suffer, and why he or she is to suffer it. Gov. Kaine asserted that it had been three years since the last evidence regarding Walton's mental state had been presented. He also stated that Walton's clemency petition to the governor presented significant information suggesting that he has schizophrenia, that such a mental illness can cause serious deterioration of mental competence, and that "there is more than a minimal chance" that Walton no longer knows why he is to be executed or is even aware of the punishment he is about to receive.

Because of a history of judicial concern about Walton's mental status, Gov. Kaine concluded Walton's clemency petition should receive serious consideration and his scheduled execution should be delayed to review the matter further and to allow for the receipt of current and independent information about Walton's mental condition. At the time the statement was issued, a spokesman for the Governor said that no procedure had been devised to reexamine Walton's mental status.

Since becoming governor in January of 2006, Gov. Kaine has been asked in his first six months in office to grant clemency in four cases in the hours preceding a scheduled execution. In the three other cases, clemency was denied. Virginia governors have granted clemency in seven cases since the death penalty was reinstated by the Supreme Court in 1976. Tom Jackman, *Mental State Still at Issue in Va. Death Penalty Case*, WASH. POST, June 10, 2006, at B01; Candace Rondeaux & Michael D. Shear, *Kaine Delays Execution of Inmate for 6 Months*, WASH. POST, June 9, 2006, at A01; Press Release, Office of the Governor Timothy M. Kaine, Statement of the Governor on the Scheduled Execution of Percy Levar Walton (June 8, 2006), http://www.governor.virginia.gov/MediaRelations/NewsReleases/2006/Jun06/0608b.cfm.

Developments in Other Federal Courts

Federal District Court in Connecticut
(located within the Second Circuit)

School Officials Can Be Held Liable for Failing to Protect Special Education Students from Bullying

Bullying in schools is increasingly recognized as a significant problem, with students enrolled in special education programs particularly vulnerable to this bullying. The United States District Court of Connecticut ruled that when school officials fail to take adequate steps to protect such students from bullying they may be sued for the harm resulting from this bullying.

A boy enrolled in a Connecticut middle school had been diagnosed with a learning disability and enrolled at various times in a special education program. It was alleged that fellow students bullied, harassed, and threatened the boy as a result of his disability, that this caused him to miss thirty-seven days of school in the sixth grade, that the situation became worse the next year when a student who had assaulted his mother the year before was seated behind him in class, that the boy again became excessively absent from school as this student and others bullied, punched, and attacked him, that school officials failed to redress these problems despite his mother's complaints, and that shortly thereafter the boy committed suicide.

The mother sued the local Board of Education, the Superintendent of Schools, the school's Vice Principal, and the school's Guidance Counselor. Prior to trial, the defendants argued that even assuming that all the facts the mother asserted were true, the law did not provide a basis for her lawsuit.

The court, however, ruled that existing law does provide a number of bases for such a lawsuit. For example, a violation of the Due Process Clause of the Fourteenth Amendment may have occurred. The court noted that the United States Supreme Court in *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189 (1999), held that a state does not have an affirmative constitutional obligation to protect its citizens unless the individual was at the time in the custody of the state or was exposed to danger created by the state.

The court concluded, nevertheless, that school officials could be held liable under the Fourteenth Amendment if they knew about the bullying situation and failed to act in response to the situation. For example, if one of them had knowingly placed her son in a class with a student who was a known threat to him and then refused to move him despite the mother's request, combined with a failure to provide him with the special education services to which he is entitled under federal law, then a Fourteenth Amendment violation could be established. The court held that it is sufficient to show that school officials failed to act and had assisted in some way in creating or increasing the danger to the victim.

The court also ruled that if it could be shown that the boy was intentionally subjected to invidious discrimination based on his disability at the hands of school officials who had not treated him similarly as they treated other individuals without such disabilities, a violation of the Equal Protection Clause of the Constitution could be established.

Other available lawsuits included: (1) a federal constitutional claim that the defendants failed to adequately train and supervise school employees in how to deal appropriately with children with a learning disability and to establish necessary anti-bullying and harassment policies; (2) a claim for damages (albeit not punitive damages) under the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act based on the boy's special education placement and bullying situation; (3) a claim that the defendants conspired to deprive the boy of his federal constitutional rights; and (4) a state

law negligence claim that the defendants breached their duty to prevent and protect him from intentional harm, to provide him with a safe and productive learning environment, and to supervise the students or to take steps to prevent the bullying. Scruggs v. Meriden Bd. of Educ., No. 3:03CV2224(PCD), 2005 WL 2072312 (D. Conn. Aug. 26, 2005).

The mother in this case previously received national attention following the suicide of her son when a jury found her guilty on a risk of injury criminal charge for placing her son's health at risk because of the living conditions in their home. The boy had hanged himself in his bedroom closet with a necktie.

The judge who reviewed and ultimately upheld this conviction described it as "a troubling case." The judge noted that the mother, who did not physically abuse her child, was a single parent raising two children and worked two jobs, sixty hours a week, to support her family. The court added that the boy faced constant bullying at school, while school officials knew that her son missed a lot of school, was often tardy, and had severe personal hygiene problems, and yet did nothing to protect him from the bullying. The court further found that there was no evidence that anything in the home environment was likely to have injured the child's physical health nor that the mother had caused the boy's suicide.

However, the judge did find that there was sufficient evidence for the jury to conclude that cluttered and unsanitary living conditions were likely to injure the child's mental or emotional health, citing evidence that (1) the boy lived in an apartment that had a foul and offensive odor and was so crowded with furniture, trash, clothing, and other debris that there was barely a place to walk, and (2) bathroom facilities were dirty, unsanitary, and lacked privacy as the door leading to his seventeen-year-old sister's bedroom could not be closed. Further, the boy was in great distress as demonstrated by the fact that he (1) was so upset about the constant bullying at school that he defecated in his pants there, (2) had bad body odor as a result of his refusal to bathe, (3) was so fearful that he kept knives near him when he slept to protect himself, and (4) was faced with the prospect of being home alone during the days because his mother no longer made him go to school.

