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The Refusal of Antipsychotic Medication: A Clinical View

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The right of involuntarily committed mental patients to refuse antipsychotic medications is currently an issue of litigation in courts across the country and of debate in the legal and psychiatric literature. Though lawyers and psychiatrists bring to the controversy widely divergent perspectives, the ultimate aim of their dialogue should be to protect patients' rights while delivering effective care. Unfortunately, however, many legal decisions and commentaries are based upon a limited number of law review articles which present incomplete and inaccurate versions of medical facts and thus do little to rectify the widespread misunderstanding of antipsychotic medications. This article describes some of the realistic benefits and risks of treatment with antipsychotic medication and outlines the complex clinical issues involved in the refusal of medication by involuntarily committed patients. A basic understanding of these clinical issues is a prerequisite to formulation of responsible policy regarding the refusal of medication.

The Risk/Benefit Calculation

Virtually every type of medication carries with it both beneficial and undesired effects. A familiar example of this is aspirin, which relieves fever, inflammation, and pain but can also cause severe gastrointestinal irritation. The decision of whether to treat with aspirin, therefore, inevitably involves the weighing of benefits against risks. This risk/benefit ratio varies according to the type of medication prescribed and the circumstances under which the medication is to be administered, including the duration of the proposed treatment.

An important distinction when calculating the risk/benefit ratio of antipsychotic medications is between short term administration and long term maintenance treatment. In the discussion which follows "short term" administration refers to a time ranging from several days to several months. "Long term" maintenance therapy, on the other hand, refers to a time ranging from many months to years.

Benefits and Risks of Short Term Treatment with Antipsychotic Medication

The evidence for the benefits of treatment with antipsychotic drugs is compelling. There are now over ten thousand reports in the literature supporting the efficacy of pharmacotherapy in treating major mental disorders. Several hundred studies investigate the pharmacologic treatment of schizophrenia using random assignment of subjects and double-blind procedures. The best of these are the approximately seventy studies that are controlled, i.e., that compare the efficacy of active medication with that of a placebo.

The most comprehensive of the randomized, controlled, double-blind stu-

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Continued from page 1

dies to date was undertaken by Cole and his co-workers at the National Institute of Mental Health. This NIMH collaborative study was a multihospital project in which schizophrenic patients randomly were assigned to receive antipsychotic drugs or placebos. Their clinical courses then were evaluated for six weeks using a double blind methodology. (See Table I.) In the NIMH collabortative study, the majority of patients on placebo showed no improvement; half of them worsened during the six-week trial. Indeed, some of the placebo patients deteriorated to such a degree that for them the trial had to be terminated prematurely, and treatment with medication had to be instituted on an emergency basis. Approximately seventy-five percent of the drug treated patients versus twenty-five percent of the placebo treated patients showed much improvement within six weeks. And, twenty percent of the drug treated patients versus fifteen percent of the placebo treated patients showed slight improvement. Thus, the increment of improvement produced by antipsychotic medications for the treatment of schizophrenia in six weeks in this study was a substantial one. These results are representative of those found in many other studies which have been carried out in both the U.S. and other countries.

What is the nature of the improvement that antipsychotic medications produce in schizophrenic patients? One can conceptualize schizophrenia—in a somewhat overly simplified fashion—as a mental syndrome consisting of both positive and negative symptoms. Hallucinations, delusions, and disorganization of thinking may be classified as "positive symptoms." "Negative symptoms" may include social withdrawal, blunting of emotion, and impairment of goal directed behavior. In producing improvement, antipsychotic medications ordinarily eliminate or markedly reduce positive symptoms. They also ameliorate negative symptoms but are less successful at this.

So well established has the short term efficacy of antipsychotic drugs become that it may well be unethical to withhold them because, for example, of a desire to conduct a controlled study of long term efficacy. Prior to the advent of the antipsychotic medications, many schizophrenic individuals spent substantial parts of their lives in mental hospitals. Indeed, while the impetus behind the massive changes in institutionalization which have taken place within the last twenty-five years may have been primarily an economic one, antipsychotic medications have played a major role in allowing deinstitutionalization to occur.

TABLE I

NIMH Collaborative Study

Clinical Outcome After Six Weeks of Treatment

	Much Improvement	Slight Improvement	No Change	Worse
Drug	75%	20%	5%	0%
Placebo	25%	15%	15%	45%

What are the risks of short term treatment with antipsychotic medications? The prevalence of side effects has been discussed in several thousand articles. The frequency of occurrence for certain undesirable side effects can be quantitatively estimated. The most serious side effects, such as bone-marrow suppression or liver sensitivity, occur perhaps two to five times in ten thousand patients. The least serious side effects are the most common; these include dry mouth, blurred vision, dizziness upon standing, drowsiness, and constipation. These side effects are temporary but annoying, generally minor in intensity, and more of a nuisance than a serious medical threat. The average patient will have one or two of these minor side effects.

In terms of their frequency and the discomfort they can cause, the most significant risk of short term treatment with antipsychotic medications is extrapyramidal side effects (EPS). The EPS can be placed into three categories. There are acute dystomas—sudden contractions of muscle groups—which occur during the initiation of drug treatment. If the patient is not adequately forewarned, acute dystomas can be particularly frightening. Akithesia, a motor restlessness characterized by pacing and fidgeting, can also occur. Finally, there is drug-induced Parkinsonism, characterized by tremor, slowing of movement, and muscle rigidity, in addition to a characteristic alteration of gait and frequent flattening of facial expression. Hence, one occasionally hears that after drug treatment was started the patient began to look "like a zombie."

Extrapyramidal side effects occur in anywhere from five to forty percent of patients treated with antipsychotic medications, depending upon the specific drug chosen and the age of the patient. The EPS tend to occur during the first few weeks of treatment. Afterwards they usually subside. EPS can also be managed by reducing the dosage of medication, by switching to another antipsychotic medication, or by simultaneously administering anti-Parkinsonian drugs or amantadine. When the antipsychotic medication is discontinued, the EPS cease completely within a day or two.

Benefits and Risks of Long Term Treatment with Antipsychotic Medication

The foregoing discussion applies only to short term treatment with antipsychotic medication in which the goal consists of alleviation of acute psychotic symptoms such as hallucinations, delusions, or grossly disorganized thinking. In long term, maintenance treatment the goal is quite different. Maintenance therapy is almost

Continued on page 8

In the Virginia General Assembly—1983

Natural Death Act Adopted

With the Governor's approval of House Bill No. 329, Virginia became the 15th jurisdiction to enact "natural death" (also called "death with dignity" or "right to die") legislation.

Most natural death legislation is concerned solely with providing a means by which competent adult patients may give contemporaneous consent to the withdrawing or withholding of life-prolonging treatment or by which they may do so prospectively through written declarations (or "living wills").

Virginia's Natural Death Act, 1983 Va. Laws ch. 532 enacting §54-325.8:1 *et seq.*, goes far beyond all previously enacted legislation in authorizing next-of-kin to consent to the withholding or withdrawal of treatment from any terminally ill adult who is "comatose, incompetent, or otherwise physically or mentally incapable of communication" and who has not made an advance declaration (§54-325.8:6).

Of the measures adopted by other states, only those in New Mexico, North Carolina, and Arkansas permit persons other than the patient to elect to allow the patient to die. In New Mexico, third party decisionmaking of this sort is restricted to terminally ill minors who do not express a preference to live. In North Carolina, only terminally ill patients who are irreversibly comatose may be permitted to die on the consent of a third party. And in Arkansas, while third party consent to removal of life support is authorized, the attending physician is not required to comply with the wishes of the third party decisionmaker. In New Mexico, North Carolina, and Arkansas, the third party decisionmaker need not be judicially appointed but may simply be a relative.

Unlike the Arkansas act, the Virginia Natural Death Act requires the physician either to comply with the instructions of the third party decisionmaker or to make reasonable efforts to transfer the patient.

Because "living wills" are seldom executed even where approved by statute, and because by the time the prolongation of treatment to the terminally ill patient becomes an issue the patient usually is no longer capable of giving informed consent to the provision or withdrawal of treatment, the language in §54-325.8:6 allowing third party consent to the withholding or withdrawal of treatment will prove to be the most significant aspect of the bill.

Ironically, the Report (House Document No. 32 at 8) of the committee which drafted the Natural Death Act indicated that the committee felt that it had not had sufficient time to study problems involving "terminally ill minors and incompetents" and thus would not attempt to address those problems in H.B. No. 329.

As written, the Virginia Natural Death Act fails to prescribe standards and procedures for fairly and accurately selecting a third party decisionmaker with the power of life and death over the ward. In addition, it fails as well to assure that a "living will" truly represents the previously expressed wishes of the patient and does not violate the actual wishes of the patient when it is acted on. Several states have required that, where the person making a "living will" resides in a long-term care facility, the document be witnessed by the state long-term care ombudsman or his equivalent.

The Virginia Natural Death Act also is at odds with the state's other statutory and regulatory provisions regarding medical decisionmaking for incompetent adult patients. In addition to three alternative forms of judicial guardianship provided for in §§37.1-128.02, 37.1-128.1, and 37.1-132, Virginia has a short-term guardianship procedure in its adult protective services law, §63.1-55.6, and a means for authorizing a judicial procedure without the appointment of a guardian in §37.1-134.2.

Non-judicial designations of third party decisionmakers hitherto have been authorized with reference to autopsies in §54-325.8 (onto which the Natural Death Act was grafted) or to medical records in §8.01-413. Effective July 1, 1983, the provision of treatment to residents of state mental health and mental retardation facilities may also be authorized under the new Rules and Regulations Regarding the Rights of Residents of Mental Health and Mental Retardation Facilities. Under these statutes it is much easier lawfully to deny an incompetent adult patient treatment and to permit him to die than it is to provide for the treatment through a judicial proceeding. A just and consistent statutory approach should be taken to all medical decisionmaking for incompetent patients.

Victim Impact Statements To Be Used In Sentencing

The enactment of 1983 Virginia Laws ch. 1983 enhanced the role that mental health professionals will play in criminal sentencing by allowing the court to request the preparation of a Victim Impact Statement. The Statement may be a part of the presentence report, or it may be prepared independently by the prosecution. In content, the Victim Impact Statement may include a description of the victim's psychological injury, a description of any physical injury, detail on any "change in the victim's personal welfare, lifestyle, or familial relationships," and information on any "psychological or medical services" required by the victim or the victim's family as a result of the crime. (Adding § 19.2-299.1)

Community Diversion Incentive Act

House Bill 639, which passed as ch. 344 of Virginia Laws, authorized private nonprofit agencies and the state to establish community diversion programs. Both district and circuit courts may sentence offenders to such programs in lieu of a prison term. The act clarified the procedure for the appointment of community corrections resource boards and linked court review of board recommendations with successful completion of a diversion program as mitigating factors that may

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Continued from page 3

be considered during a suspended jail or prison sentence.

The clarifying language was inserted to encourage the use of non-profit community programs that are currently operational, rather than to mandate additional governmental programs that might be duplicative. (Amending §§ 53.1-180, 53.1-181, 53.1-185; adding § 53.1-184.1)

Education for the Handicapped

Virginia Laws ch. 538 added autism to the list of statutorily listed handicapping conditions; ch. 521 gave the Board of Education discretion to implement a reimburseable transportation plan for handicapped children who ride modified approved school buses; ch. 376 delineated the responsibilities of local school divisions in placing out-of-state handicapped children in special education facilities pursuant to the Interstate Compact on the Placement of Children. (Amending §§ 22.1-213, 37.1-1; adding 22.1-218.1)

DWI

Provisions of the driving while intoxicated statutes were amended to clarify penalties for multiple offenders. Statutory punishments ranging from a one year license suspension to license revocation are now specified for second and third convictions. (Amending § 18.2-269, 18.2-271 and 46.1-421)

Hospitals and Nursing Homes

Under the provisions of ch. 533, hospitals are allowed to use up to ten percent of their beds as skilled nursing home beds without obtaining a certificate of need or employing a licensed nursing home administrator. This waiver of the usual requirements for nursing homes may be applied no more than thirty days for any one patient. Facilities must, however, qualify for certification under the appropriate sections of the Social Security Act in order to qualify for Medicare and Medicaid reimbursement. (Amending §§ 32.1-102.1 and 32.1-132)

Intermediate Appellate Court

Virginia Laws ch. 413 provided for the creation of a nine member intermediate court of appeals to have jurisdiction below the state Supreme Court. Appellate jurisdiction of the court will extend to all criminal cases (except death penalty cases), circuit court decisions in cases originating before administrative agencies, domestic relations cases, and decisions of the Industrial Commission. Appeals in those areas will be granted as a matter of right to parties seeking review of a lower court or agency decision. (Adding §§ 17-116.01 through 17-116.014)

Confinement of Children

Passage of House Bill 190 removed the previous requirement that space in a detention or sheltered care facility be unavailable before a delinquent child may be detained in a jail. The amended law also allows for children charged with rape or robbery to be detained in jail when a judge or intake officer deems other facilities not suitable, and it forbids sentencing children as adults for offenses that would be misdemeanors if committed by adults. (Amending §§ 16.1-249 and 16.1-284)

Juvenile and Domestic Relations Courts

Virginia Laws ch. 474 authorized juvenile and domestic relations courts to dispose of cases involving children who have been abandoned or otherwise lack parental care or who are in danger of abuse or neglect by a parent or custodian with a previous history of abuse. (Amending § 16.1-279)

Motor Vehicles and the Handicapped

Virginia Laws ch. 38 now allows the issuance of special license plates for vehicles used to transport handicapped persons in groups; ch. 329 now allows a summons to be issued to an unauthorized person parking in a space reserved for the handicapped without the need for obtaining a warrant first. (Amending §§ 46.1-104.1 and 46.1-11.4:1)

Immunity for Health Professionals

House Bill 149 extended the immunity provisions of the Code to health care professionals working without compensation in free clinics. The Code previously had granted immunity only to licensed physicians. Passage of House Bill 82 gave immunity from civil liability to members of psychiatric advisory committees who perform examinations of the mental or emotional conditions of licensed physicians. (Amending §§ 54.1-22, 54-291.1)

Custody of Children

The passage of House Bill 214 abolished the inference of law in favor of awarding child custody to mothers. (Amending § 31-15)

Public Intoxication

House Bill 449 provided for clarification of the 1982 amendments pertaining to public drunkenness. Law enforcement officers (not judicial officers) are authorized to transport public inebriates to a detoxification center. (Amending § 18.2-388)

Adult Protective Services

Virginia Laws ch. 604 now requires local boards of public welfare to provide protective services for the aged or infirm for whom federal or state matching funds are available. (Amending §§ 63.1-55.1 and 63.1-55.4)

Professional Boards

Virginia Laws ch. 115 reorganized the administration of mental health professional licensure. The new law disbands the Virginia Board of Behavioral Sciences and moves its component agencies, the Boards of Professional Counselors, Psychology, and Social Work, from the Department of Commerce to the Department of Health Regulatory Boards. This new act also merges the Drug and Alcoholism Counselor Certification Committees into a single Substance Abuse Counselor Certification Committee within the Board of Professional Counselors. (Amending § 2.1-204, et al.)

Continued on page 10

Civil Commitment Revisions Fail

After considering extensive, unfavorable testimony and many eleventh hour amendments, the House of Delegates Committee on Health, Welfare and Institutions declined in 1983 to approve House Bill No. 119. The complex and comprehensive proposal, sponsored by Delegate Warren Stambaugh, grew out of a year-long study by the Subcommittee on Mental Health and Mental Retardation and the State Human Rights Committee. The latter committee is an independent watchdog organization, consisting of nine private citizens, charged with the protection of residents' rights in Virginia's public mental health and mental retardation facilities.