The judge noted that Connecticut law does not require proof of any specific injury to a child's health from his parent's actions. Rather, criminal liability can be imposed when a parent provides a home that causes a risk of harm to a child's mental health. Here, the court concluded, it was reasonable for a jury to conclude that this home environment, which went far beyond messy or disorderly living conditions, was likely to injure the mental, psychological, and emotional health of this troubled and fragile child. State v. Scruggs, 37 Conn. L. Rptr. 109 (Super. Ct. 2004). The mother ultimately received a suspended sentence and five years' probation that required her to undergo counseling and perform 100 hours of community service.

U.S. Court of Appeals, Eighth Circuit

Mental Illness Can Serve as a Basis for Discharging Student Loans

Under federal bankruptcy law, an individual can be excused from repaying student loans if the debt "will impose an undue hardship on the debtor." Ordinarily, the focus is on whether repaying the debt will not prevent a minimal standard of living after factoring in the individual's current and future financial resources and expenses. The Eighth Circuit of the U.S. Court of Appeals ruled that the impact of the individual's mental health should also be taken into account when (1) the individual's mental health affects her past, current, and future earnings and (2) when the stress of the debt is likely to affect the individual's mental health adversely, causing an even greater decline in her earnings.

The individual who was the focus of this case had suffered from depressive symptoms as an adolescent. Despite continuing to struggle with depression and panic attacks, she

graduated *cum laude* from college. Even though her depression worsened, she also graduated in the middle of her class from the University of Michigan School of Law. In completing her studies, however, she accumulated more than $142,000 in student loans.

Although she passed her bar examination and was admitted to practice law, she was unable to find work as an attorney and for the next five years worked as a secretary or administrative assistant, earning roughly $30,000 a year. During this time she saw a number of mental health professionals and took a number of medications that reduced her symptoms, but the medications tended to wane in their effectiveness the longer she took them. She was diagnosed with major depressive illness, chronic dysthymic disorder, and a persistent personality disorder.

Her psychiatric expert testified that no regimen of medication had been able to bring about a sustained partial remission of her mental illness, that she suffered drowsiness and distraction as a result of her medications, and that she was not able to practice law because her mental disorders limited her interpersonal skills. He also testified that her student loans caused her stress and that stress can limit treatment for a mood disorder.

In granting the individual's request to be discharged from repaying her student loans, the Third Circuit said that courts need to go beyond the individual's economic ability to repay the debt and recognize that a debtor's health and financial position are inextricably intertwined. The court noted that illness can undercut a debtor's ability to generate income and increase her expenses, and that financial obligations can undermine a debtor's health. Here, the court found, the continuing liability from these debts posed a threat to the individual's "fragile mental health" and a barrier to her recovery.

A dissenting opinion objected that the court had never before considered whether having a debt itself constitutes an undue hardship and that this approach is not permitted under federal bankruptcy law. Reynolds v. Pa. Higher Educ. Assistance Agency, 425 F.3d 526 (8th Cir. 2005).

U.S. Court of Appeals, Ninth Circuit

Arresting Homeless Individuals for Sleeping, Sitting, or Lying on Public Property When Other Shelter Is Not Available Violates the Constitution

Cities have long struggled with how to deal with their homeless populations, particularly in light of reports that a high percentage of them are experiencing a mental illness. In what has been described as the first case involving the rights of homeless people in public spaces to reach the federal appellate level, the Ninth Circuit, in a two-to-one opinion, struck down a thirty-seven-year-old Los Angeles ordinance used to clear homeless people off the streets.

The ordinance, which imposed a maximum penalty of a $1,000 fine and/or six months in jail, had been largely unenforced until recent years when police began a concerted effort to employ it to clean-up "Skid Row," a 50-block area immediately east of downtown Los Angeles that the Ninth Circuit asserted has the highest concentration of homeless people in the country, but which adjoins a series of new condominiums and apartment buildings. The court determined that there are more than 80,000 homeless individuals in Los Angeles County on any given night and approximately 11,000-12,000 can be found in Skid Row.

The court described Skid Row as "a place of desperate poverty, drug use, and crime," but noted a report that found that homelessness results from mental illness, substance abuse, and domestic violence, with between 33% and 50% of the homeless in Los Angeles mentally ill. The court also noted that this report found that low-paying jobs and, "most significantly," the chronic lack of affordable housing caused homelessness.

The court ascertained that temporary or transitional housing, including SRO hotels and

shelters, are available for only 9,000 to 10,000 of the homeless individuals in Skid Row, which left more than 1,000 of them unable to find shelter each night. The court added that the availability of low-income housing in Skid Row had shrunk in recent years, that there are almost 50,000 more homeless people in Los Angeles County than available beds, and the wait-lists for public housing and for housing assistance vouchers in Los Angeles are three to ten years long.

The majority described the Los Angeles ordinance as one of the most restrictive municipal laws regulating public spaces in the United States as "anyone who merely sits, lies, or sleeps in a public way at any time of day" is subject to conviction. In contrast, the approach employed in other cities requires some conduct (e.g., obstructing pedestrian or vehicular traffic) in combination with sitting, lying, or sleeping in a state of homelessness or provides "safe harbor" provisions that limit enforcement to clearly defined hours (e.g., 7 a.m. to 10 p.m.) or to clearly defined and limited geographical zones. The majority added that individuals who are arrested also tend to lose what few possessions they may have.

The majority held that because the number of homeless persons in Los Angeles far exceeds the number of available shelter beds, Los Angeles violated the Eighth Amendment by criminalizing the unavoidable act of sitting, lying, or sleeping at night while being involuntarily homeless. The majority reasoned that under the Constitution persons cannot be punished for who they are independent of anything they have done, and persons cannot be punished for acts that they are powerless to avoid (i.e., involuntary actions or conditions that are the unavoidable consequence of one's status or being).

The majority asserted that the enforcement of the Los Angeles ordinance at all times and in all places against homeless individuals who are sitting, lying, or sleeping because they cannot obtain shelter violated the Cruel and Unusual Punishment Clause of the Eighth Amendment because homeless individuals are in a chronic state that may have been acquired "innocently or involuntarily" and because it is not possible to remain in "perpetual motion" as required by the City's ordinance. Because sitting, lying, and sleeping are unavoidable, biological consequences of being human and because homeless individuals in Los Angeles' Skid Row district have no access to private spaces and thus can conduct these acts only in public, the majority concluded that Los Angeles was criminalizing their status as homeless individuals.

The majority rejected the argument that constitutional protection should not be afforded because individuals may become homeless because of factors within their immediate control or because they can obtain shelter on some nights. The majority responded that individuals cited or arrested under this ordinance had no choice other than to be on the streets at the time and any past acts that contributed to their current need to sit, lie, and sleep on public sidewalks at night were not sufficiently proximate to this conduct for the imposition of penal sanctions to be permissible.

The majority stressed that its holding was limited in that it did not prevent a city from criminalizing conduct that is not an unavoidable consequence of being homeless, such as panhandling or obstructing public thoroughfares, and that it did not prevent a city from prohibiting sitting, lying, or sleeping at certain times or in certain places or when beds are available for the homeless in shelters. It also noted that it was not implying that there must be a showing of mens rea (i.e., specific intent to commit a crime) for a criminal conviction to pass constitutional muster.

A dissenting opinion argued that this ordinance did not target status, but rather the conduct of sitting, lying, or sleeping on city sidewalks. Thus, Los Angeles was not making the status of being homeless a criminal offense and did not violate the federal

constitution. In addition, because being homeless is a transitory state, the dissent maintained that this was not a chronic state that may have been contracted innocently or involuntarily. The dissent added that this ordinance targeted behavior that can be committed by those with homes as well as those without and thus was not focused on the status of homelessness.

The dissent also asserted that no federal appellate court had ever held that conduct derivative of a status may not be criminalized and that immunization from criminal liability should not be based on the government's decision not to provide a social benefit program. Jones v. Los Angeles, 444 F.3d 1118 (9th Cir. 2006).

Los Angeles Response to Report of Hospital "Dumping" of Homeless. The Ninth Circuit in supporting its assertions in *Jones* regarding the desperate nature of conditions in Skid Row in Los Angeles cited a September 23, 2005, news report that local hospitals and law enforcement agencies from nearby suburban areas had been caught "dumping" homeless individuals in Skid Row upon their release. Cara Mia DiMassa & Richard Minton, *Dumping of Homeless Suspected Downtown*, L.A. TIMES, Oct. 17, 2005, at A1.

In response, the mayor of Los Angeles ordered an investigation and the Los Angeles city attorney announced in December of 2005 that his office was considering filing civil and criminal charges against any hospitals involved in this practice. The City Attorney noted that civil actions to enjoin unlawful practices and significant penalties could be sought under Section 17200 of the California Business and Professions Code against hospitals that fail to follow appropriate procedures for the treatment and discharge of homeless patients or that fail to provide the level of post-discharge care and oversight that is standard among medical providers in the area. The City Attorney also stated that this law enabled his office to seek remedies for violations of federal law, including the patient discharge requirements under the federal Emergency Medical Transfer and Active Labor Act, as well as for violations of patient discharge requirements under the California Health and Safety Code. Office of the City Attorney, *City Attorney Expands Investigation of Alleged Homeless "Dumping" on Los Angeles's Skid Row* (Dec. 22, 2005), http://www.lacity.org/atty/attypress/attyattypress6934474_12222005.pdf.

Attorneys Discuss Impact on Hospitals of Lack of Discharge Alternatives. A series of interviews with attorneys who ranged from advocates for the homeless to representatives of hospitals agreed that while discharging homeless patients by hiring taxicabs to drop them off on Skid Row in downtown Los Angeles is a poor idea, the bigger problem is that hospitals may have no good alternatives. They noted that Medicare regulations impose extensive discharge planning obligations on virtually all hospitals in the United States and that the federal Emergency Treatment and Labor Act (EMTALA) mandates that homeless patients, like all patients, who have presented themselves to a hospital's emergency room must generally be "stabilized" prior to discharge. But because many communities do not provide adequate discharge alternatives, hospitalization often becomes the only care available.

However, hospitals that retain patients pending appropriate placement may not be reimbursed by Medicare or Medicaid for extra hospital days and they may have to absorb the costs. It was suggested that this is why psychiatric services are among the top three money-losing services in general care hospitals and why many inpatient beds for psychiatric patients are being closed across the country.

Recommended changes included funding the EMTALA mandate by providing federal payments to hospitals that are required to treat psychiatric patients that present to their emergency department; removing a Medicaid provision that prohibits federal reimbursements to free-standing psychiatric

hospitals that serve patients ages twenty-one to sixty-four; and increasing available housing for the homeless and patients with mental health issues. Susan Carhart, *Inadequate Social Resources Put Hospitals at Risk for Litigation, Bad Public Relations*, 15(17) BNA'S HEALTH L. REP. 485 (Apr. 27, 2006).

National Survey Documents Lack of Community Services. The lack of services to low-income people with serious mental illnesses was documented in a national survey that included interviews conducted between January and June 2005 with more than 1,000 health care leaders from twelve nationally representative markets. Further, these gaps were perceived to be growing wider as a result of budget pressures at both the local and state levels. Residential services, including housing, group quarters, transitional shelters, and other support services, were consistently mentioned as being in short supply. A lack of psychiatric inpatient beds for acute care was another major gap in services widely cited. In addition, outpatient capacity was reported to have not kept pace with decreases in inpatient capacity, and shortages of key outpatient care staff were described as worsening.

These gaps in community services were seen as responsible for (1) the high and increasing rates of mental illness among homeless people, (2) correctional facilities having become the "de facto institution for the mentally ill," and (3) the increased use of emergency departments among people with mental illnesses living in the community despite long waits for needed services upon visiting an emergency department.

While Medicaid has become the single largest payer of mental health services for low-income people, low reimbursement from Medicaid was the most frequently cited reason for gaps in outpatient capacity for mental health services, with Medicaid payment rates 64% of Medicare reimbursement. Declining reimbursement relative to cost was also cited as one of the main reasons for inpatient capacity constraints in many communities and the elimination of less profitable psychiatric wards. Recent state budget pressures were reported to have added to these service gaps, with some mental health care providers noting that states had narrowed the definition of serious mental illness in determining eligibility for services.