H.B. No. 119 attempted to reshape state civil commitment standards in ways intended both to facilitate appropriate admissions and to prevent inappropriate admissions. In doing so the bill drew sharp criticism from such diverse sources as the American Civil Liberties Union of Virginia and the Virginia Office of the Attorney General for allegedly making it too easy to commit someone. Mental health professionals attacked the proposal for what was seen as an increased burden on them for performing court-ordered evaluation and for the seemingly opaque phrasing of the bill.

Background

The impetus for reforming the existing state commitment law was provided in 1981 by a survey by Nancy Ehrenreich, Edward Baxa, and Virginia Roddy of the Institute of Law, Psychiatry and Public Policy. Their survey concluded that Virginia judges (at least those observed by the authors) ignored in large measure the procedural safeguards prescribed by the commitment statute. While the authors could not conclude that any persons were being committed who did not meet the substantive commitment standards, a denial of procedural justice clearly was occurring.

A subsequent study by Allen Gouse, Joseph Avellar, and Donald Biskin [see 2 *Developments in Mental Health Law* 33 (1982)] confirmed the suspicion raised by the Ehrenreich survey that many persons were being committed to state facilities who did not meet the commitment standards. And while Gouse and his colleagues did not specifically attribute the inappropriate admissions to procedural laxity in the commitment hearings, it seems fair to assume that the lawyers involved in commitment hearings were aggravating the problem of inappropriate admissions by failing to take the libertarian policies behind the commitment law seriously.

Proposed Revisions

Because of the finding of the Gouse study that considerably more inappropriate commitments occurred on the *parens patriae* or "substantial inability to care for himself because of mental illness" standard, the proposed bill narrowed the definition of "inability to care for himself." This was done by requiring proof that the patient's mental disorder precluded provision of basic, minimum needs either by the patient or others.

Similarly, the police power or "imminent danger to himself or others by reason of mental illness" standard was narrowed to require proof of a "recent overt act or threat" by the patient which evidenced dangerousness.

The good possibility that these changes in the commitment standards would reduce commitments, if not reliably restrict commitments to persons who met the standards (and whom the state had the capacity to look after), was ignored in the lively public debate engendered by the bill's inclusion of a third standard of commitment.

This proposed third alternative ground of commitment, founded neither in the traditional police power nor in the *parens patriae* justifications of commitment, would have provided that the court need only find the patient in danger of substantial "serious mental or emotional deterioration" in order to commit. This was defined in the bill:

> *that, as evidenced by recent behavior, the person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional or physical distress or dysfunction: and this distress or dysfunction is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.*

Since the patient under this third standard might well be able to care for himself and might pose no danger, the only rationale for commitment would be treatment. The American Civil Liberties Union cautioned that under this ambiguous standard anyone might be committed. Others argued that even if treatment were needed, and proved to be helpful, treatment alone could never justify a deprivation of liberty. And the Attorney General's Office expressed concern that a new population, the "seriously deteriorated," would be added to an already burdened state hospital system. The Attorney General's Office also might have feared civil rights actions by persons committed under this third criterion for either a denial of substantive due process or a violation of a right to treatment newly derived from the fact that the state had committed solely on a treatment rationale.

It is difficult to trace the proposal of this third criterion of commitment to anything in the controversy which initially led to the rewriting of the law. The bill's drafters included this third criterion, despite their personal misgivings, specifically to stimulate public discussion, and they succeeded in this respect.

Temporary Detention Strategies

H.B. No. 119 adopted two other strategies to reduce admissions to state hospitals. Both strategies failed to attract support because of their high

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Continued from page 5
initial cost and the uncertainty that they would effectively reduce long-term admissions.

The first strategy was to make it easier to involuntarily detain and treat a person for a few days with the hope that the earlier, effective treatment would divert patients from long-term commitments. The bill relied heavily on psychiatrists and psychologists to exercise responsibly clinical discretion in detaining and treating patients prior to the formal commitment hearing. While current law allows treatment for only 48 hours prior to a commitment hearing (or 72 hours if that period otherwise would expire on a weekend or holiday) and requires the prior authorization of a magistrate or judge, H.B. No. 119 would have permitted up to 96 hours of pre-commitment detention and treatment, the first 4 hours of which might be compelled by a physician, a psychologist, or a law enforcement officer without judicial authorization.

On the other hand, H.B. No. 119 actually would have raised the standard for temporary detention from "needs hospitalization," as it now reads in §37.1-67.1, to a required showing of probable cause that the basic commitment criteria are met *and* that "continued custody is required to prevent harm to the respondent or others pending the commitment hearing." H.B. No. 119 also gave a new authority and responsibility to the temporary detention facility to discharge or to decline to admit patients who it clinically determines not to be in need of "emergency detention."

Under H.B. No. 119, an attorney would be appointed within 24 hours of detention, and thus 72 hours before the hearing. In addition to permitting the patient's symptoms to go into remission and allowing clinicians to perform better evaluations, the longer pre-trial detention period would give defense attorneys more time to prepare. Under current law, defense attorneys are often appointed only minutes before the final commitment hearing. H.B. No. 119 would have also allowed the defendant a 24 hour continuance if more trial preparation were needed.

Costs

The incremental cost of increasing the length of temporary detention was estimated by legislative staffers to range from $2.7 million to $4.5 million. While a savings was anticipated from these and other aspects of the bill, it was thought to be no more than a 10% reduction in commitments and a consequential avoidance of $1.2 million in hospitalization costs. This savings seemed slight next to the projected increase in temporary detention costs, coupled with about $2.5 million in new costs incurred to reimburse the various professional participants in the commitment proceedings for their augmented responsibilities.

The increased and more carefully delineated responsibilities for the legal and mental health professionals involved in the hearings, the bill's second procedural strategy for reducing admissions, drew fire not only because of its estimated $2.5 million price tag but because the bill seemed to some to impose unnecessary burdens on the community service boards.

Under current law, the court appoints a physician or psychologist to advise whether the criteria for commitment are met. Independently, the court receives a survey of alternatives to institutional confinement from the local community services board. H.B. No. 119 put the responsibility for a single comprehensive evaluation on the shoulders of the community services board alone. At the same time, it explicitly mandated (in §37.1-67.1:3C) an overall increase in the data which must be reviewed and reported to the court.

Additionally H.B. No. 119 would have insisted that at each commitment hearing a community services board representative and the petitioner be present. Neither community services board representatives nor petitioners attend the final commitment hearing in some Virginia jurisdictions under present practices. The role of the community services board thus may have been expanded beyond its existing capabilities.

Summary

H.B. No. 119 was, in summary, an ambitious attempt to strike a new balance between clinical needs and libertarian principles. The high estimates of increased costs, which caused the bill to die in committee, may have reflected short-sighted pessimism over the reductions in long-term commitments which the bill would achieve or the true cost of caring for mentally disordered persons in Virginia.

On the positive side, the bill was unusually successful in raising public awareness and understanding of commitment issues and has led to the formation of nearly a dozen statewide task forces engaged in drafting proposals and position papers for the 1984 Virginia General Assembly. □

Forensic Training

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

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

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

In The United States Supreme Court

Psychological Harm

• In *Metropolitan Edison Co. v. People Against Nuclear Energy*___ U.S. ___ 51 U.S.L.W. 4371 (April 4, 1983), the Supreme Court decided that the National Environmental Policy Act (NEPA) does not require the federal government to consider the adverse psychological effects of a *risk* of a nuclear accident. While the Court expressed a willingness to require inclusion of psychological harm in an Environmental Impact Statement, it insisted that psychological harm have a "reasonably close causal relationship" to the *actual* change in the physical environment (here, restarting a reactor on Three Mile Island), rather than to a *potential* change which might have been brought about by an accident.

The Court's causation requirement, imported from tort law rather than the language of NEPA, may be read as an attempt to impose practical limits on the controversies which might arise under NEPA rather than a careful reading of NEPA or the literature in the behavioral sciences on the causation of stress. Without such limits, wrote Justice Rehnquist for this unanimous Court, federal "agencies would, at the very least, be obliged to expend considerable resources developing psychiatric expertise" to assess the psychological damage due to a risk of an accident.

Finally, however, the Court seems to have despaired of ever reliably finding in a courtroom

> *the differences between someone who dislikes a government decision so much that he suffers anxiety and stress, someone who fears the effects of that decision so much that he suffers similar anxiety and stress, and someone who suffers anxiety and stress that "flow directly" ... from the risks associated with the same decision.*

51 U.S.L.W. at 4374. The Court declined to believe that a recent serious nuclear accident on Three Mile Island made the risk of restarting a reactor there more "real."

Drug Courier Profile

• The "drug courier profile" recently came under scrutiny by the Supreme Court in *Florida v. Royer*, 51 U.S.L.W. 4293 (March 23, 1983). A badly divided Court affirmed a Florida Court of Appeal decision which had found a similarity with a drug courier profile insufficient to justify an investigatory stop.

The plurality decision, however, turned on a finding that the detective who had stopped Royer for questioning in Miami National Airport because he matched the drug courier profile had exceeded the permissible scope of an investigatory stop and had, in effect, illegally arrested Royer. Thus, though Royer's behavior in the terminal may have justified an investigatory stop, it did not rise to the level of probable cause necessary to justify his arrest. Royer's consent to the search which uncovered marijuana in his luggage was tainted by his unlawful arrest.

In a concurring opinion, Justice Brennan said even a true investigatory stop of Royer would not have been justified simply

> *because he was carrying American Tourister luggage which appeared to be heavy; he was young; he was casually dressed; he appeared to be pale and nervous and was looking around at other people; he paid for his airline ticket in cash with a large number of bills; and he did not completely fill out the identification tags for his luggage, which was checked to New York.*

51 U.S.L.W. at 4299. Brennan's interpretation of the fourth amendment thereby would render the "drug courier profile" of no value to law enforcement officers, while the Court's decision would authorize its use for brief investigatory questioning in airports. □

In the Virginia Supreme Court

The Court recently decided two cases that highlighted the relationship between physical injuries sustained on the job and subsequent mental or psychological "injuries" purportedly connected to the physical trauma. In *Dairymen/Flav-o-rich, Inc. v. Shaffer*, __Va.__(1983) (No. 820570; 225 VRR 146), a claimant who had suffered a shoulder injury and a minor concussion on the job qualified for temporary total disability benefits. He later returned to work briefly, then resigned, claiming that he suffered from a "nervous condition" caused by his earlier industrial accident. The Virginia Supreme Court held that there was adequate residual evidence to sustain the connection between the accident and the resulting psychiatric condition. Disability benefits were reinstated.

Watkins v. Halco Engineering, Inc., __Va.__(1983)(No. 820546; 225 VRR 84) yielded the opposite result. In that case a welder sustained a back injury on the job. He later sought psychiatric treatment for episodes of depression and psychic distress. In a claim for disability benefits, the welder attempted to link the job-related injury to his depressive state. The Virginia Supreme Court held, however, that the psychiatric problems were not the result of the accident on the job but were caused by the claimant's intense aversion to the academic study he had undertaken after his accident. Benefits were denied. □

Continued from page 2

always carried out on an outpatient basis following psychiatric hospitalizations for acute illness. The outpatients may, at this time, manifest no overt signs of psychotic symptomatology. Rather, the purpose of maintenance treatment is to prevent recurrence of symptoms which could lead to rehospitalization. The function of maintenance antipsychotic treatment is one of prophylaxis.

In brief, more than thirty double-blind studies show that continued administration of antipsychotic drugs following hospitalization significantly reduces the rate of relapse. In Hogarty's study, one of the largest and most widely known, after one year, ten percent of the patients on placebo had relapsed each month, whereas only two and a half to five percent of the patients on medications had returned per month. Similarly, Caffey found that outpatients on placebo relapsed at a rate of fourteen percent per month, while those on antipsychotic medications at one to two percent per month.

The principal risk of maintenance treatment with antipsychotic medications is that of tardive dyskinesia. This is a movement disorder, usually characterized by choreoathetoid motions—twitching and writhing of the mouth, lips, tongue, trunk, or extremities. Among patients who have received prolonged treatment with neuroleptic medications (i.e., continuous administrations over a period of several years), the incidence of tardive dyskinesia is estimated as approximately fifteen percent. This figure varies, depending upon the total duration and amount of drug treatment and the age of the patient.

If the tardive dyskinesia is noticed early in its course, drug treatment can be discontinued. In some patients, the symptoms of tardive dyskinesia disappear over the course of six months to a year following discontinuance of the antipsychotic medication. In other patients, however, the tardive dyskinesia is not alleviated by cessation of antipsychotic drug therapy. For these individuals, there is currently no cure once the tardive dyskinesia is well established.

This puts clinicians and some of their patients between a rock and a hard place. Outpatients with a severe recurrent mental disorder in remission can be faced with the very difficult choice between receiving maintenance prophylactic pharmacotherapy with the risk of tardive dyskinesia and foregoing the medication and thereby exposing themselves to a substantially increased rate of relapse, with consequent rehospitalization and disruption of their lives. The treating psychiatrist must explain these alternatives to patients and their families and make recommendations accordingly. This is a grave and troubling issue for psychiatrists.

The principal risk of maintenance treatment with antipsychotic medications is that of tardive dyskinesia.

Legal writers (e.g., Alexander Brooks) unfortunately have tended to confuse short term with long term risks of antipsychotic medications. Given that the vast majority of involuntary hospitalizations are brief, the relevant risks to take into account in treatment refusal which takes place during an individual's involuntary hospitalization are those of *short term* antipsychotic drug administration. What is involved in these acute situations is weighing the risks and benefits of a course of treatment which involves a few weeks to a month of antipsychotic drug administration. The principal risks of this treatment are the autonomic and extrapyramidal side effects discussed above. In the vast majority of cases (approximately ninety-five percent, as in the NIMH collaborative study), patients have a good clinical response to short term treatment, and they return home. The risk of tardive dyskinesia resulting from a short term course of treatment is virtually nil. When patients return home, the question of whether to initiate long term maintenance therapy on antipsychotic medication arises. There is a substantial risk of tardive dyskinesia for those who are treated over the course of many years, but these are mainly outpatients for whom overriding medication refusal is not a real issue.

One special type of patient, the chronic, continuously ill psychotic patient, may require long term antipsychotic mediction inside the hospital. Treatment decisions concerning this type of patient involve a different set of risks and benefits than for the typical involuntary psychiatric patient. For the continuously hospitalized patient, a careful balancing must be made among the risk of tardive dyskinesia, the benefits for the patient of receiving antipsychotic drugs, and the risk to the patient of being on a long term psychiatric ward without drug treatment (and hence severely regressed). Such atypical cases, however, constitute a very small percentage of the involuntary patient population. They should be discussed as such and not as representative cases.

What Are the Alternatives to Antipsychotic Medications?

It is also important to weigh the risks and benefits of alternative forms of treatment. An assumption implicit in much of the writing about medication refusal is that "less restrictive" alternative forms of treatment exist and are available to the psychotic patient. It is also assumed that drugs somehow constitute a second class of treatment and that psychotherapy, although more costly, is under ideal circumstances to be preferred. Indeed, one of the *amici* briefs filed for the respondent in the *Mills v. Rogers* case refers to "the availability of other effective and more acceptable forms of treatment."