Although a few states and communities bolstered community mental health funding and programs, these increases were described as not having had a noticeable impact on the capacity of community-based services for the mentally ill and not coming close to meeting the large need for services, particularly for housing. Peter Cunningham, Kelly McKenzie, & Erin Fries Taylor, *The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illnesses*, 25(3) HEALTH AFF. 694 (May/June 2006).

Federal District Court in California (located within the Ninth Circuit)

Security Company Can Be Held Liable for Patient's Attack on Physician, but Public Entity that Designed or Maintained the Conditions Within the Facility Can Not

Although incidents of violence are relatively infrequent in facilities that provide housing to individuals with mental illness, protecting the safety of residents and staff is a continuing concern. After a physician was killed by a patient who had been admitted and held pursuant to California law for a seventy-two-hour evaluation as a person who is dangerous or gravely disabled as the result of a mental disorder, family members of the physician sued the facility where the attack occurred, the County responsible for the facility, and the privately owned entity that had contracted to provide security services at the facility.

The attack occurred while the doctor was alone with the patient in an isolated room approximately 100 feet from the nearest nurses' station. He was conducting a physical examination and obtaining the patient's history. During the preceding year, staff had

complained about safety at the facility and penalties had been imposed by the State of California's Division of Occupational Safety and Health. However, little subsequent change in safety policies and procedures ensued.

The facility relied primarily on an unwritten "buddy system" policy that required staff to be accompanied by another person at all times when dealing with patients and the presence of a "panic button" in each examination room. A federal district court in California ruled that the family could proceed with its lawsuit against the security company, but rejected the claims again the facility and the County.

Facility Liability. As for the facility, the court noted that as a general rule governmental entities do not have an obligation under the federal constitution to provide minimal levels of safety and security in the workplace, unless the governmental entity's affirmative conduct placed the employee in danger (a so-called "danger creation" exception recognized by the Ninth Circuit). The court concluded that the family had failed to show any affirmative act by the facility that caused or increased the danger to the physician and ruled that merely showing that the facility maintained an unsafe work environment was insufficient.

The court noted that although the policy was unwritten and not always complied with, measures were in place to try to minimize the danger to employees and there was no evidence that the facility would have denied a request by the physician to have another staff member accompany her or would not have permitted her to use another, less isolated room. Ursua v. Alameda County Med. Ctr., No. C 04-3006 BZ, 2005 WL 3002175 (N.D. Cal. Oct. 27, 2005).

County Liability. As for the County, the family asserted that the County should be held liable for the defective design of the facility, which resulted in an unsafe facility. The court found, however, that under California law the County was entitled to "design immunity," which served as a complete defense to the family's negligence claim against the County. The court determined that the County was not required to show that the architects or other decision-makers specifically discussed and approved the safety and location of the room where the attack occurred, but only to show the overall reasonableness of the design.

The court added that the presence of panic buttons in the rooms indicated that the architects did consider staff safety in designing the building and that as a general matter the courts must defer to the judgment and approval of the public officials involved unless there is some violation of guidelines or standards. Here, the court noted, multiple agencies had reviewed and approved the design and there was no evidence that the County violated any laws, codes, or regulations in designing the facility. Ursua v. Alameda County Med. Ctr., No. C 04-3006 BZ, 2005 WL 3002175 (N.D. Cal. Nov. 8, 2005).

Security Agency Liability. However, the court did rule that the family could proceed with its lawsuit against the security agency. The court held that a security company may be held liable where its failure to act reasonably under the circumstances causes injury to those it has contracted to protect. The court determined that under California law a security company owes a duty to the employees of the entity that hired it and that pursuant to its contract this security company was responsible for protecting the patients and staff at the facility.

Further, the court found there was evidence that the security company may have breached this duty by making unilateral changes in the assignment of security guards, including a failure to provide a roving security guard. The court also cited a series of examples of substandard services provided by the security company.

The court concluded that a reasonable jury could find that if the security company had provided the level of security that it had agreed to provide, the attack on the physician

might have been prevented or intervention could have occurred in time for the physician to survive. Ursua v. Alameda County Med. Ctr., No. C 04-3006 BZ (N.D. Cal. Nov. 9, 2005), http://www.cand.uscourts.gov/cand/judges.nsf/61fffe74f99516d088256d480060b72d/63b3e70a3a2db0e0882570b40082f647/$FILE/SJM.ABC.ORD.pdf.

Developments in Other State Courts

Indiana

Indiana Supreme Court Rules that Defendants Can Not Be Required to Show Their Mental Retardation by Clear and Convincing Evidence in Death Penalty Cases, and Evidence Can Include Tests and Manifestations that Occurred After the Age of 21

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court ruled that a death penalty cannot be assigned to criminal defendants who are mentally retarded, but did not define mental retardation nor establish the procedures to be used in making this determination. The Indiana Supreme Court answered a number of related questions in applying Indiana's definition of a "mentally retarded individual" as being "an individual who, before becoming twenty-two years of age, manifests: (1) significantly subaverage intellectual functioning; and (2) substantial impairment of adaptive behavior."

For example, the court ruled that placing the burden on defendants to prove by clear and convincing evidence that they are mentally retarded is not permissible. The court noted that it is unconstitutional to require a defendant to prove his incompetence to stand trial by clear and convincing evidence.

Because mentally retarded defendants may be less able to give meaningful assistance to their counsel, are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes, the court determined that requiring defendants to establish mental retardation by clear and convincing evidence would result in the execution of some persons who are mentally retarded and outweighs the state's interest in seeking justice.

Arkansas, Maryland, Missouri, Nebraska, New Mexico, and Tennessee have reached a similar conclusion. However, Arizona, Colorado, and Florida require defendants to show mental retardation by clear and convincing evidence, while Georgia requires defendants to demonstrate mental retardation beyond a reasonable doubt.

The court also determined IQ tests are not conclusive evidence of intellectual functioning and that a court may consider other evidence of mental capacity. Thus, a defendant's scores on academic achievement tests can be considered notwithstanding testimony that they may vary as much as fifteen to twenty-five points from a person's true IQ.

The Indiana Supreme Court also permitted the consideration of evidence of intellectual functioning after reaching the age of twenty-two, including a defendant's ability to fill out applications for employment and hold a number of jobs over the years. IQ tests given after the defendant turned twenty-two could also be weighed because otherwise a defendant older than twenty-two who had never been tested could never be found mentally retarded based on IQ testing. Although such evidence may be of less significance, the court concluded it was still relevant.

The Indiana high court also addressed the adaptive behavior prong of the mental retardation test. A plurality of the court found that *Atkins* required at least general conformity with definitions accepted by those with expertise in the field, such as definitions provided by the American Association on Mental Retardation (AAMR) or the DSM-IV.

Although the Indiana statutory definition is somewhat different from that provided by the DSM-IV, the court found it very similar to the AAMR definition of adaptive functioning and thus within the range of permissible standards. The court found that the trial court used an adaptive behavior standard that was too restrictive in that it embraced only the bottom 10-25% of those individuals who would

be found to have a substantial impairment of adaptive behavior under clinical standards.

The court rejected arguments that a defendant's sentence should be reduced because of limited mental capabilities that do not reach mental retardation or because the defendant suffered from a mental illness at the time of the crime. The court ruled that the death penalty is appropriate for an individual who is able to function and adapt as an adult in society and was able to comprehend the wrongfulness of his actions.

A dissenting opinion argued that IQ test scores obtained after a defendant turns twenty-two are irrelevant, that evidence of adaptive behavior must be limited to how well a person deals with everyday life demands before the person reaches the age of twenty-two, and that the DSM-IV definition of impairment of adaptive functioning should be the guiding test. Pruitt v. State, 834 N.E.2d 90 (Ind. 2005).

Michigan

Psychiatric Hospital Not Liable for the Death of a Patient Following a Struggle with Hospital Staff

The Michigan Court of Appeals refused to impose liability on a psychiatric hospital for the death of a patient who had been admitted to its care. The man had been transported by the police to the psychiatric facility, where he was found to be in need of care but capable of giving informed consent. After he signed a voluntary admission form, the hospital admitted him, gave him medicine for back pain, and placed him in a "quiet room."

Overnight he became increasingly agitated, culminating in a struggle with hospital staff and the injection of a calming drug. The man stopped breathing, allegedly as a result of the staff's compression of his breathing capacity during the struggle, and subsequently died. A lawsuit filed on behalf of the man's estate argued that the hospital had failed to meet its contractual obligations to provide adequate treatment and violated the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

The Michigan Court of Appeals began by dismissing the contractual claim. The court found that the signed voluntary admission form did constitute a contractual agreement between the hospital and the patient, but concluded that the contract only *authorized* treatment and did not impose any particular treatment obligations. Although Michigan law establishes a preexisting duty to provide mental health services under these circumstances, the court ruled that this contract did not establish such a duty and therefore the contract could not provide a basis for recovery of damages resulting from an asserted failure to provide needed care.

As for the EMTALA claim, the court determined that it requires hospitals (1) to afford an appropriate medical screening to all persons who come to its emergency room seeking medical assistance, and (2) to provide those services necessary to "stabilize" any emergency medical condition found to exist in these patients.

The court rejected the plaintiff's argument that hospital staff failed to meet the second requirement. The court ruled that that this provision only applies in the event of a patient discharge or the transfer of a patient outside the facility. Noting that EMTALA was not intended to provide a federal malpractice statute, because this patient was neither transferred nor discharged, but rather admitted, the EMTALA requirements were deemed inapplicable.

A dissenting opinion, while agreeing with the ruling on the contractual claim, asserted that EMTALA requires that a hospital *either* provide stabilizing medical treatment *or* transfer the patient elsewhere. The dissent noted that the federal courts of appeals have split on this issue and that at least one court (the Ninth Circuit) that had adopted the position held by the majority had qualified its ruling by adding that admission for inpatient

care does not terminate EMTALA liability if the admission was not done in good faith. The dissert argued that an allegation, as here, that the patient had been provided no mental health treatment after admission called into question whether the admission had been made in good faith and thus did not terminate the hospital's EMTALA obligations. Lanman v. Kalamazoo Psychiatric Hosp., No. 263665, 2006 WL 73747 (Mich. Ct. App. Jan. 12, 2006).

Detroit Police Department Agrees to Videotape Interrogations of Murder Suspects Following Settlement of Lawsuit Focused on False Confession Obtained from a Suspect with Mental Illness

The Detroit Police Department, under pressure from a pair of consent decrees with the Department of Justice and pursuant to the settlement of a lawsuit brought by the family of a man with mental illness who spent seventeen years in prison after confessing to a rape and murder that he did not commit, agreed to videotape interrogations of all suspects in crimes that carry a penalty of life in prison without the possibility of parole.

In 2002, the only states that required videotaped interrogations were Minnesota and Alaska, but at least 450 police departments across the country now do so. This change has been driven by DNA testing that has led to the release of numerous prisoners and raised concerns about the prevalence of coerced and false confessions. Many police departments have embraced this change because they believe it will show that the confessions they obtain, which are often pivotal to their ability to secure convictions, are not coerced.

The lawsuit that provided the impetus for the videotaping policy in Detroit focused on the arrest and conviction of Eddie Joe Lloyd. Lloyd, who suffered from delusions that he had a special ability to solve crimes, sent a letter to the police while he was a patient at the Detroit Psychiatric Institute in early 1984. Lloyd had been involuntarily committed for an evaluation following a violent dispute with a clerk in a welfare office a few weeks earlier. In the letter, Lloyd offered to help in the investigation of the killing of a sixteen-year-old girl, who was the latest victim in a series of rapes and murders. Lloyd claimed to have overheard someone at a store mention something relevant to the investigation. Although he had written similar letters in the past that falsely claimed he knew things that would allow the police to solve other heinous and well-publicized crimes, the police said in this case he mentioned details that had not been released to the public.

A detective conducted three interviews with Lloyd at the psychiatric facility and, according to Lloyd and the lawsuit, fed him details of the crime and convinced him that confessing would help the police find the real killer. Lloyd signed a written confession and gave a tape recorded statement (which was later played to the jury), refused to allow his attorney to pursue an insanity defense, was convicted of first degree felony murder by a jury that deliberated less than half an hour, and was sentenced to the maximum term available, life in prison.