These assumptions are not borne out by the existing data, which reveal no evidence that psychotherapy in the absence of drugs is beneficial to the large population of schizophrenic patients. It should be mentioned, though, that for some patients with certain types of reactive psychoses, drugs may not be the optimal form of treat-

If ... the patient's refusal is honored without questioning, the psychiatric hospitalization will be prolonged and become de facto preventive detention.

ment. Individual schizophrenic patients or certain subgroups of schizophrenic patients may benefit from psychotherapy without drugs. However, the characteristics of such discrete subgroups have yet to be identified, and the hypothesis that some schizophrenic patients may benefit from psychotherapy alone has yet to be proven or disconfirmed empirically.

On the other hand, some evidence suggests that drugs combined with psychotherapy may achieve results slightly superior to those achieved by drugs alone when used on inpatient units. Hogarty's study indicates that there is a clear-cut superiority in results obtained from drugs combined with psychotherapy compared to drugs alone when schizophrenic patients are followed in a long term outpatient program.

A false dichotomy has been created between drugs and psychotherapy for the treatment of schizophrenic disorder—as if the two are mutually exclusive. They probably act synergistically. Both treatments can be, should be, and in the better staffed institutions usually are given concurrently. Furthermore, the patient may be so disturbed without drug treatment that social treatment is ineffective. The efficacy of social treatment is dependent upon the beneficial effects of drug treatment. While drugs seem to act most effectively in reducing psychotic symptoms like hallucinations, delusions, catatonic posturing, etc., psychotherapy serves to help the patient understand himself, develop attachments, and improve interpersonal skills. Each form of treatment should be viewed in the context of what it does best. To place drugs and psychosocial treatment in opposition to each other, or to propose that psychotherapy is an effective substitute for drugs, is to set up a straw man.

It is true that many patients in the overcrowded state hospitals do not receive effective psychotherapy. Psychotherapy can be very helpful to many patients, and it is worth emphasizing the importance of providing patients with more adequate psychosocial treatments. However, the issue of improving state hospitals should not be confused with the right to refuse treatment.

Treatment Refusal and Civil Commitment

When we discuss overriding the wishes of patients who refuse to take their medicationss, it is important to recognize that the controversy arises around only a small fraction of all patients on antipsychotic medications. First of all, most people on antipsychotic medication are outpatients. Obviously, these individuals decide whether or not they take the medications that have been prescribed for them. Furthermore, in most hospitals the majority of psychiatric inpatients have signed themselves into the facilities on a voluntary basis. If a voluntary patient refuses medication prescribed as part of the treatment plan, one would hope that the patient could discuss this with the physician as well as with other members of the treatment team. In any case, these persons are ultimately free to leave the hospital and, if they choose, seek alternate treatment elsewhere. It is only with involuntarily committed patients who refuse medication that the issue of "involuntary" treatment should arise.

Why should medication refusal on the part of the committed patient be treated in a manner substantially different from that of medication refusal on the part of the voluntary patient? There are two important reasons for this. Giving committed patients an unqualified right to refuse treatment (1) overemphasizes the social control function of psychiatry at the expense of its therapeutic function and (2) legitimizes the use of mental hospitals as facilities for prolonged preventive detention.

With regard to the first reason, over the past twenty years civil commitment statutes have moved increasingly toward providing a 'dangerousness' or police power rationale as opposed to a 'treatment' or *parens patriae* rationale for involuntary mental hospitalization. In most states, the older civil commitment criteria, which were based upon a finding of mental illness and need for treatment, have been replaced by criteria which call for a finding of imminent dangerousness.

This new focus upon dangerousness is criticised in some psychiatric quarters since it seems to emphasize the role of mental health clinicians as agents of social control, or policemen, rather than as providers of care.

In addition, the relationship between mental illness and violence is not a simple one. It is conceptually inappropriate to think of psychiatric treatment as directly reducing an individual's dangerousness. If the violent behavior stems from the mental illness, the antipsychotic medication can benefit the psychotic process and perhaps secondarily reduce the potential for violence. The issue is usually not this straightforward. There are many other determinants of violent behavior, and antipsychotic medications are not anti-violence drugs, per se.

The other reason for placing the civilly committed patients' drug refusal into a different light is the more compelling one. The most likely consequence of an involuntary psychotic patient not receiving antipsychotic medication is that he will continue to be psychotic and remain in the hospital. If the patient receives medication, the psychotic symptoms probably will abate sufficiently within three to four weeks for discharge to be considered. When the patient goes home, he can make autonomous and perhaps rational decisions with regard to his future treatment. If, however, the patient's refusal is honored without questioning, psychiatric hospitalization will be prolonged and become *de facto* preven-

Continued on page 11

1983 Forensic Proposals

The 1983 General Assembly considered a plethora of bills promising to reform the way in which criminal courts address psycho-legal issues. Bills were introduced: to reformulate the test for insanity in Virginia and provide procedures for the trial of insanity cases; to modify procedures for the commitment and release of insanity acquittees; to provide authority for judges and juries to issue verdicts of guilty but mentally ill (GBMI); to provide procedures for the evaluation of defendants in capital sentencing proceedings; to modify procedures for the hospitalization of pretrial jail detainees; and to clarify the qualifications required of mental health professionals to conduct evaluations of competency to stand trial.

Only one of these bills passed. House Bill No. 802 amends Virginia Code §19.2-169.1 to provide that evaluations of competency to stand trial may be performed by "at least one psychiatrist, clinical psychologist, or master's level psychologist who is qualified by training and experience in forensic evaluation." This amendment, effective July 1, resolves an uncertainty over the academic qualifications required of psychologists who conduct court-ordered competency to stand trial assessments. It also draws attention to the requirement of specialized training and experience.

All of the other "forensic" bills introduced in this session died in committee. Several of these bills were developed by a special Task Force appointed by the Secretary of Human Resources to study the insanity defense (and related issues) and to recommend legislative changes. [See details in Vol. 2 *Developments in Mental Health Law* 37 (1982).] These bills, Senate Bill 361 (Definition of Insanity; Administration of the Defense), House Bill 747 (Commitment and Release of Insanity Acquittees), and House Bill 779 (Treatment of Jail Detainees; Capital Sentencing Evaluations) appear to have fallen victim to the brevity and heavy work load of this "short session." Given the enormous work load of the General Assembly in this session, the comprehensiveness of the Task Force bills, and the absence of an organized lobby to familiarize legislators with the provisions of these bills, it is likely that these bills were passed by simply because the committees to which they were referred for consideration had little or no opportunity to study them in any detail before having to vote on them.

Three identical GBMI bills were introduced, House Bills 88, 670, and 757. These bills would permit a verdict of guilty but mentally ill upon a finding, by the trier of fact, beyond a reasonable doubt, that the defendant was guilty of an offense and was mentally ill, but not legally insane, at the time of the commission of the offense. Consideration of these bills was deferred pending disposition of the Task Force bills. When the Task Force bills were passed by, it was agreed that the GBMI bills should be passed by as well. It is expected that the Task Force bills and one or more of the GBMI bills will be reintroduced next year.

Finally, a resolution (Senate Joint Resolution 30) providing for the appointment of a joint subcommittee to study procedures for the commitment and release of insanity acquittees was killed.

— W. Lawrence Fitch

In the Virginia General Assembly — 1983

Continued from page 4

Minimum Drinking Age Raised

The minimum age for on-premises consumption of beer has been raised from 18 to 19 by 1983 Virginia Laws ch. 608 (H. 300). This brings to a close a two-year experiment in which the minimum drinking age for on-premises consumption was 18 while the minimum drinking age for off-premises consumption was 19.

In addition to raising the on-premises drinking age, this new law (effective January 1, 1984) requires all driver's license applicants 18 years old or younger to show proof that they have completed successfully an approved driver's education program which included "an alcohol safety and education component." These and related new provisions (such as that prohibiting the employment of bartenders under age twenty-one and that allowing the court to suspend for one year driver's licenses for under-age possession of alcoholic beverages) have as their primary objective traffic safety rather than the reduction of spill-over drinking by high school students who in the past were believed to have obtained beer from 18-year-olds.

The traffic safety issue was also addressed in ch. 621, which mandates the revocation of operators' licenses that have been used to purchase alcoholic beverages fraudulently. Revocation had previously been a discretionary matter for the court. (Amending §§ 4-37, 4-62, 4-63, 4-98.10, 4-112.1, 46.1-368, 46.1-375, 46.1-383.3, and 46.1-384.1)

Continued on page 12

Developments in Mental Health Law

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Continued from page 9

tive detention.

The effects of chronic institutionalization upon the individual are, in themselves, harmful. Persons who spend long periods of time in institutions develop personality changes from the experience of institutionalization itself, becoming apathetic and less able to function independently. Furthermore, when a person with a psychotic disorder is not treated early in the disorder's course, a process of deterioration sets in which is not completely remedied by later initiation of treatment. Thus, for the law to grant involuntarily hospitalized psychotic patients the "autonomy" to refuse their medication and then to lock them up for prolonged periods of time in state institutions while they undergo a gradual process of clinical and social deterioration is to grant these patients a very shabby form of personal autonomy indeed.

Conclusions

What course of action should be taken when an involuntarily committed patient refuses medications? Some have suggested appointment of a guardian to make treatment decisions if the patient is found to be incompetent. This can be a very lengthy process. An alternative might be to have a separate judicial hearing on the issue of competency to make treatment decisions performed at the same time as the original civil commitment hearing, or to have an administrative hearing triggered by treatment refusal.

Appelbaum views medication refusal primarily as a problem in the working relationship between patient and doctor. He advocates that it be approached by the clinician as an issue to be explored by both parties rather than be turned into an adversarial, legal struggle. He systematically has enumerated the reasons why a patient might refuse his antipsychotic medications, including very realistic concerns about side effects, pressure from family or friends not to accept medication, anger at the clinician, or delusions that he is being poisoned. Appelbaum emphasizes that the clinician should be wary of viewing the refusal as a strictly legal issue and should avoid resorting to judicial means of overriding the patient's wishes.

Where the issue of refusal cannot be clinically resolved by doctor and patient ... we favor review of the proposed treatment regimen by an independent psychiatrist.

We would add that, unfortunately, in many of our understaffed and overcrowded state hospitals there is a grossly inadequate ratio of psychiatrists to patients. Under these circumstances there can be no meaningful working clinical alliance between patient and doctor. In circumstances where the issue of refusal cannot be clinically resolved by doctor and patient or where their working relationship is an inadequate one, we favor review of the proposed treatment regimen by an independent psychiatrist. We feel that this is a sound policy for clinical as well as, perhaps, legal reasons.

Others have contended that the covert issue in the controversy over antipsychotic medication refusal is quality of care. Appalled by conditions in some of our public hospitals, activist lawyers, unable to obtain significant legislative help, have turned to the judiciary in an effort to use newly constituted rights as a lever to improve conditions in public hospital facilities. While their motives might be laudable, the strategy may well backfire, contributing further to the deterioration in care.

Given the current political climate and the recent massive cutbacks in needed public services, it would require considerable effort on the part of those who formulate public policy to create the conditions under which an equitable system for providing adequate mental health care could be established. Misunderstanding or distorting the actual utility and limitations of antipsychotic medications and unduly increasing the lag time between involuntary hospital admission and initiation of treatment are destructive of the effort to provide humane and effective care. □

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Continued from page 10

Expanded Civil Immunity for PSRO Members

Virginia Laws ch. 567 extended civil immunity to physicians or dentists who, as a function of their membership on a public investigatory board, review complaints concerning the mental or physical impairments of practitioners. (Amending § 8.01-581.13)

Long-Term Care Oversight Committee Created

House Joint Resolution No. 37 established a joint legislative subcommittee to monitor the long-term care of "the physically and mentally handicapped and of the frail elderly." The specific charge of the subcommittee is to oversee "an integrated approach" by the several state agencies sharing responsibility for long-term care and to make recommendations for new legislation to the 1984 General Assembly. The question of establishing statutory rights of residents in homes for adults and enforcing those rights was raised in the 1983 General Assembly by Delegate Mary Marshall's House Bill No. 312, which died in committee. The new joint subcommittee is expected to consider these rights and related issues in public hearings later this year.

In related legislation, the statutory requirement that mandated the issuance of a biennial plan for elderly services from the Department for the Aging was eliminated; the mission of the Department for the Aging was amended to include improvement of the quality of life for older Virginians; and the Secretary of Human Resources and the Commissioner of the Department of Rehabilitative Services were added to the membership of the Long-Term Care Council. (Amending §§ 2.1-373, 2.1-373.4, 2.1-373.5, and 2.1-373.6)

Probation for Drug Users

Defendants convicted for the first time of illegal drug use may be required to enter an education and evaluation program as a condition of probation. Chapter 513 of Virginia Laws authorize a court to require a "drug free" period and submission to drug screening as additional stipulations of the probationary term. (Amending § 18.2-265)

Handicapped Children Interagency Coordinating Committee

Senate Bill 86 established the Interagency Coordinating Committee on Delivery of Related Services to Handicapped Children. The Committee's charge includes planning for and coordination of service delivery to handicapped children as well as oversight of problems and recommendations in this area at the state and local level. The Committee will include representation from the Departments of Education, Social Services, Corrections, Health, and five other agencies having administrative responsibilities relating to handicapped children. (Adding § 2.1-599) □

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Involuntary Sterilization in Virginia:

From Buck v. Bell to Poe v. Lynchburg

by Paul A. Lombardo, Ph.D.*

The arrival of 1984 will mark the sixtieth anniversary of the passage of Virginia's pioneer statute authorizing involuntary sexual sterilization.[1] Although ten years have passed since the last vestiges of the 1924 law were deleted from the Virginia Code, its impact on the lives of the state's citizenry continues to be felt. During the fifty years that it remained in force, the Virginia Statute for Eugenical Sterilization gave a legal imprimatur to over 8,300 operations. When the first and most notorious of those sterilizatons was approved by the United States Supreme Court in the case of *Buck v. Bell*[2], the stage was set for the passage of similar legislation in twenty-five other states. It has been estimated that more than sixty thousand people were sterilized in America under the authority of such laws.

The Virginia law also had an international impact. Certainly the most dramatic example can be found in Adolph Hitler's "Law for the Prevention of Offspring with Hereditary Diseases." That 1933 German decree contained language that echoed phrases in the Virginia statute. In only ten years, some two million Europeans underwent forced sterilization as part of the Nazi program.[3]

The irony of the transatlantic sterilization connection was underlined in the screenplay of *Judgment at Nuremberg*, which portrays Wilhelm Frick, the Nazi legal administrator, citing the precedent of *Buck v. Bell* in his own defense during the war crimes trial. The dramatic representation was not without historical foundation. In 1936 Henry Laughlin had received an honorary medical degree from the Nazi controlled University of Heidelberg for his contributions to the "science of race cleansing." Laughlin was the author of the model law after which both the Virginia and German sterilization laws were fashioned,[4] and he supplied important testimony in favor of sterilization at the trial of Carrie Buck.

While its links to the Holocaust provide us with one reason to review the history of Virginia's now defunct sterilization law, it is also appropriate because litigation stemming from the sterilization era continues in the 1980 case of *Poe v. Lynchburg Training School and Hospital*.[5] That case has revived allegations of abuses endured by Virginians in state facilities who were "treated" under the provisions of the sterilization law. Some of the more noteworthy revelations surfacing during the *Poe* suit have focused upon the archaic language that had survived in Virginia law and, as late as the 1970s, was used as the basis to describe mentally disabled patients and to mark them for sterilization.