After more than a decade in prison, Lloyd was able to obtain DNA testing of crime-scene evidence that established he had not committed the crime and eventually won his release. Two years later he died at the age of fifty-four. Jeremy W. Peters, *Wrongful Conviction Prompts Detroit Police to Videotape Certain Interrogations,* N.Y. TIMES (Apr. 11, 2006); Jodi Wilgoren, *Confession Had His Signature; DNA Did Not*, N.Y. TIMES (Aug. 26, 2002).

New Hampshire

Without Evidence of Specific Acts Demonstrating Actual or Likely Serious Bodily Injury, Discontinuation of Prescribed Medications Can Not Serve as Basis for Involuntary Hospitalization

The New Hampshire Supreme Court reversed an order to involuntarily hospitalize a woman

with a history of mental illness who had discontinued her prescribed medications. In 1999, a judge had ordered the woman involuntarily hospitalized after she overdosed on prescribed medications. The commitment was for a maximum of two years but she was conditionally discharged prior to the expiration of that period. In New Hampshire, an individual who has been involuntarily committed can spend the remainder of the period of commitment in the community if the individual agrees to comply with imposed conditions.

In 2001, she was involuntarily admitted again, this time for a maximum of three years, although again she received a conditional discharge. One of the conditions of her discharge was that she take her prescribed medications. In December 2002, the conditional discharge was temporarily revoked and she was hospitalized for twenty days after she discontinued her medications on two occasions and experienced what was described as "agitation, pressured speech, and preoccupation with side effects of the medications."

In May 2004, three weeks before the expiration of the three-year involuntary commitment order, police found the woman wandering the streets in a confused state and complaining of chest pains. She was taken to an emergency room, where a physician examined her and recommended a psychological assessment. During this assessment, the woman acknowledged she was not taking her prescribed medications. This resulted in another temporary revocation of her conditional discharge.

Three days after the expiration of the three-year involuntary commitment, an employee of a mental health center, who had been contacted by members of the woman's family, filed a petition for involuntary commitment of the woman. The petition focused on her history of not taking her prescribed medications and her stated intent to stop taking these medications and to take a homeopathic medicine in their place. A judge ordered her hospitalized and extended her conditional discharge for an additional three years.

The New Hampshire high court ruled that this order was impermissible under state law. First, although New Hampshire law authorizes a lower standard of proof for revoking conditional discharge ("to prevent the recurrence of the circumstances which led to the person's dangerous condition") than for issuing the initial involuntary admission order ("potentially serious likelihood of danger to himself or others"), the court determined that this lower standard did not apply when, as here, the initial involuntary admission order had expired. Under New Hampshire law, the court explained, a conditional discharge order could not exceed the length of the involuntary admission order.

Second, the court determined that there was insufficient evidence to justify a new involuntary admission and related conditional discharge order. The court noted that before involuntary admission can be ordered under New Hampshire law there must be a finding of a threat, a likelihood, an attempt, or an actual infliction of serious bodily injury on oneself or another or a lack of capacity to care for one's own welfare such that there is a likelihood of serious debilitation if admission is not ordered. Because the interests at stake, namely loss of liberty and social stigmatization, are substantial, the court required that this dangerousness be proven by clear and convincing evidence.

The court ascertained that the evidence of the woman's dangerousness consisted of her poor insight into her illness and a history of choosing to discontinue her medications. The court concluded, however, that evidence that the woman experiences agitation, delusion, and paranoia when off her medications does not make her "dangerous" as defined by New Hampshire law because these symptoms do not constitute the requisite specific acts of actual or likely serious bodily injury. The court rejected the assertion that the woman's claim

of chest pains or walking on a street proved her present or future dangerousness.

Further, while an overdose is a specific act that has the potential to cause serious bodily injury, the court determined that an overdose occurring five years earlier was not sufficiently recent or sufficiently similar to current events to establish present or future dangerousness. The court noted that the woman had discontinued her medication multiple times since then and had not experienced a subsequent overdose.

Even though a psychiatrist testified that the woman was currently dangerous, the court concluded that "without evidence of dangerous conduct, even the most persuasive psychiatrist's report is insufficient to justify commitment." *In re* B.T., 891 A.2d 1193 (N.H. 2006).

Hospital and Physician Liable Under EMTALA for Transferring Suicidal and Intoxicated Patient to Jail for Protective Custody

A recently completed national survey of hospitals found that 55% of all hospital admissions (excluding pregnancy and childbirth) in 2003 entered the hospital through the hospital's emergency department, a total of 16 million patients. The fifth most-often given reason for admission was mental health and substance abuse disorders (5.8% or nearly 1,000,000 patients, with 387,500 patients admitted for the treatment of mood disorders). Anne Elixhauser & Pamela Owens, *Reasons for Being Admitted to the Hospital Through the Emergency Department, 2003,* Healthcare Cost and Utilization Project (H·CUP) (Feb. 2006), http://www.hcup-us.ahrq.gov/reports/statbriefs.jsp.

Since 1986, most hospitals are required under federal law to take certain steps to ensure appropriate care for emergency room patients. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency rooms to (1) properly screen all patients seeking medical assistance and, (2) if the patient has an emergency medical condition, either treat the patient as necessary to stabilize the patient's condition or transfer the patient to another medical facility when such a transfer is relatively safe and medically advisable.

Patients with a mental health or substance abuse disorder arriving at an emergency room may pose special challenges for treatment staff. For example, their arrival may have been precipitated by police officers responding to a confrontation in the community. Although they may pose safety and management issues, the mandates of EMTALA are still relevant.

In a New Hampshire case, a woman with a history of alcohol abuse and mental illness became increasingly depressed and suicidal after a day of drinking. Around midnight she drove to the emergency room of a nearby hospital and told the physician on duty that she had been drinking and had been thinking about killing herself. The physician asked the woman if she would see a counselor from an organization that treated patients with a mental illness at the hospital, but the woman declined because she was involved with the organization through her job. Without discussing the matter further with his patient, the physician then called the police and provided medical clearance to have the woman taken to jail for protective custody "for suicidal intent and alcohol intake."

The woman successfully sued the hospital for violating EMTALA and the New Hampshire Patients' Bill of Rights Act, and the physician for professional negligence. The New Hampshire Supreme Court upheld this verdict on appeal. Focusing primarily on EMTALA's requirements, the court initially determined that the woman had produced sufficient evidence that she presented an "emergency medical condition" when she arrived at the hospital intoxicated and feeling suicidal with a plan to carry out her suicide.

The court further determined that she had not been properly "stabilized" before being

transferred because a psychiatric patient is considered stable for purposes of discharge under EMTALA only when he or she is no longer considered to be a threat to self or others. The court found that the evidence indicated that neither her suicidal ideation and plan nor her alcohol intoxication had been stabilized when she was transferred to the jail. The court added that for a transfer to be permissible under EMTALA, the transfer must be to another medical facility.

The court also ruled that EMTALA trumped a state law that permitted peace officers to take into protective custody and place for up to twenty-four hours in jail a person who is intoxicated in the judgment of an officer. The court reasoned that EMTALA was enacted to prevent hospitals from transferring patients without first assessing or stabilizing their emergency conditions, and allowing a hospital to summon a police officer for the purpose of removing and jailing an intoxicated, unstabilized patient would undercut this goal.

The court also rejected a pair of defenses asserted by the physician. First, the court ruled that the physician's actions were not protected by New Hampshire's "Duty to Warn" statute, which allows a physician to notify the police of a communicated, serious threat of physical violence. The court concluded that no warning is necessary for a threat of suicide because the potential attacker and the potential victim are the same person and thus the law did not apply here.

Second, the court rejected the physician's argument that he was protected by a New Hampshire law that permits a person who reasonably believes another person is about to commit suicide to use reasonable force to thwart a suicide effort. The court ascertained that there were less harmful steps the physician could have taken to keep this woman safe from harm and ruled that the physician violated his duty of care by placing her in protective custody instead of pursuing other treatment options. Carlisle v. Frisbie Mem'l Hosp., 888 A.2d 405 (N.H. 2005). The New Hampshire Patients' Bill of Rights Act, which reads in part that a "patient shall be transferred or discharged . . . only for medical reasons" can be found at http://www.gencourt.state.nh.us/rsa/html/xi/151/151-21.htm.

Parent May Be Denied Access to Child's Mental Health Records During Divorce and Custody Proceedings

Children may be receiving mental health services while their parents are in the process of becoming divorced. During a custody dispute, a parent may seek to gain access to a child's mental health records in an effort to establish through the discussions between the child and the child's therapist that the other parent has engaged in inappropriate conduct. Although parents generally have a right to access the mental health records of their children, the New Hampshire Supreme Court ruled that this right is significantly limited when asserted in connection with divorce proceedings and custody disputes.

In the case before the court, the father alleged that the mother had alienated his children from him, and sought access to the records and notes of the children's therapists to obtain supporting evidence for his claim that the mother interfered with his right of visitation. While acknowledging that parents have a constitutional right to raise and care for their children, the court noted that in a custody dispute there is a "distinct possibility" that a parent will not make a decision regarding access to the child's mental health records based on the child's best interests.

Indeed, the court added, in this context it may be the parents that are the source of the child's distress and allowing parents unfettered access to their children's therapy records may inhibit the child from seeking or succeeding in treatment, and forced disclosure may result in substantial emotional harm to the child. Further, denying a minor the opportunity to at least object to the involuntary disclosure of his or her therapy records in this context is likely to have a negative effect on the minor's relationship with

the therapist and taint the child's perception of the fairness of the legal process.

The court cited rulings from California, Florida, Kentucky, Maryland, Massachusetts, and Missouri that have afforded protection to the mental health records of children who are at the center of a custody dispute or whose interests may be in conflict with those of their parents.

As a result, the court held that parents do not have an absolute right of access to these records under either the federal or New Hampshire constitutions or under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, and ruled that this right must yield to the parens patriae power of the State when the child's welfare is at stake. Determining access is a decision to be made by the judge with jurisdiction over a custody dispute, who must determine if it is in the best interests of a child to have confidential and privileged therapy records revealed to his or her parents, with particular emphasis to be given to the preservation of the child's ability to engage in open and productive therapeutic treatment.

Further, the trial court should consider whether the child is of sufficient maturity to make a sound judgment about access to these records based on (1) the child's age, intelligence, and maturity, (2) the intensity with which the child advances his preference, and (3) whether the preference is based upon undesirable or improper influences. If the child is found to be a mature minor, the court is to give substantial weight to the child's preference in deciding whether a parent should be entitled to access the child's mental health records. *In re* Berg, 886 A.2d 980 (N.H. 2005).

Texas

Andrea Yates Found Not Guilty by Reason of Insanity After Retrial

At roughly the same time that the United States Supreme Court was issuing its ruling in *Clark v. Arizona*, 126 S. Ct. 2709 (2006), that states can limit the scope of their insanity defense, a Texas jury returned a verdict that Andrea Yates was not guilty by reason of insanity for drowning her young children in their bathtub at home five years ago. Texas, like Arizona, employs an insanity defense that is limited to what the Supreme Court refers to as the moral incapacity test (i.e., that as a result of mental illness, the defendant did not know right from wrong).

Yates was suffering from postpartum psychosis when she drowned all five of her children, ranging in ages from six months to seven years, one-by-one on the morning of June 20, 2001. Yates, a former nurse and high school valedictorian, had undergone psychiatric treatment for two years prior to the incident following the birth of her fourth child. During this period, she attempted to commit suicide twice, had been hospitalized for psychiatric treatment several times, and had been prescribed Haldol, a medication to control hallucinations and other symptoms associated with psychosis.

Evidence at trial indicated that Yates waited for her husband to leave for work before drowning her children. She placed four of the bodies on the bed in the master bedroom under a sheet but left her eldest son floating in the bathtub. Yates then telephoned her husband and the police. When the police arrived, she told them she had killed her children because she believed that she was a "bad mother," that her children were "damaged" as a result, and that killing them was the only way she could save them from Satan and ensure their place in heaven.

The district attorney charged Yates with capital murder and sought the death penalty. In response, Yates entered a plea of not guilty by reason of insanity. It was not disputed that Yates suffered from a mental illness. The State's sole mental health expert, however, testified that Yates, although psychotic, knew that what she did was wrong, based in part on the fact that she had called the police.