The language highlighted in *Poe* has been traced to the original 1924 sterilization law, which provided for sterilization of all residents of state facilities for the mentally ill or mentally retarded who were afflicted with inherited "defects." Specifically covered were patients with "hereditary forms of insanity that are recurrent, idiocy, imbecility, feeblemindedness or epilepsy ... and by the laws of heredity ... the probable potential parents of socially inadequate offspring likewise afflicted ...."[6]

Such were the explicit pronouncements of Virginia law on the uses of sterilization to combat inherited defect. The *Poe* case has renewed the challenge to the practice of involuntary

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Continued from page 13
sterilization and has questioned again the "scientific" assumptions upon which Virginia law had been based.

Although the language quoted above offends contemporary sensitivities, historical research suggests that it was the order of the day during the era when Virginia's sterilization act was passed. Those who argued for sterilization as an early brand of genetic engineering stood in the vanguard of social reform, convinced of the progressive values embodied in their reproductive politics. A review of the public positions of a few of the earliest champions of sterilization in Virginia can help us understand the social and political values that were reflected in the sterilization law.

Among the earliest and most vocal supporters of legislation was Joseph DeJarnette, a prominent crusader for the sterilization cause for more than fifty years. DeJarnette played an essential role in the campaign for Virginia's law and in the outcome of *Buck v. Bell*. He also left a clear record of his support for the progress of the sterilization movement overseas. The attitudes of DeJarnette and others like him provide a strong counterpoint to recent critics of sterilization who are represented in the *Poe* suit.

DeJarnette's efforts were preceded by the work of Charles Carrington, a physician who performed Virginia's first documented sterilization, not in a facility for the mentally impaired, but in a prison. At least some of DeJarnette's later success can be credited to Carrington's bringing sterilization into public light.

An Early Attempt at Legislation — 1910

Although Charles Carrington received little of the notoriety of the nationally prominent advocates of sterilization, he was among the first to perform the procedure on an institutionalized population. While surgeon to the Virginia Penitentiary in Richmond, Carrington wrote a series of papers reporting the positive effects of the operation. At the 1908 meeting of the National Prison Association, Carrington proudly revealed that he had sterilized two inmates, the first in 1902. His paper argued that "if sterilization were properly enforced with habitual criminals we would have fewer habitual criminals."[7] Carrington gave a second paper at the meeting of the Virginia Medical Society in 1909. That presentation announced his intention to lobby at the next session of the legislature for a law that would "require the sterilization of certain classes of our criminals."[8]

Within a few months, Carrington's bill "to prevent procreation by confirmed criminals, idiots, imbeciles, and rapists" had been to committees in the Senate and the House of Delegates of the Virginia General Assembly. Only two days before the Senate committee approved the bill, Carrington gave another paper entitled "Hereditary Criminals—The One Sure Cure."[9] In it he linked insanity, crime, and general degeneracy as inherited defects. Pointing out the increase in the prison population, he disparaged the value of education in fighting crime. Repeating a popular non sequitur, Carrington simultaneously traced criminality to inherited mental defect and noted that "... very many of our criminals are splendidly educated."[10] With the Biblical warning that "the sins of the fathers shall be visited upon the children," he concluded that "heredity is the greatest causal factor in crime."[11]

Carrington urged the support of his bill as a means to combat the curse of hereditary defect. He admitted that it was modeled on the 1907 Indiana law under sanction of which Dr. H. C. Sharp had performed more than five hundred operations. In Carrington's opinion, Sharp's accomplishment placed him among the "leading criminologists and humanitarians of the century."[12]

Carrington's bill made it compulsory not only for prisons but for "every institution in the State, entrusted with the care of criminals, idiots and imbeciles"[13] to have the mental condition of inmates examined. If the institutional examining committee concluded that

> *... procreation by any of said inmates is inadvisable by reason of said inmate being a confirmed criminal, a rapist, an idiot or imbecile, and that there is no probability of improvement of the mental and physical condition of said inmate, it shall be lawful ... to perform such operation for the prevention of procreation by said inmate as shall be decided safest and most effective.*[14]

Carrington's bill was endorsed by the Virginia Medical Society, favorably reported by the House Committee on Prisons and Asylums, and passed the Senate by a vote of 20-8.[15] It was later rejected by the House of Delegates. The *Virginia Medical Semi-Monthly* attributed the House of Delegate's negative vote on the bill to "much blind sentiment" that was part of the debate. According to the medical journal, the legislation had to await "a better understanding of its true object" and "the abatement of strong prejudice."[16]

Specifically covered by the sterilization law were patients with "idiocy, imbecility, feeblemindedness, or epilepsy ... the probable potential parents of socially inadequate offspring...."

Though 1910 was not to be the year for a sterilization law in Virginia, the campaign for sterilization continued. The belief that the "feebleminded" were a source of social problems led Dr. L. S. Foster, superintendent of Eastern State Hospital, to call for sterilization of that group. At the 1912 meeting of the Virginia Medical Society, Foster reported a series of case studies from Virginia's mental hospitals in an attempt to show a trail of hereditary "diseases" including alcoholism, syphilis, feeblemindedness, and immorality. Foster pointed to these diseases as a major cause of increasing social welfare costs. He also linked

Continued on page 18

In the United States Supreme Court

The United States Supreme Court recently decided two cases of particular interest to forensic mental health professionals and criminal lawyers. In *Barefoot v. Estelle*, the Court held that the Constitution was not violated when two psychiatrists, called by the state to testify as experts at a capital sentencing hearing, predicted that the defendant, whom neither psychiatrist had personally examined, would commit acts of violence in the future if he were not executed. In *Jones v. U.S.*, the Court found a constitutional basis for the automatic, indeterminate hospitalization of an individual acquitted by reason of insanity of attempted petit larceny.

Prediction of Dangerousness

• In *Barefoot v. Estelle*, 51 U.S.L.W. 5189 (July 6, 1983), the petitioner, Thomas A. Barefoot, had been convicted by a Texas jury in 1978 of the capital murder of a police officer. Following his trial, a sentencing hearing was held to determine whether the death penalty should be imposed. To obtain a death sentence in Texas, the State is required to prove beyond a reasonable doubt that "there is probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society." To establish Barefoot's propensity for violence, the State produced (1) Barefoot's criminal record (which contained no convictions for violent acts), (2) several character witnesses (who, without mentioning particular examples of Barefoot's conduct, testified that Barefoot's reputation for being a peaceable and law abiding citizen was bad in their communities), and (3) the two psychiatrists, Drs. John Holbrook and James Grigson. More than half of the sentencing hearing was consumed by the testimony of the psychiatrists. Although neither psychiatrist personally had examined Barefoot (or had requested the opportunity to do so), both testified in response to hypothetical questions which assumed certain facts about Barefoot's background that Barefoot was a sociopath who was not amenable to treatment and who in the future would commit criminal acts of violence that would constitute a continuing threat to society. Grigson testified that there was a "one hundred percent and absolute" certainty that Barefoot would commit violent criminal acts in the future whether he was in society at large or in prison.

On cross-examination, Grigson was questioned by the defense concerning empirical studies demonstrating the unreliability of psychiatric predictions of future dangerousness. Grigson admitted he was unfamiliar with these studies but argued that the conclusions of these studies were accepted only by a "small minority" of psychiatrists, explaining, "It's not the American Psychiatric Association that believes that."

On appeal to the Supreme Court, Barefoot complained that the sentencing court's admission of the testimony of Drs. Holbrook and Grigson violated the Eighth and Fourteenth Amendments to the Constitution. Pointing to a substantial body of research demonstrating that psychiatric predictions of future dangerousness are wrong more often than they are right and noting that juries tend to attach special credibility to the opinions of experts, Barefoot argued that the jury that sentenced him probably was misinformed concerning his propensity for violence. Thus the sentence they handed down probably was erroneous. Barefoot argued further that, even if psychiatrists in general could have assessed meaningfully his potential for violence, the testimony of Holbrook and Grigson nonetheless was barred constitutionally because (1) neither psychiatrist personally had examined him and (2) both psychiatrists' opinions invaded the province of the jury by directly addressing the ultimate issue to be decided.

The American Psychiatric Association (APA), participating in the case as an *amicus curiae*, attested that psychiatrists cannot predict meaningfully whether someone will be violent in the future: "The unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession." And the APA brief also noted that psychiatric training is not relevant to the factors that validly can be employed to make such predictions and suggested that a layman with access to relevant statistics can do at least as well and possibly better.

The Court rejected Barefoot's arguments and the position of the APA, observing that "[n]either petitioner nor the Association suggests that psychiatrists are always wrong with respect to future dangerousness, only most of the time." The Court reasoned that "if it is not impossible for even a lay person sensibly to [predict dangerousness], it makes little sense, if any, to submit that psychiatrists, out of the entire universe of persons who might have an opinion on the issue, would know so little about the subject that they should not be permitted to testify." The Court spoke of the desirability of allowing "open and far-ranging argument that places as much information as possible before the jury" and noted that, in an adversarial proceeding, weaknesses in a witness's testimony are always subject to exposure by the opposing party. Confining itself to constitutional issues, the majority of the Court did not discuss rules of evidence that clearly forbid opinion testimony except by experts having specialized knowledge or skills beyond the ken of the layman.

With regard to Barefoot's objection to the admission of psychiatric testimony having no basis in personal examination, the Court recognized the "well established practice" of experts who testify on the basis of hypothetical questions and concluded that the failure of Grigson and Holbrook to examine Barefoot personally went to the weight of their testimony, not to its admissibility. Finally, the Court found no constitutional basis to Barefoot's

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"It is impossible to square admission of this purportedly scientific but actually baseless testimony with the Constitution's paramount concern for reliability in capital sentencing," wrote Justice Blackmun in dissent.

Continued from page 15

argument that the psychiatrists should not have been permitted to address the ultimate issue before the jury.

In a stinging dissent to the majority opinion, Justice Blackmun, joined by Justices Brennan and Marshall, reviewed the research on the predictability of future dangerousness, examined long-standing constitutional doctrine requiring capital sentencing procedures to insure reliable verdicts, and protested that "[i]t is impossible to square admission of this purportedly scientific but actually baseless testimony with the Constitution's paramount concern for reliability in capital sentencing. ... The admission of unreliable psychiatric predictions of future violence, offered with unabashed claims of 'reasonable medical certainty' or 'absolute' professional reliability, creates an intolerable danger that death sentences will be imposed erroneously." The minority concluded, "In a capital case, the specious testimony of a psychiatrist, colored in the eyes of an impressionable jury by the inevitable untouchability of a medical specialist's word, equates with death itself."

Rejecting the majority's claim that the unreliability of predictions of dangerousness can be brought to the jury's attention on cross-examination of the expert or by the presentation of rebuttal witnesses, Justice Blackmun declared that "[u]ltimately, when the court knows full well that psychiatrists' predictions of dangerousness are specious, there can be no excuse for imposing on the defendant, on pain of his life, the heavy burden of convincing a jury of laymen of the fraud."

NGRI Commitments

- In *Jones v. U.S.*, 41 U.S.L.W. 5041 (June 29, 1983), Michael Jones, the petitioner, had been acquitted by reason of insanity of attempting to steal a jacket from a department store in the District of Columbia. Immediately following his trial, Jones was ordered committed to St. Elizabeths Hospital for evaluation and treatment. Seventy-four days later, a "50-day hearing" was held to determine Jones's eligibility for release. At this hearing, Jones was required to prove by a preponderance of the evidence that he was no longer mentally ill or dangerous. He failed, and his commitment was continued. Although Jones was entitled to another judicial hearing after six months, because of "some procedural confusion" Jones's next hearing was not held until nine months later. By this time, Jones had been hospitalized for more than a year, the maximum period he would have spent in prison had he been convicted. He demanded that he be released or recommitted pursuant to standards and procedures applicable to civil commitment, including a jury trial and proof by clear and convincing evidence of his mental illness and dangerousness. The court rejected Jones's demand for a civil commitment hearing and continued his commitment to St. Elizabeths.

  On appeal to the Supreme Court, Jones contended that, because he was denied the procedural safeguards that the Court has said in other cases must be provided in civil commitment proceedings, his initial commitment violated the due process clause of the Fourteenth Amendment. He argued further that even if the Court recognized a legitimate justification for the automatic commitment of insanity acquittees (e.g., to insure that they not escape confinement altogether), such a justification was insufficient after an acquittee had been confined for as long a period as would have been possible had he been convicted of the offense charged. Further confinement would be constitutionally permissible only under ordinary civil commitment standards and procedures.

  The Court rejected both of Jones's arguments. It observed that Jones's acquittal entailed a finding beyond a reasonable doubt that Jones had committed the criminal act charged (i.e., that he in fact did attempt to steal the jacket), and it reasoned that such a finding "certainly indicates dangerousness." Further, the Court declared, it is not unreasonable to infer that someone who was insane at the time of an offense continues to be mentally ill at the time of his trial. With regard to the standard of proof by which the criteria for commitment must be established, the Court stated that "important differences between the class of potential civil commitment candidates and the class of insanity acquittees ... justify differing standards of proof." The requirement that civil commitment be proved by clear and convincing evidence is intended to prevent the commitment of persons for "some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable," the Court noted. The danger of such an erroneous commitment is diminished in the insanity context, the Court went on to say, because (1) the acquittee himself has advanced the insanity defense and has proved (though only by a preponderance of the evidence) that he was mentally ill and that his criminal conduct was the product of his mental illness and (2) "a criminal act by definition is not within a range of conduct that is generally acceptable."

  Was Jones entitled to be released or recommitted pursuant to civil commitment standards after the expiration of the maximum sentence he could have received had he been convicted? The Court replied "[t]hat there simply is no necessary correlation between severity of the offense and length of

Continued on page 22

Recent Court Rulings

In the Virginia Supreme Court

Contracts With Incompetent Party Not Necessarily Void

• In *Upton, Committee v. Hall*, 225 Va. ____, 225 V.R.R. 152 (March 11, 1983), the Court reaffirmed its position that contracts made with incompetent persons are voidable under certain conditions but are not necessarily void in all cases. The case involved the sale of a parcel of land, a portion of which was owned by a woman who had been adjudicated incompetent. The Court ruled when one party contracts with another party who is incompetent, pays fair value in the exchange, and acts in good faith without knowledge of the other party's incompetence, the contract will be set aside only if the competent party can be restored to *status quo ante*. However, if the competent party is aware of the incompetency or if the consideration paid is grossly inadequate, the contract can be voided. Since in this case there was no evidence that the buyers either knew of or took advantage of the seller's incompetency, the sale was allowed to stand.

"Necessaries" Doctrine Violates Equal Protection

• The doctrine of "necessaries" makes a husband liable for necessary goods and services provided to his wife by a third party. The doctrine was based in the common law rule that wives could have no estate separate from their husbands. Since a husband holds entitlement to his wife's domestic services, he is in return liable for her support. The Court abolished this rule as unconstitutionally gender-based in *Schilling v. Bedford County Memorial Hospital, Inc.*, 225 Va. ___, 225 V.R.R. 489 (June 17, 1983).