After the jury returned a guilty verdict (and ultimately pronounced a life sentence), it was discovered that the State's expert had made a misstatement in his testimony, which resulted in the Texas Court of Appeals vacating the verdict. The case attracted considerable national attention, with some indication that after initial abhorrence at the nature of the acts, public opinion evolved to where a certain understanding of and sympathy for Yates' condition began to emerge.

The retrial, perhaps because the death penalty was no longer available, did not generate as much attention. Although the month-long trial itself differed little from the first trial (albeit without the misleading information provided in the first trial), the jury returned a verdict of not guilty by reason of insanity after deliberating for about twelve hours.

After the trial, the foreman of the jury stated: "We understand that she knew it was legally wrong. But in her delusional mind, in her severely mentally ill mind, we believe that she thought what she did was right." Yates, now age forty-two, was committed to a maximum-security state hospital where she will reside unless a court at some point decides that she does not pose a danger to herself or others. Carol Rust, *Yates Is Not Guilty by Reason of Insanity*, WASH. POST, July 27, 2006, at A03; Rick Casey, *Yates Jury Wiser than Hired Guns*, HOUS. CHRON., Aug. 2, 2006.

Commentators responding to the Supreme Court's ruling and the Yates' verdict asserted that critics of the insanity defense (as well as critics of associated efforts to discern whether a defendant should be held morally responsible for a criminal act) may characterize the defense as a "quaint relic of a bygone era" in light of scientific findings that show that a range of factors influence human behavior. They countered, however, that although there is a need to be skeptical about claims of non-responsibility, a civilized society does not punish those who can be deemed morally impaired by mental disorder, to do otherwise would be immoral and unjust, and that the criminal justice system "can reasonably decide whom to blame and punish." Morris B. Hoffman & Stephen J. Morse, *The Insanity Defense Goes Back on Trial*, N.Y. TIMES, July 30, 2006.

Other Developments

Surge in Medicaid Outpatient Spending on Psychotherapeutic Drugs Noted

The federal government pays for one-third of all mental health services provided in this country, primarily through Medicaid and Medicare. Associated costs, as well as health care costs in general, have risen steadily in recent years. Prescriptions for psychotherapeutic drugs have spurred a dramatic increase in Medicaid spending on outpatient prescription drugs. Outpatient prescriptions (i.e., prescriptions not given to patients in hospitals or nursing homes) doubled from 1997 to 2002 from $11.6 billion to $23.7 billion. This average increase of 20% per year reflected both a greater number of prescriptions being written and the availability of newer classes of drugs, which are typically more expensive.

Antidepressants and all other psychotherapeutic drugs made up the largest category of drugs prescribed to Medicaid beneficiaries in 2002. Spending on antidepressants rose 130% during the five-year period, with the number of Medicaid enrollees taking antidepressants increasing 50% during this span (an increase from 2.5 million enrollees in 1997 to 3.7 million enrollees in 2002). The total amount spent on all psychotherapeutic drugs for this population during this period increased 127%. *New AHRQ Study Shows Medicaid Spending on Outpatient Drugs More than Doubled in Recent Years* (Apr. 26, 2006), http://www.ahrq.gov/news/press/pr2006/meddrugpr.htm.

DHHS Office of Inspector General

Proposed Pediatric Psychiatric Day Treatment Facility Owned by Three Psychiatrists Does Not Violate Federal Law

Under federal law, the ability of a health care provider to refer a Medicare or Medicaid patient to a facility with which the provider has a financial relationship is limited. Such "self-referrals" had become quite common in the United States in the late 1980s and early 1990s and were considered to be generating excess referrals, compromising professional judgment, causing unfair competition, and significantly adding to the cost of health care.

A pair of laws passed by Congress in 1989 and 1993 (commonly known as the anti-kickback laws or Stark I and Stark II, respectively), significantly limit health care providers' ability to make self-referrals involving patients whose health care is federally funded. Because of confusion over their scope, a mechanism was implemented that allows health care providers to request an "opinion letter" from the federal Department of Health and Human Services' Office of Inspector General (OIG) on whether a proposed business venture is likely to result in sanctions under federal law.

Three psychiatrists who wanted to form a partnership to open a pediatric psychiatric day treatment facility requested such an opinion letter from the OIG. The planned day treatment facility, which would be solely owned by the three psychiatrists, would provide up to six hours per day of supervised care, including various forms of psychiatric and substance abuse therapy, for pediatric patients.

While finding that the proposed agreement could generate prohibited remuneration under the federal law, the OIG concluded that it would not draw sanctions as the plan was currently constituted because of several factors that adequately mitigated the risk of federal health care program fraud and abuse.

For example, the OIG determined that the proposed venture was unlikely to serve as a vehicle to compensate the psychiatrists for referrals of federal health care program beneficiaries to the facility because fewer than 5% of the facility's patients will be

beneficiaries of federal health care programs and the vast majority of such patients will be referred to the facility by providers who are not owners of the facility. The OIG added that only a small part of the facility's revenue (no more than 2%) was expected to be derived from federally funded patients referred to the facility by a psychiatrist owner. Because 95% of the patients will be referred to the facility by clinicians who have no ownership stake in the facility and 98% of the facility's revenues will be derived from non-federal health care sources, the OIG reasoned the venture was unlikely to drive over-utilization of federal health care benefits.

Further reducing the OIG's concerns was a provision that all patients referred by one of the psychiatrist-owners must be subjected to an independent evaluation by an evaluator whose compensation was not contingent on the results of the evaluation. This was viewed as an additional safeguard on over-utilization or inflated costs. The OIG also noted that pediatric psychiatric day treatment by its nature inherently limits the number of potential federal health care program patients. Office of Inspector Gen., Dep't of Health & Human Services, Advisory Opinion No. 05-12 (2005).

Submission Guidelines

Developments in Mental Health Law (DMHL) encourages the submission of articles on timely and interesting topics regarding mental health law. The DMHL reading audience typically has legal or mental health training but not necessarily both. We seek articles that are of interest to this diverse audience.

Submissions can be mailed to: Editor, *Developments in Mental Health Law,* P.O. Box 800660, 1107 Main Street, Charlottesville VA 22908-0660. Inquiries can be sent via e-mail to the Editor at th4n@virginia.edu. The quickest means for the editor to contact you is via e-mail, so please include an e-mail address, if possible.

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