Schilling was sued by the hospital that treated his wife, even though he had refused to co-sign a promissory note to pay hospital expenses. The trial court had found that he was liable, nevertheless, under the "necessaries" doctrine. On appeal, Schilling argued that the doctrine violated both the Virginia Constitution and the Fourteenth Amendment of the Federal Constitution by creating a gender-based classification not substantially related to furtherance of an important governmental objective. The Supreme Court refused to make the doctrine "gender-neutral," as the hospital proposed, by making both husbands *and* wives liable for each other's expenses. It instead struck down the "necessaries" doctrine in a reversal of the lower court's decision. □

In the Federal Courts

Immunity For Services Board

• A federal court order in *Ralph T. Campbell, et al. v. The Board of Supervisors of Charlotte County, et al.*, 553 F. Supp. 644 (E.D. Va. 1982), dismissed tort complaints against the Crossroads Services Board and Charlotte County Board of Supervisors. The Court ruled that both groups were protected by the non-waivable and complete immunity for intentional torts that applies to all counties and county subdivisions in Virginia. The Court also suggested that tort claims against such groups were probably barred in federal court by provisions of the Eleventh Amendment to the Federal Constitution. Another count in the suit was dismissed as to all other defendants when the Court ruled that the law prohibiting conspiracies to injure another in his trade or business, Va. Code Ann. §§ 18.2-499, 500 (Rpl. Vol. 1982), should be construed to exclude individual employment as a protected activity.

Rights Of Prison Inmates

Two recent federal court decisions addressed rights of Virginia prison inmates.

• In *Palmer v. Hudson*, 697 F.2d 1220 (4th Cir. 1983), an inmate brought a civil rights action against a prison guard. The inmate charged that the guard intentionally destroyed his property during a search for contraband. The Court of Appeals ruled that due process was not violated by a random, unauthorized act of a state officer if the state provided an adequate post-deprivation remedy. It went on to rule that irregular, unannounced shakedown searches of prisoners' property are permissible as a means to discover contraband. The case was returned to the lower court to determine whether the search in question was routine or whether it was conducted to harass the prisoner in violation of his substantive right to privacy.

• In *Sellars v. Roper*, 554 F.Supp. 202 (E.D. Va. 1982), an inmate who fought with a correctional officer and was subsequently put into isolation alleged a violation of his right to due process. Among the charges lodged by the prisoner were that he had been struck during the fight, that he had no access to outdoor exercise facilities during his isolation, and that he had no access to a law library. In an opinion which confessed that the court was "rudderless on the problem" of determining when a blow struck by a prison officer was a tort (actionable in state court) and when the same blow might be a violation of the Eighth or Fourteenth Amendment (actionable in federal court), Judge Warriner dismissed the case on a motion of summary judgment for the defendant. His opinion indicated, however, that an action for assault and battery was still available to the prisoner in the state courts. □

Continued from page 14
the malady of feeblemindedness to a general propensity for crime. Unlike Carrington, who would have sterilized criminals, Foster's emphasis was on prevention. In order to prevent the birth of those likely to become criminals, Foster urged that the feebleminded must be sterilized. Like Carrington, Foster emphasized legislation: "We must have a sterilization law upon the statute book of every state."[17]

In the early years of the 20th century, comments such as those made by Carrington and Foster became more common among physicians who worked in institutional settings. Perhaps most influential and certainly most persistent in advocating the passage of a sterilization law in Virginia was Dr. Joseph DeJarnette.

Through articles in medical journals and public speeches, DeJarnette reached out to physicians and laymen alike for support of his sterilization policy. DeJarnette's institutional reports provided a direct line to legislators and to the Governor and an official medium in which to preach the sterilization gospel. Those publications also reveal a pattern of increased boldness among sterilization advocates and allow us to trace the development of one prominent physician's attitudes toward the mentally disabled.

"Sterilization DeJarnette"

Dr. DeJarnette was graduated from the Medical College of Virginia in 1888 and began an internship at Western Lunatic Asylum at Staunton, Virginia, in 1889. By 1906 he had become superintendent of that institution (by then renamed Western State Hospital), and he began his campaign for a sterilization law shortly thereafter. His first comments on the efficacy of sterilizing the retarded were modest but noteworthy. In his report to the Governor in 1908, DeJarnette recommended that the "unfit" should be prohibited from marrying. This group included not only "those who have dipsomania, insanity, epilepsy [and] feeblemindedness" but also the syphilitic and tubercular. He cited the axiom that "prevention is far better than cure" and proposed the "elimination of defectives and weaklings."[18] His other remarks prescribing sterilization for his patients proved prophetic:

> *Some writers actually recommend sterilization of this class. This sounds extreme to the unthinking, and appears harsh, but in the course of time, probably many years, some plan of this nature will almost certainly be resorted to. A few years ago the anti-spitting acts and laws for the prevention of tuberculosis were ridiculed, while now even the most ignorant are beginning to recognize their importance and observe them.*[19]

He tried in future reports to hurry along the day when procreation among "the unfit" would be, like spitting on the sidewalks, legally prohibited. In his 1909 report, the call for legislation was repeated along with the declaration that reproduction of the "class" of defectives "is a crime against their offspring and a burden to their state."[20] The 1911 report demanded that "sterilization of all weaklings should be legally required."[21]

Procedural protection and representation of those who were sterilized were often lacking.

DeJarnette's 1913 report revealed important indications of his views on the progress of medical science and the need to encourage, rather than impede, the operations of Darwinian principles. Only the fit should survive, he asserted, but with such developments as incubators for "weak babies" and medical control of the traditional childhood diseases, "numbers of weaklings are matured and reproduced much to the injury of the race."[22] DeJarnette went on to compare the reproductive freedom of animals and humans and made it clear that his perspective was, at best, nonlibertarian.

> *In the case of the farmer in breeding his hogs, horses, cows, sheep, etc., he selects a thoroughbred, and even in farm and garden products he selects the best seed to produce from, but when it comes to our own race any sort of seed seems good enough, and the rights of the syphilitic, epileptic, imbecile, drunkard and unfit generally to reproduce must be allowed, for otherwise we are encroaching upon the so-called inalienable rights of man.*[23]

In later years DeJarnette pressed for sterilization as a solution to the state's economic burdens. Care of "the defective quota of our population" cost "one seventh of the state's income," and sterilization was recommended as "cheap and effective."[24]

DeJarnette's attention to a frugal stewardship of the state's resources was matched by his claim to scientific objectivity. He quoted regularly from the literature of the eugenicists and cited what he saw as the absolute scientific accuracy of the laws of heredity. Alcoholism, prostitution, crime, venereal disease, neurological disorders, and mental retardation all would disappear, he declared, if those who were possessed of such afflictions were forbidden to reproduce. And while the segregation and education of many "defectives" was recommended as a partial solution, DeJarnette always fell back on his faith in sterilization as the final solution. It would prove a benefit to the patient and society, he argued, and "[i]n many instances the patient can be sterilized without his knowledge."[25]

By 1920 DeJarnette's report suggested that "[i]f heredity, alcohol and syphilis can be controlled, we will stop building hospitals for the insane and dependents." Alongside his comments on the "Causes and Prevention of Insanity" DeJarnette published his poem entitled *Mendel's Law: A Plea for a Better Race of Men.* (See box.)

The poem represented all of DeJarnette's strongest beliefs about heredity, mental deficiency, and the role of sterilization as the key to human

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Mendel's Law: A Plea For A Better Race of Men*

Oh, why are you men so foolish—
You breeders who breed our men
Let the fools, the weaklings and crazy
Keep breeding and breeding again?
The criminal, deformed, and the misfit,
Dependent, diseased, and the rest—
As we breed the human family
The worst is as good as the best.

Go to the house of some farmer,
Look through his barns and sheds,
Look at his horses and cattle,
Even his hogs are thoroughbreds;
Then look at his stamp on his children,
Lowbrowed with the monkey jaw,
Ape handed, and silly, and foolish—
Bred true to Mendel's law.

Go to some homes in the village,
Look at the garden beds,
The cabbage, the lettuce and turnips,
Even the beets are thoroughbreds.
Then look at the many children
With hands like the monkey's paw,
Bowlegged, flatheaded, and foolish—
Bred true to Mendel's law.

This is the law of Mendel,
And often he makes it plain,
Defectives will breed defectives
And the insane breed insane.
Oh, why do we allow these people
To breed back to the monkey's nest,
To increase our country's burdens
When we should breed from the good and the best.

Oh, you wise men take up the burden,
And make this your loudest creed,
Sterilize the misfits promptly—
All not fit to breed.
Then our race will be strengthened and bettered,
And our men and women blest,
Not apish, repulsive and foolish,
For we should breed from the good and the best.

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*From *Report of the Western State Hospital* (1920). By Joseph S. DeJarnette, M.D.

Continued from page 18

progress. So proud of the poem was DeJarnette that he printed it again in his 1922 report. Apologizing for his personal indulgence, he offered the

> *hope [that] I shall be pardoned for quoting a second time my poem "Mendel's Law." I do it [to] attract the attention of the reader and enlist his sympathy and assistance in this great effort for the betterment of our citizenship.*[26]

He also included it in two medical articles published after the sterilization law was enacted. In remarks during the celebration of the fiftieth anniversary of his service to Western State Hospital, DeJarnette again recalled the poem and noted nostalgically that the sentiments it expressed had earned him the nickname: "Sterilization DeJarnette."[27]

Buck v. Bell

Perhaps the most important public statements DeJarnette made in support of sterilization occurred in the case of Carrie Buck. The Virginia law authorizing involuntary sterilization was enacted in 1924. Carrie, an inmate of the Virginia Colony for the Epileptic and Feebleminded (now the Lynchburg Training School), was designated by Dr. Albert Priddy, the Colony superintendent, to become the first person to be sterilized under the law. The suit that followed was instigated by supporters of the new law and represented an attempt to establish its constitutionality and, in the words of the law, to forestall "the transmission of insanity, idiocy, imbecility, epilepsy and crime."

DeJarnette was called as an expert witness in the suit of *Buck v. Priddy*. His testimony consisted of a long discourse on the nature of feebleminded-ness and the operation of Mendel's Law and the mechanism of heredity. He described the case of the infamous Kallikak family whose more than one hundred defective offspring were an example of a genetic disaster that produced great expense for the state. The sterilization law would, he argued, avoid such expense for Virginia. DeJarnette was also confident that

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The 1911 report demanded that "sterilization of all weaklings should be legally required."

Continued from page 19

sterilization would promote social welfare in non-economic areas. Its result, he declared, would be that "the standard of general intelligence would be lifted ... [and] it would lower the number of criminals."[28]

Carrie Buck's attorney suggested that the increased transmission of venereal disease might be one result of a sterilization program. When he was asked what benefit would come from releasing sterilized women from institutions while they were still subject to such disease, DeJarnette responded:

> *It benefits society by not taking care of them, and by the work they do. They are the hewers of wood and drawers of water, and there is not very much more likelihood that they would spread venereal disease if sterilized than if they were not.*[29]

When the case finally reached the United States Supreme Court in 1926 as *Buck v. Bell* (Dr. Bell succeeded Priddy as superintendent in 1925), DeJarnette was vindicated. The dramatic opinion of Justice Oliver Wendell Holmes, Jr., representing the nearly unanimous vote of the Court (8-1), condemned Carrie, her mother, and her daughter with the declaration "Three generations of imbeciles are enough."[30]

In response to Holmes, DeJarnette praised the 1924 law and the Supreme Court opinion. Of Carrie's own fortunes he added:

> *It would be impossible to estimate the blessing of sterilization to a family with a mentally defective daughter liable to be oversexed and at any time entail upon her family a life of care and disgrace.*[31]

DeJarnette's reports continued to keep track of developments in eugenics. He left a record which detailed the number of patients sterilized in Virginia and other states. Beginning in 1933, DeJarnette's reports began to cover international events. Following the statement that "sterilization ... is our greatest work," DeJarnette noted a development in Europe:

> *Chancellor Adolf Hitler has recommended a national law for Germany to sterilize her unfit, showing that the idea is becoming more or less universal.*[32]

The next year DeJarnette announced that the German sterilization law had been put into effect and that " ... England is agitating the subject very seriously."[33] Future reports listed sterilization statistics in the Third Reich, comparing them to the figures in the United States and pressing for increased use of the law in Virginia.

In 1935 DeJarnette again looked to the German example:

> *No person unable to support himself on account of his inherited condition has a right to be born. In Germany the sterilization law embraces chronic alcoholics, certain hereditary physical diseases, the hereditarily blind and deaf, the criminally insane, feebleminded and epileptic. By December 31, 1934, Germany had sterilized 56,224.*[34]

From 1935 to 1939 DeJarnette continued to emphasize the comparison between the German program and the number of Americans who had been sterilized. Approximately 80,000 Germans were sterilized in only six years, while only 27,000 Americans underwent the procedure during the same period. In 1940, after Hitler's invasion of Poland and the entry of France and England into the European war, DeJarnette's comparisons ceased.

DeJarnette's work in Virginia did not cease, however. He remained as superintendent of Western State Hospital, a post he held for more than fifty years. A new sanitarium bearing his name was erected adjacent to Western State. He published articles on sterilization, gave clinics to demonstrate the procedure, and made a standing offer to train anyone interested in the operation. This would, he noted, "save a great deal of trouble in working out the technique as we had to do."[35]

At the age of eighty-one he was still making speeches and was characterized by one Richmond newspaper as "the leading disciple of eugenic sterilization" in Virginia.[36]

Viewed in isolation, the rhetorical excesses of a man like DeJarnette demonstrate one curious but powerful point of contact between medicine and politics in the early years of the sterilization era. Yet while attitudes toward mental illness changed significantly in later years, the sterilization law remained in force. As time passed, minor changes in statutory language were made to satisfy developing definitions in the field of mental health. The list of those to be sterilized that had

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Developments in
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Continued from page 20

included the "insane, idiotic, imbecile, feeble-minded or epileptic" was shortened in 1950 to read "mentally-ill, mentally deficient or epileptic."[37] In 1968 the General Assembly removed epileptics from the list.[38] Yet from 1924 to 1974, surviving two major recodifications of Virginia law, the eugenic criteria that would prevent reproduction among the likely parents of "socially inadequate offspring" remained in place.

The legislature had occasion to review the law in 1960 when concern was voiced that it did not adequately reflect modern medical knowledge of heredity and mental illness.[39] But the Advisory Legislative Council that was directed to study the problem found "no substantial complaint" about the law's application. Despite the fact that the value of sterilization had been challenged by some physicians and geneticists as early as 1920, the Council discovered "no medical or scientific data" to support a major amendment of the statute.[40] Involuntary sterilization of institutionalized patients remained the law in Virginia.

The attitudes of DeJarnette and others like him provide a strong counterpoint to recent critics of sterilization.

Poe v. Lynchburg Training School

When the original sterilization law finally was repealed in 1974[41] and all other references to sterilization of those with "hereditary forms of mental illness that are recurrent" were removed from law in 1979, it appeared that the language of eugenics and the thousands of Virginians who had been sterilized under eugenic legislation would recede quietly into history. But the continuing effect of the law on those who had been judged unfit to bear children did not disappear.

In December of 1980 several former patients of state hospitals filed a class action lawsuit against those institutions. Their suit alleged that some 7,200 people had been sterilized, like them, and many had never been told the nature of the operation they were to undergo. Additionally, the suit claimed that diagnoses of retardation or mental illness were often inaccurate and that by not informing the patients clearly of their intentions, state officials had violated the procedural conditions contained in the sterilization law. Court appointed guardians had failed to protect these patients, and court appointed attorneys had not properly represented them. The lawsuit, supported by the American Civil Liberties Union, asked the Federal Court to declare the sterilizations unconstitutional. The suit also demanded that the state notify all those who had been sterilized and provide them with free medical and mental health services to mitigate the damages of their involuntary sterilizations.

At a preliminary hearing, the state attempted to have the suit dismissed. Although District Court Chief Judge Robert Turk agreed that the Supreme Court decision in *Buck v. Bell* settled the constitutionality of the sterilization law, the allegations of improper administration of the law were adequate to allow the suit to proceed on other grounds.[42]

As of the summer of 1983 the suit was still pending. Though no ruling has been made by the Court, the suggestion that patients may have been sterilized without their knowledge echoed too clearly the predictions of Dr. DeJarnette[43] to be dismissed out of hand. Nor did claims of irregularities in the sterilization program seem exaggerated. As early as 1943, the State Hospital Board itself reported the need for "official action to bring the sterilization procedure at the Lynchburg Colony in line with the statute."[44] Even then, it is clear from state records, procedural protection and representation of those who were sterilized were often lacking.

Regardless of the outcome of *Poe v. Lynchburg*, the damage to the lives of some who were sterilized can never be repaired. This is especially true of Carrie Buck, the first person to suffer the false charges of feeblemindedness and epilepsy that were used to justify her sterilization. More than fifty-six years after Justice Oliver Wendell Holmes inaccurately described her as the second of "three generations of imbeciles," Carrie died at the age of seventy-six. She was buried January 31, 1983, in her hometown of Charlottesville, Virginia. While she was alive, Carrie noted with embarrassment the dubious place in history that was hers as a result of *Buck v. Bell*. Perhaps it is fitting she will be spared the reminder on the anniversary of the law that made her name famous. □

Notes

1. 1924 Va. Acts ch. 394.
2. 274 U.S. 200 (1927).
3. Allan Chase, *Legacy of Malthus* 135, 343-350 (1977).
4. See unpublished dissertation of Frances Hassencahl, "Harry H. Laughlin, 'Expert Eugenics Agent' " 359 (1970).
5. 518 F.Supp. 789 (W.D. VA. 1981).
6. VA. CODE, Section 1095 h (1930).
7. Carrington, "Sterilization of Habitual Criminals with Report of Cases," 13 *Virginia Medical Semi-Monthly*, 398 (1908-1909).
8. "Sterilization of Habitual Criminals," 14 Id. at 421 (1909-1910).
9. "Hereditary Criminals — The One Sure Cure," 15 Id. at 4 (1910-1911).
10. Id.
11. Id. at 6.
12. Id.
13. 1910 Virginia Bills-Senate, no. 298.
14. Id.
15. 1910 Virginia Senate Journal 534.
16. Editorial, 15 *Virginia Medical Semi-Monthly* 24 (1910).
17. 17 Id. at 472 (1913).
18. 1908 *Report of the Western State Hospital* 10. Hereafter cited as *Report, WSH.*
19. Id. DeJarnette later claimed this as the first public statement in Virginia in favor of sterilization.
20. 1909 *Report, WSH* 17.
21. 1911 Id. 17.
22. 1913 Id. 12.
23. Id.
24. 1915 Id. 9-10.
25. 1919 Id. 10.
26. 1922-23 Id. 12.
27. See transcript of "Celebration of Dr. J. S. DeJarnette's Fiftieth Anniversary of Continuous Service" (July 21, 1939) in the papers of J. S. DeJarnette, Western State Hospital, Staunton, Virginia.
28. *Buck v. Bell*, Record at 77.
29. Id. at 81.
30. *Buck v. Bell*, 274 U.S. at 207.
31. 1928 *Report, WSH* 11.
32. 1933 Id. 2.
33. 1934 Id. 2.
34. 1935 Id. 9.
35. 1929 Id. 9.
36. Bob Burhans, "DeJarnette Presses Campaign for Sterilization of Unfit," *Richmond News Leader*, January 23, 1947, 14A.
37. 1950 Va. Acts ch. 465.
38. 1968 Id. ch. 477.
39. 1960 Virginia Senate Joint Resolution No. 18.
40. 1962 Virginia Documents (Senate) #5.
41. VA. CODE Section 37.1 was repealed by 1974 Va. Acts ch. 296.
42. See note 5 supra.
43. See note 25 supra.
44. Minutes of the State Board of Hospitals, April 13, 1944.

Continued from page 16
time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment."

In a dissenting opinion, in which he was joined by Justices Marshall and Blackmun, Justice Brennan declared that indefinite commitment without the due process protections constitutionally required for civil commitment "is not reasonably related to any of the Government's purported interests in confining insanity acquittees for psychiatric treatment." If the Government's purpose were to punish the acquittee, such differential treatment might be understandable, Brennan reasoned, though "it is questionable that confinement to a mental hospital would pass constitutional muster as appropriate punishment for any crime."

Brennan observed that an acquittal by reason of insanity is "backward-looking, focusing on one moment in the past, while commitment requires a judgment as to the present and future." Since not all mental disorders of the sort that may satisfy the mental disease element of the insanity defense persist for an extended period of time, to infer that someone acquitted by reason of insanity remains mentally ill for the purposes of commitment may be unreasonable. Further, he contended, given the "subtleties and nuances of psychiatric diagnosis," it may be inappropriate to permit a verdict of insanity, reached by a lesser standard of proof, to negate for all time the Government's responsibility to demonstrate committability by clear and convincing evidence. Finally, pointing to overwhelming evidence that psychiatric predictions of dangerousness are unreliable, particularly in the absence of a history of violent behavior, Brennan doubted that a "single attempt to shoplift" was sufficiently indicative of future dangerousness to obviate the need for independent consideration of the issue for the purposes of commitment.

Justice Stevens also filed a dissenting opinion in the *Jones* case in which he conceded the constitutionality of Jones's initial commitment but contended that, because "[t]he character of the conduct that causes a person to be incarcerated in an institution is relevant to the length of his permissible detention," after confinement for the maximum period fixed by the legislature as punishment for the offense, the Government should be required to shoulder the burden of proving by clear and convincing evidence that additional confinement is appropriate.

W. Lawrence Fitch

Arbitrary Detentions

The Supreme Court struck down a California law that prescribed criminal penalties for loitering. *Kolender v. Lawson*, ____ US ____; 51 USLW 4532 (May 2,1983). The law, Cal. Penal Code §647 (e), declared that anyone "who loiters or wanders upon the streets or from place to place without apparent reason and who refuses to identify himself" was guilty of a misdemeanor. The law also required people who were stopped in public to provide "credible and reliable" identification and to account for their presence to police officers who might detain them.

Respondent Lawson, a Rastafarian whose distinctive appearance and habit of taking long walks in the middle of the night led to several arrests, challenged the statute in federal court. The opinion by Justice O'Connor confirmed Lawson's charge that the law was unconstitutionally vague and violative of Fourteenth Amendment due process standards. The lack of definition for "credible and reliable" identification left enforcement of the law to the unguided discretion of every police officer. The liberty interests of citizens do not allow such arbitrary detentions and searches without probable cause, O'Connor concluded.

Although the case turned on a Fourteenth Amendment point, the opinion made it clear that First Amendment considerations also were significant. The potential for such laws to be enforced selectively against particular groups of people led O'Connor to stress that "our concern here is based upon the 'potential for arbitrarily suppressing First Amendment liberties'." □

Forensic Symposium

The Forensic Evaluation Training and Research Center has scheduled the annual fall symposium for Friday, November 18, from 9:30 a.m. to 4:00 p.m. The symposium will be held at the School of Law, University of Virginia, in Charlottesville. All who have completed the forensic training program in the past are urged to attend.

Included in the program will be the presentation of a model case, with discussion of the evaluation, report writing, and testimony led by persons with specialized expertise in those areas. In addition to general sessions, there will be several workshop sessions focusing on particular topics. Jane D. Hickey, Assistant Attorney General, will address the issue of "Tarasoff duty" in forensic settings. James C. Dimitris, M.D., Director of the Forensic Unit at Central State Hospital, will deliver a presentation on malingering, and Michael A. Solomon, M.D., Director of the Court-Ordered Evaluation Unit at Western State Hospital, will discuss issues in jail psychiatry.

Other topics and presenters scheduled include Joel Dvoskin, Ph.D., the Director of Forensic Services for the Department of Mental Health and Mental Retardation, on state policy matters and Sheila Deitz, Ph.D., Research Director for the Institute of Law, Psychiatry and Public Policy, on training program research.

More information will be mailed directly to all who have completed the forensic training. Questions may be referred to Wendy Nachamie or Larry Fitch at 804-924-5435.

Mental Disability Evaluation Training Project

The Institute of Law, Psychiatry and Public Policy, in cooperation with the Virginia Department of Mental Health and Mental Retardation, the Department of Social Services, and the Department of Rehabilitative Services, will soon provide training to clinicians and advocates in the Social Security mental disability process. The training, which will be directed by C. Cooper Geraty, LL.M., is in response to the recent improper denials for terminations of Social Security benefits to mentally disabled Virginians. Because many of these improper denials or terminations are the result of clinicians' providing inadequate data to the decisionmakers, the training primarily will be directed at ensuring that comprehensive, accurate, and legally appropriate information is contained in the applicant's treatment records. Further, because the receipt of these benefits has been recognized as an important factor in the success of community placement of mentally disabled persons, it is expected that the training will promote such appropriate placement.

A four-day course in mental disability evaluation training for clinicians will be offered on seven occasions from November through March to psychiatrists, physicians, clinical psychologists, and social workers, who can thereafter serve as members of a disability evaluation team in state and local facilities. The course will provide intensive didactic and clinical training in the process and framework of the Social Security benefit programs, in the relevant federal statutory and case law, in evaluating each of the four major mental disability categories recognized by Social Security, and in disability report writing and expert testimony. The course is expected to improve the capacity of state and local mental health and mental retardation professionals to perform skilled clinical evaluations of mental disability.

A series of one-day training sessions also will be provided for case-managers, mental health, mental retardation and substance abuse program administrators, and members of advocacy groups. These sessions will inform participants of the requirements of and problems in the application process and will suggest areas of involvement and assistance which have the potential of aiding qualified disabled persons in obtaining benefits. A consumer pamphlet designed to inform the general public of Social Security mental disability eligibility criteria and benefits will be produced in May 1984.

The training, including materials, will be available to appropriate community service board and state facility staff at no cost. However, enrollment will be limited.

A tentative schedule of the four-day training course for clinicians follows. The one-day sessions will be scheduled at a later date, but will probably occur in March and April 1984.

For further information about the training contact:

C. Cooper Geraty, LL.M.
Director, Mental Disability Evaluation Training Project
Institute of Law, Psychiatry & Public Policy
Box 100
Blue Ridge Hospital
Charlottesville, VA 22901
(804) 924-5035/
924-5435

Training Schedule

November 15-18, 1983
November 28-December 1, 1983
December 13-16, 1983
January 10-13, 1984
January 23-26, 1984
February 6-9, 1984
March 13-16, 1984

All sessions are scheduled to be held in Charlottesville. The training will begin at noon the first day and conclude at noon the fourth day.□

Letters

To the Editor:

I have just read with great interest the excellent article by Drs. Solomon and Davis on antipsychotic medications in the most recent issue of your very valuable publication, *Developments in Mental Health Law.* I am pleased that these writers have analyzed in detail the difference between short-term and long-term risks in the administration of antipsychotic medications.

In their article, Solomon and Davis attribute to me a confusion that I absolutely do not hold and have never expressed. On page 8, they say, "Legal writers (e.g., Alexander Brooks) unfortunately have tended to confuse short-term with long-term risks of antipsychotic medications." Such an observation may be true of other legal writers, but it happens that I do not harbor or express such a confusion.

In my article, "The Constitutional Right to Refuse Antipsychotic Medications," in 8 *Bull. Am. Acad. Psychiatry and Law,* 179 (1980), which Solomon and Davis cite, I make the following statement (at p. 215): "The main problem is that of chronic patients. The cost-benefit trade-off for acute, short-term patients may favor compelled medications for short periods of time. But for chronic, long-term patients, for whom antipsychotic medication is a permanent aspect of their lives, the cost-benefit trade-off changes." I then continue with a description of why it is the long-term problem we should be concerned about, and not the short-term acute issue.

Alexander D. Brooks
Professor of Law
Rutgers School of Law at Newark

In reply:

Professor Brooks is correct in that he did distinguish between short-term and long-term side effects of antipsychotic medications in his 1980 article in the *AAPL Bulletin.* Both Dr. Davis and I feel, however, that he overemphasized the most severe examples of the side effects. The extreme cases are not representative and should not be discussed as such.

At last year's meeting of the American Academy of Psychiatry and Law, I heard Professor Brooks speak on the right to refuse treatment. In his presentation he demonstrated that, unlike many legal commentators, he is sensitive to the plight of mentally disordered patients and to the difficult dilemmas that face clinicians who endeavor to treat them.

Michael A. Solomon, M.D.

A Mental Retardation/Developmental Disabilities Prevention Conference is planned for December 14-16, 1983, in Williamsburg, Virginia. Current research, effective prevention strategies, and development of legislative action plans will be focal points. Registration fee: $40. For information, contact *Marcia Penn, Director of Prevention and Information Services, P.O. Box 1797, Richmond, Virginia 23214. (804) 786-1530.*

Developments in Mental Health Law
Box 100
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Developments in Mental Health Law

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Civil Commitment in Virginia:

1984 Legislative Proposals

by C. Cooper Geraty*

Among legislative proposals before the General Assembly in 1984 is House Bill No. 4. The bill offers substantial revisions to Virginia's civil commitment process. The bill is the final product of a two-year reform effort. The effort began in 1982 with an examination of procedures actually in use and an identification of problems under current law by the Joint Subcommittee on Mental Health and Mental Retardation. In its 1983 Session, the General Assembly turned its attention to the issue in its review of an earlier draft of the bill.[1] And since that time, there has been extensive public comment and redrafting. House Bill No. 4 is co-sponsored by Delegates Warren J. Stambaugh and Jay W. DeBoer.

In response to the problems identified by the Subcommittee and through public comment, House Bill No. 4 addresses the civil commitment process in much greater detail than does existing law. It is, therefore, rather lengthy. (Excerpts from the bill begin on page 32.) This article will not attempt to discuss each provision of the bill but rather will highlight several important areas. These are (1) the structure of the process prior to the commitment hearing, (2) the commitment hearing procedures, (3) the substantive criteria for commitment and for pre-commitment hearing detention, and (4) the increased responsibilities of the community services boards.[2]

Pre-Hearing Process

Comments and other information provided to the Subcommittee identifed two general problem areas in the pre-hearing phase: the lack of sufficient clinical input, particularly at the initial determination of temporary detention, and the lack of adequate legal procedure and attorney preparation. The proposed solution to these problems is to establish a longer pre-hearing process which allows adequate time for necessary legal and clinical steps to be taken.

The Petition

Except in the emergency situations discussed below, the legal step which begins the process is the filing of a sworn petition which must allege that the respondent of the petition meets the general commitment criteria and which must state facts supporting the allegation.

A judge or magistrate, the latter of whom may act only after consultation with a person designated by the community services board, must then review the petition. If the judge or magistrate determines that probable cause does *not* exist to believe that the respondent meets the general commitment criteria, the petition must be

Continued

*C. Cooper Geraty is Director of the Mental Disability Evaluation Training Project, Institute of Law, Psychiatry & Public Policy and Assistant Professor of Law, General Faculty, University of Virginia. B.A., Davidson College, 1972; J.D. University of Virginia, 1976; LL.M. University of Virginia, 1983. [Editor's note: Mr. Geraty has made indispensable contributions over the last two years to the drafting and analysis of these legislative proposals.]

Also in this issue...

Continued from page 25

dismissed. If it is determined that such probable cause *does* exist, a summons must be issued for the respondent to appear before a judge for a preliminary conference.[3] **H.B. 4 § 37.1-67.1:3.**

Protective Custody

At this point, if it is also determined that the respondent meets the protective custody criteria, the judge or magistrate may issue a protective custody order, which expires at the end of twenty-four hours or at the end of the preliminary conference, whichever occurs first. **H.B. 4 § 37.1-67.1:4.**

Temporary Protective Custody

In emergency situations, where the respondent meets the temporary protective custody criteria, the respondent may be detained prior to the filing of a petition by a law enforcement officer or by the director of a facility, or the respondent may be ordered into such custody by a judge. The purpose of temporary protective custody is to prevent harm to the person or others through the provision of emergency care, treatment[4] and pre-admission screening. **H.B. 4 § 37.1-67.1:5A.** A temporary protective custody order is valid for a maximum of four hours. Unless a petition is filed *and* a protective custody order is issued within that time period, the person must be released. **H.B. 4 § 37.1-67.1:5B.**

The Preliminary Conference

The second major legal step is the preliminary conference, held before a judge within twenty-four hours of the issuance of a summons, if the respondent is in custody, or within a reasonable time if the respondent is not in custody. **H.B. 4 § 37.1-67.1:7A.** Whenever possible, the conference must be held in the jurisdiction in which the respondent resides. **H.B. 4 § 37.1-67.4.** Based upon testimony of the respondent and the petitioner, any available results of the community services board's pre-admission screening, and other relevant and available evidence, the judge must determine if there is probable cause to believe that the person meets the general commitment criteria. **H.B. 4 § 37.1-67.1:7D.** If the judge finds that probable cause does *not* exist, the petition must be dismissed and the respondent, if in custody, must be released. **H.B. 4 § 37.1-67.1F.**

Voluntary Admission

If the judge finds probable cause that the respondent meets the commitment criteria, the judge must inform the respondent of a number of legal rights pertaining to the commitment process and of the right to apply for voluntary treatment. **H.B. 4 § 37.1-67.1:7C, E.** In order to be eligible for such treatment, the respondent must be able to make an informed decision concerning the need for treatment and must consent in good faith to and have been accepted for voluntary treatment.

If the respondent meets the emergency placement criteria, the judge must schedule the commitment hearing to occur within seventy-two hours.

If these conditions are met, and if the judge determines voluntary treatment is "appropriate," the judge is empowered to order the person to accept hospitalization under certain conditions or to accept other specific non-hospital treatment. The proceedings must then be terminated. **H.B. 4 § 37.1-67.1:7E.**

Emergency Placement

If probable cause does exist and if the respondent either is not eligible for or does not request voluntary treatment, the judge must schedule the commitment hearing and must determine if the respondent should be detained in emergency placement pending the hearing. If the respondent meets the emergency placement criteria, the judge must schedule the commitment hearing to occur within seventy-two hours and issue an emergency placement order which is valid for seventy-two hours or until the conclusion of the hearing, whichever is earlier. If detention pending the hearing is not necessary, the hearing must be scheduled to occur within a reasonable time. **H.B. 4 § 37.1-67.1:7F, G.**

Pre-Admission Screening and Evaluation

In addition to, and occurring concurrently with these legal steps, the bill requires substantial clinical input in the pre-hearing process. The first clinical input is pre-admission screening, which is required to take place as early in the commitment process as practical and is authorized to begin prior to the filing of a petition.[5] Reasonable efforts must be made to complete the screening prior to the preliminary conference, which will normally occur within approximately twenty-four hours of the filing of a petition if the respondent is in custody. If possible, either a written report or an oral summary of the screening results must be provided at the conference.[6] **H.B. 4 § 37.1-67.1:2.**

The Independent Clinical Evaluation

The other clinical screening component is the independent clinical evaluation process. The purposes of the evaluation are to develop clinical evidence for the commitment hearing promptly and to promote diversion out of the commitment process of those persons who do not require court-ordered treatment. The judge initiates the evaluation process at the preliminary conference, upon a finding that probable cause exists to believe that the respondent meets the commitment criteria. At this time, the judge directs the community services board to provide for an independent clinical evaluation of the respondent's mental condition and need for treatment. **H.B. 4 § 37.1-67.1:9A.** The evaluator is required to complete the evaluation and file a report of the evaluation results with the court and with the respondent's attorney within forty-eight hours. In addition to the certification discussed below, the evaluator's report must supplement and update the information contained in the pre-admission screening report and provide recom-

Continued on page 30

Seventh Annual Symposium on Mental Health and the Law

March 16-17, 1984

University of Virginia
Charlottesville, Virginia

The Institute of Law, Psychiatry and Public Policy is pleased to announce the Seventh Annual Symposium on Mental Health and the Law. The Symposium will cover major current issues of mental health and the law and is planned for lawyers, psychiatrists, psychologists, nurses, social workers, and educators. The program will include both plenary sessions and small workshops tailored to a wide range of interests. The Symposium is co-sponsored by the Virginia Department of Mental Health and Mental Retardation, the University of Virginia School of Medicine (Office of Continuing Education), and the University of Virginia School of Continuing Education.

Schedule

Friday, March 16, 9 a.m. to 5:30 p.m.
&
Saturday, March 17, 9 a.m. to 12:30 p.m.

Location

Fenwick Auditorium, School of Nursing, University of Virginia
Brandon Avenue, Charlottesville

Registration Fee

$25, regular $35, for physicians* $35, with CEU credits*

[* Applications pending for CME credit in Category 1 of the Physician's Recognition Award of the American Medical Association and for CEU credit through the University School of Continuing Education.]

Program

Friday, March 16, 1984

8:30 A.M. **Registration & Coffee**

9:15 A.M. **Introductory Remarks**
Willis J. Spaulding, J.D.

9:45 A.M. **Commissioner's Address**
Joseph J. Bevilacqua, Ph.D.

10:30 A.M. **Coffee**

11:00 A.M. **P. Browning Hoffman Memorial Lecture in Law and Psychiatry: "Can We Resurrect the Rehabilitation Model in Criminal Justice?"**
Seymour L. Halleck, M.D.

12:00 Noon **Luncheon** (on own)

1:00 P.M. **Civil Commitment in Transition**
1. In a Federal Court: Judicial Scrutiny of the New York Commitment Process in *Project Release v. Prevost*
Presenter — John Petrila, LL.M.
Discussant — Leonard S. Rubenstein, J.D.
2. In a State Legislature: The Politics of Commitment Reform in Virginia
Presenter — The Honorable Warren G. Stambaugh
Discussant — Richard J. Bonnie, LL.B.

3:00 P.M. **Coffee**

3:30 P.M. **Professional Liability for Patient Suicide or Attempted Suicide**
Presenter — Jane D. Hickey, J.D.
Discussants — Nancy H. Halleck, LL.M.
Gregory A. Peterson, M.D.

5:00 P.M. **Recess**

Saturday, March 17, 1984

8:30 A.M. **Coffee**

9:00 A.M. **Workshops**

1. Forensic Evaluation of the Mentally Retarded Offender
W. Lawrence Fitch, J.D.
Joel A. Dvoskin, Ph.D.

2. Commitment and Release of Persons Found Not Guilty by Reason of Insanity: An Examination of the Supreme Court's Decision in *Jones v. United States*
Nancy H. Halleck, LL.M.

3. A Review of Revisions to the Federal Substance Abuse Confidentiality Regulations
Willis J. Spaulding, J.D.

4. Advocacy Techniques in Social Security Disability Claims Based on Mental Impairment
C. Cooper Geraty, LL.M.

5. State Civil Rights Legislation for Persons with Disabilities: 1984 Developments
Carolyn White Hodgins, M.S.

6. Public Guardianship: A Report on Florida's Comparison of Professional and Volunteer Models
Winsor C. Schmidt, Jr., J.R.

10:30 A.M. **Compensation for Mental Disability under the Social Security Act: New Psychiatric Perspectives**
Presenter — C. Robert Showalter, M.D.
Discussants — C. Cooper Geraty, LL.M.
John H. Noble, Ph.D.

Seventh Annual Symposium on Mental Health and the Law

Speakers

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

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

W. Lawrence Fitch, J.D.
Director, Forensic Evaluation Training & Research Center
Institue of Law, Psychiatry & Public Policy
University of Virginia

Nancy H. Halleck, LL.M.
Office of Mental Health Counsel
New York Office of Mental Health

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

John H. Noble, Ph.D.
Assistant Commissioner for Policy and Resources Development
Department of Mental Health and Mental Retardation
Commonwealth of Virginia

John Petrilla, LL.M.
Deputy Counsel
New York Office of Mental Health

Winsor C. Schmidt, Jr., J.D.
Mental Health Law Fellow
University of Virginia
Associate Professor of Public Adminstration
Florida State University

The Honorable Warren G. Stambaugh
Delegate, Virginia General Assembly
Member of Virginia Bar
Arlington, Virginia

Joel A. Dvoskin, Ph.D.
Director of Forensic Services
Department of Mental Health and Mental Retardation
Commonwealth of Virginia

C. Cooper Geraty, LL.M.
Director, Mental Disability Evaluation Training Project
Institute of Law, Psychiatry & Public Policy
University of Virginia

Seymour L. Halleck, M.D.
Professor of Psychiatry and Adjunct Professor of Law
University of North Carolina, Chapel Hill

Carolyn White Hodgins, M.S.
Director, State Advocacy Office
for the Developmentally Disabled
Commonwealth of Virginia

Gregory A. Peterson, M.D.
Forensic Psychiatry Fellow
University of Virginia

Leonard S. Rubenstein, J.D.
Attorney, Mental Health Law Project
Washington, D.C.

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

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

Local Arrangements

Accommodations: The Institute has reserved a block of rooms at the Howard Johnson Motel, approximately .3 mile from the symposium site. Special room rates are $30 single and $38 double. Reservations must be made before March 1 by calling the motel at (804) 296-8121. Attendance at the symposium should be mentioned in making reservations. Other nearby motels include the Cavalier Inn and the Boar's Head Inn.

Parking: A limited number of reserved parking spaces are available at no charge upon request by early registrants. Permits and maps will be mailed prior to the symposium. Some parking on nearby streets should also be available.

Registration

Registration can be assured by completing the attached registration form and returning it with registration fee by February 24, 1984. Please make checks payable to Institute of Law, Psychiatry and Public Policy. Late registrations will be accepted on a space available basis through March 16, 1984. Registrations and questions should be addressed to:

Elaine M. Hadden
Institute of Law, Psychiatry and Public Policy
Box 100, Blue Ridge Hospital
Charlottesville, VA 22901
(804) 924-5435

Registration Form

Name _____ Telephone _____
last first

Agency or Firm _____

Mailing Address _____

_____

Fee (check one) ____$25 regular ____$35 with CEU ____$35 with CMEs (all physicians)

Need parking permit_____ Assistance for disabled person requested _____

Virginians with Disabilities Act Introduced

At the request of Governor Charles S. Robb, a bill calling for the enactment of the "Virginians with Disabilities Act" will be considered by the 1984 General Assembly. Its chief patron is Delegate Warren G. Stambaugh.

Describes and Protects Civil Rights

The proposed Virginians with Disabilities Act is most significant for its prohibition in Chapter 9 of discrimination against persons with mental or physical impairments in all state programs, private employment (where there are ten or more employees), all post-secondary education, voting activities, public transportation, public accommodations, and housing accommodations.

Current Virginia Law provides no comparable guarantee of the civil rights of disabled persons. Such protection as it does afford is offered only to persons with physical impairments. In sharp contrast, the proposed Virginians with Disabilities Act seeks to assure the rights of "any person who has a physical or mental impairment which substantially limits one or more of his major activities, has a record of such impairment, or is regarded as having such an impairment."

Chapter 9 authorizes the award of damages, injunctive relief, and reasonable attorney fees to persons whose rights under the Act are violated.

And Chapter 9 would make it a misdemeanor (punishable by a maximum fine of $1000), to intentionally deny any person his rights under the Act or to interfere with his exercise of those rights.

Creates Department for the Rights of the Disabled

Chapter 8 of the bill would create the Department for the Rights of the Disabled. This Department would absorb the present functions of the State Advocacy Office for the Developmentally Disabled and undertake many new activities as well. The Department, among its other powers and duties, would be authorized by the Act to "[p]ursue legal, administrative, and other appropriate remedies to protect the rights of persons with disabilities." Its authority would include bringing actions for damages or injunctive relief under Chapter 9.

Creates Board for the Rights of the Disabled

The proposed Department for the Rights of the Disabled would also provide technical assistance in the nature of planning and needs assessment to a newly created Board for the Rights of the Disabled. The Board would succeed both the current Governor's Overall Advisory Council on Needs of Handicapped Persons and the Developmental Disabilities Planning Council.

Reflects Year-Long Deliberations

Under the proposed legislaton the Board would be charged with the specific task of annually preparing for the Secretary of Human Resources an assessment of the service needs of persons with disabilities, including advocacy service needs. The Board would also report annually on the economic impact of the Virginians with Disabilities Act, considering for example the employment of and income tax revenues from persons with disabilities, or the cost of state services mandated by the Act.

The Board would have no management authority over the advocacy functions of the Department for the Rights of the Disabled.

Reorganizes Rehabilitative Services.

In addition to civil rights protection, the proposed Virginians with Disabilities Act would provide a new statutory basis for the operation of the state Department of Rehabilitative Services and the Board of Rehabilitative Services. The Act, among other things, would require the Board to promulgate regulations to govern eligibility for vocational rehabilitation.

The proposed Virginians with Disabilities Act is the product of a year's deliberations by the Governor's Overall Advisory Council on Needs of Handicapped Persons (GOAC). The GOAC was assisted by the State Advocacy Office for the Developmentally Disabled in conducting public hearings across the state. The Institute of Law, Psychiatry and Public Policy assisted in the preparation of the GOAC's final draft of its legislative proposal.

Repeals Eugenics Statutes

Both the proposed Act and another Bill (HB 259, sponsored by Delegate Phoebe M. Orebaugh), call for the repeal of Sections 20-46 and 20-47 of the Virginia Code. Those Code Sections prohibit the marriage of persons who have been adjudicated legally incompetent under certain circumstances (such as the woman to be married being age 45 or less). The present law had its origins in eugenics legislation enacted in 1918 and even today is chiefly aimed at discouraging procreation, rather than at regulating marriage.

Other bills to watch. . .

S.B. 37	Virginia Fair Housing Law
S.B. 44	Licensure
S.B. 55	Rate Setting for Children's Facilities
S.B. 108	Funding for Education of Certain Privately Placed Children
S.B. 218	Disclosure of Patient Information to Third Party Payors by Professionals
S.J.R. 32	Study of Elementary Developmental Guidance and Counseling Programs
H.B. 50	Institutions for the Mentally Ill
H.B. 161	Powers and Duties of Community Services Boards
H.B. 241	Coverage for Group Accident and Sickness Insurance
H.B. 260	Definition of Homes for Adults
H.B. 290	Insanity Defense
H.B. 330	Transfer of Patients in Mental Health Facilities

Continued from page 26

mendations for the respondent's care and treatment. **H.B. 4 § 37.1-67.1:9C.**

The evaluator is given substantial decision-making authority through a certification procedure. The evaluator must make one of three certifications to the court, two of which terminate the process. The first possible certification is for voluntary hospitalization or treatment and may be made at any time prior to the hearing. To be appropriate for voluntary treatment, the respondent must need hospitalization or other treatment, must be able to make an informed decision regarding the need for treatment, and must have consented in good faith to and have been accepted for voluntary hospitalization or certain outpatient treatment programs. Upon certification for an acceptance to such treatment, the petition must be dismissed by the court. **H.B. 4 § 37.1-67.1:10(1).**

The second certification is that there is no substantial evidence that the respondent meets the involuntary commitment criteria. This certification requires that the person, if in custody, be released, and that the petition be dismissed. **H.B. 4 § 37.1-67.1:10(2).** The purpose of this certification is to terminate, as soon as possible and with as little judicial involvement as possible, those cases in which it can be determined clinically that the person does not meet the commitment criteria.

The third certification is the only one which triggers a commitment hearing. If the evaluator certifies that there is substantial evidence for finding that the respondent meets the commitment criteria and that the respondent either objects to voluntary treatment or is unable to make an informed decision concerning voluntary treatment, a commitment hearing is required. **H.B. 4 § 37.1-67.1:10(3).** Therefore, under the proposed procedures, a commitment hearing is held only for those persons who are not clearly appropriate for other dispositions. By the time the evaluator has provided the certification to the court, either the process has been terminated or sufficient clinical information has been obtained and adequate legal procedures and preparation should have occurred so that a thorough and just commitment hearing may occur.

The bill contains three types of possible pre-hearing detention: temporary protective custody (4 hour maximum), protective custody (24 hour maximum), and emergency placement (72 hour maximum).

The Commitment Hearing

The commitment hearing is scheduled at the preliminary conference to occur within a reasonable time if the respondent is not ordered to emergency placement, or within seventy-two hours if an emergency placement order is issued. Upon receipt of the evaluator's certification, and at the request of the respondent and for good cause shown, the judge may grant one continuance. If the respondent is subject to an emergency placement order, the continuance cannot exceed twenty-four hours unless extraordinary circumstances are present. The emergency placement order may be extended for the period of continuance. **H.B. 4 § 37.1-67.1:11A.**

The bill's hearing procedures address the two major problems identified in the current hearing process: (1) inadequate clinical information being available at the hearing and (2) hearings that are often not conducted in a thorough and judicious fashion. The problem of obtaining sufficient clinical information is addressed by requiring pre-admission screening in all cases and by the independent clinical evaluation process described above. In addition to the required certification, which must be provided to the court prior to the hearing, the bill requires the evaluator or other qualified person who assisted in the evaluation or conducted the pre-admission screening to be present at the hearing. Also, the respondent is explicitly provided an opportunity to question any persons who prepared certifications or reports. **H.B. 4 § 37.1-67.1:11D.** These required sources of clinical information, supplemented by the results of any examinations obtained at the respondent's expense pursuant to **H.B. 4 § 37.1-67.1:7B,** should provide information of sufficient quality and scope to adequately inform the judge of the clinical particulars of each case.

Appointment of Counsel

- **For the respondent.** In order to provide hearings that are conducted in a thorough and judicious fashion, the respondent's attorney is appointed earlier in the process, the attorney is required to fulfill certain preparation steps, and the hearing is made more adversarial. Whenever possible, the respondent's attorney must be appointed at the time of the initial issuance of the summons upon the filing of the petition. **H.B. 4 § 37.1-67.1:3.** If such appointment is not possible, the attorney must be appointed at the preliminary conference. **H.B. 4 § 37.1-67.1:7B.** During the period between appointment and the hearing, the attorney is encouraged to begin preparation by specific provisions requiring that the respondent be interviewed as far in advance of the hearing as possible, that all relevant diagnostic and other reports be examined, and that reasonable steps be taken to interview the petitioner and all other material witnesses. **H.B. 4 § 37.1-67.1:11C.** The bill also specifically provides that the respondent be given a fair opportunity to confront and cross-examine persons who prepared reports or certifications. **H.B. 4 § 37.1-67.1:11D.**
- **For the petitioner.** One of the main causes of the informal, non-adversarial nature of the existing hearing process was identified to be the lack of counsel for the petitioner. The proposed legislation encourages a more adversarial hearing by mandating that the petitioner be afforded the opportunity to be represented by counsel. In addition,

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Continued from page 30

the court may appoint counsel if the interest of justice will be served by doing so. **H.B. 4 § 37.1-67.1:11B.** By making adequate clinical information available early in the process and by promoting its full exposition through a truly adversarial process, the commitment hearings contemplated in the proposed legislation are expected to provide a superior forum for addressing the ultimate decision in the process.[7]

Commitment Criteria

A number of comments were received regarding the inexactness of the wording in the existing commitment criteria. The existing "imminent danger to self or other"[8] standard was criticized as being too vague, and the "substantially unable to care for himself"[9] standard was seen as needing further identification of relevant self-care areas. Also a number of suggestions were received regarding the proper underlying basis for commitment criteria.[10] Some comments suggested that only a criterion grounded on dangerousness should be established because only dangerous conduct justifies the substantial deprivation of liberty effected by involuntary commitment. Other comments pointed to the importance of treating seriously mentally ill persons and supported the more paternalistic, non-dangerousness based criterion of "unable to care for self."

The bill retains both the "dangerous to self or others" and the "unable to care for self" standards, but each criterion has been modified to define more exactly the conditions to which it is applicable. The requirement of a recent manifestation of potential danger has been added to the "danger to self or others" standard, so that it reads:

> *. . .the court must find . . . that the respondent, as a result of mental illness, . . .presents an imminent danger to himself or others as evidenced by a recent overt act or threat. . . .*

H.B. 4 § 37.1-67.3:1. It was hoped that this addition would offer an objective indicium of dangerousness and would thereby increase the precision with which the criteria were applied.

The "substantially unable to care for self" standard was amended in two ways. First, the new language excludes commitment of persons who perhaps could not provide for their minimum needs on their own but who can fulfill those needs with the assistance of others. Second, four specific self-care areas of concern were added. The new criterion reads:

> *. . .the court must find. . .that the respondent, as a result of mental illness,. . . is substantially unable to provide for himself, or secure from others, his minimum needs for food, clothing, shelter or physical safety.*

The evaluator is required to complete the evaluation and file a report of the evaluation results with the court and with the respondent's attorney within forty-eight hours.

H.B. 4 § 37.1-67.3:1. These changes were intended to focus judicial inquiry and thereby increase the uniformity of application of the standard and to promote community treatment of those persons who can function with assistance in their home environments.

Other Detention Criteria

The current criteria for pre-commitment hearing detention are "probable cause" that the person is "mentally ill and in need of hospitalization" and that the person "cannot be conveniently brought before the judge...." **Va. Code § 37.1-67.1 (Supp. 1982).** A number of comments indicated that the vagueness of these detention criteria may be at least partially responsible for the perceived excessive use of detention. As noted above, the bill contains three types of possible pre-hearing detention: (1) temporary protective custody (four hour maximum), (2) protective custody (twenty-four hour maximum); and (3) emergency placement (seventy-two hour maximum). The first two types occur prior to the preliminary conference while the third occurs after the preliminary conference.

Protective Custody

The criteria for protective custody and for temporary protective custody are very similar. The protective custody criteria require a finding of probable cause that the respondent meets the general commitment criteria and a finding that

> *. . .the respondent, as a result of mental illness, appears to present a demonstrable and immediate risk of inflicting serious harm on himself or others or is manifestly unable to provide for his basic needs.*

If a magistrate, rather than a judge, is making the protective custody determination, reliable information from or consultation with certain mental health professionals is required prior to the determination. **H.B. 4 § 37.1-67.1:4.** These criteria are much more specific than the current law's detention criteria and contain a strong requirement of objective evidence of the risk of potential harm.

Temporary Protective Custody

The temporary protective custody criteria authorize facility directors and law enforcement officers to take, or a judge to order, a person into custody, if one of them

> *. . .believes that the person, as a result of mental illness, presents a demonstrable and immediate risk of inflicting serious harm on himself or others or is manifestly unable to provide for his basic needs.*

This belief must be based on direct observation of the person or the receipt of "reliable information concerning the person's present condition" from certain mental health professionals. **H.B. 4 § 37.1-67.1:5A.**

Emergency Placement

The protective custody and temporary protective custody orders are valid only for a maximum cumulative total of twenty-eight hours, by which time the preliminary conference must be

Continued on page 36

The Proposed Legislation: House Bill No. 4

The following are excerpts from the House Bill No. 4, submitted to the 1984 Session of the General Assembly. Sections which remain substantially unchanged have not been reprinted.

[§§ 37.1-1 and 37.1-63 omitted here]

§ 37.1-63.1. Definitions.—The following words, when used in this chapter relating to involuntary admissions, shall have the following meanings:

"Least restrictive treatment environment" means those conditions which are necessary for providing available treatment for mental illness and which restrict the patient's physical or social liberties no more than necessary to achieve a substantial therapeutic benefit or to significantly reduce a foreseeable risk of harm to the patient or others.

"Protective custody" means detention of a person alleged to be mentally ill and in need of emergency placement when such detention is authorized under the procedures specified in §§ 37.1-67.1:4 or 37.1-67.1:5.

"Qualified psychologist" means either: (i) a clinical psychologist licensed in Virginia: or (ii) a psychologist who has a doctorate from a training program approved by the American Psychological Association and at least one year of clinical training or experience, is skilled in the diagnosis of mental illness, and is employed by the Department or by a community services board or is employed on a contractual basis by a community services board.

"Qualified mental health professional" means a person designated by a community services board as qualified by training and experience to provide appropriate mental health services, including but not limited to evaluating mental condition and advising the courts as to such condition and disposition.

"Respondent" means the person who is alleged to suffer a mental illness which subjects that person to the involuntary admission and treatment provisions of this title and who must answer these allegations during involuntary commitment proceedings.

[§ 37.1-64 omitted here]

§ 37.1-67.1:1. Involuntary admission and treatment; duties of community services boards.— It shall be the responsibility of each community services board in the Commonwealth to establish, pursuant to regulations adopted by the Board, procedures necessary to carry out the responsibilities assigned to it by Articles 1,2 and 3 of Chapter 2 of this title relating to involuntary admission and treatment for mental illness. The courts having jurisdiction over the political subdivisions served by any community services board shall cooperate with the community services board in coordinating compliance with the provisions of such articles. The community services board and the court shall develop a plan to implement such coordination and shall annually submit such plan to the Supreme Court of Virginia and to the Department for approval. Such plan shall include a method for the collection and reporting of data relating to the involuntary admission procedure.

The Board shall promulgate the regulations specified in this section no later than January 1, 1985. The community services boards shall submit the first plan required by this section no later than May 1, 1985.

§ 37.1-67.1:2. Involuntary admission and treatment; preadmission screening.— It shall be the responsibility of each community services board to ensure that procedures are established for preadmission screening by a qualified mental health professional of any person against whom a petition for involuntary commitment has been filed pursuant to § 37.1-67.1:3. Such screening shall take place as early in the commitment process as practical and may occur prior to the filing of the petition. If preadmission screening has not been completed prior to the issuance of a summons, the community services board shall make a reasonable effort to complete preadmission screening prior to the time set for the preliminary conference required by § 37.1-67.1:7. At the conference, the prescreener shall provide to the court either a written or an oral summary of the preadmission screening results if the screening is completed or shall provide such information as is available if the screening is not completed. The report shall state whether the respondent is mentally ill and in need of treatment, identify the services necessary to treat the respondent, provide an inventory of available services, provide an individualized assessment of relative benefits of community and institutional care, and state an opinion concerning whether protective custody appears to be necessary pending the commitment hearing. Upon completion of the preadmission screening report, the community services board shall promptly provide a copy to the independent clinical evaluator designated pursuant to § 37.1-67.1:9 and to the attorney for the respondent.

This section shall not be construed to authorize detention of the person against whom a petition has been filed or is being considered. Detention is permitted only if authorized pursuant to the procedures specified in §§ 37.1-67.1:4 or 37.1-67.1:5.

§ 37.1-67.1:3. Involuntary admission and treatment; petition and issuance of summons.— The involuntary admission of any person shall be initiated by the filing of a sworn petition by any responsible person. The petition shall allege that the respondent meets the commitment criteria set forth in § 37.1-67.3:1 and shall set forth facts supporting the allegation. The petition for involuntary admission shall be filed with any judge as defined in § 37.1-1 or with a magistrate. A community services board may require that preadmission screening of the respondent be conducted prior to the filing of a petition for involuntary admission. In the event that a community services board does not require preadmission screening prior to the filing of a petition, a copy of the petition shall be promptly provided to the community services board in any case in which a summons is issued.

Upon the filing of a petition, the judge, or a magistrate upon reliable information from or after consultation with a qualified mental health professional designated by the community services board, shall determine whether there is probable cause to believe that the respondent meets the commitment criteria set forth in § 37.1-67.3:1. If the judge or magistrate determines that probable cause does not exist, the petition shall be dismissed. If the judge or magistrate determines that probable cause exists, he shall issue a summons requiring the respondent to appear before a judge at a specified time for a preliminary conference as required by § 37.1-67.1:7. The summons shall be served on the respondent and shall be accompanied by a copy of the petition and a written notice informing the respondent of the rights and procedures enumerated in paragraph C of § 37.1-67.1:7. Whenever possible, the judge or magistrate shall ascertain whether the respondent is represented by an attorney and, if not, shall appoint an attorney to represent him at the preliminary conference.

§ 37.67.1:4. Involuntary admission and treatment; protective custody order.— Upon a finding of probable cause pursuant to § 37.1-67.1:3, the judge, or a magistrate upon reliable information from or after consultation with a qualified mental health professional, may issue an order that the respondent be held in protective custody pending the preliminary conference required by § 37.1-67.1:7 if the respondent, as a result of mental illness, appears to present a demonstrable and immediate risk of inflicting serious harm on himself or others or is manifestly unable to provide for his basic needs. Such order shall expire at the end of twenty-four hours or at the end of the preliminary conference, whichever occurs first. Nothing in the section shall be construed to require the protective custody of any respondent.

§ 37.1-67.1:5. Involuntary admission and treatment; temporary protective custody.— A. A director of a facility or a law-enforcement officer may take a person into temporary protective custody, or a judge may order a person taken into temporary protective custody, prior to the filing of a petition, for the purpose of emergency care or treatment and preadmission screening, if (i) the director, officer or judge has directly observed the person or has received reliable information concerning the person's present condition from a qualified mental health professional; and (ii) based on such observation or information, the director, officer or judge believes that the person, as a result of mental illness, presents a demonstrable and immediate risk of inflicting serious harm on himself or others or is manifestly unable to provide for his

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Continued from page 32

basis needs.

B. Any person taken into temporary protective custody pursuant to this section shall be released within four hours unless a petition is filed pursuant to § 37.1-67.1:3 and a protective custody order is issued pursuant to § 37.1-67.1:4.

§ 37.1-67.1:6. Involuntary admission and treatment; placement.— A. Any person taken into temporary protective custody pursuant to § 37.1-67.1:5 or any respondent ordered into protective custody pursuant to § 37.1-67.1:4 shall be taken to a willing facility designated by the community services board as appropriate for preadmission screening and emergency care and treatment. No such person or respondent shall be detained in a jail or other place of confinement for persons charged with criminal offenses unless such confinement is specifically authorized by the chief judge of the appropriate circuit court pursuant to regulations duly adopted by the Board. Such regulations shall specify the conditions under which custody in jail or a similar facility is permissible and in which counties and cities such custody is authorized.

B. A facility to which a person is admitted pursuant to the provisions of §§ 37.1-67.1:4 or 37.1-67.1:5 may administer appropriate emergency treatment within its capabilities, including medications, which the director of the facility or his designee determines to be necessary to protect the health or safety of the person or the safety of others. Such treatment may be administered only in conformance with the human rights regulations promulgated by the Board and may be administered without the informed consent of the person only if a psychiatrist has determined, upon personal examination, that the person is likely to cause or suffer serious harm to himself or others unless the proposed treatment is immediately administered.

§ 37.1-67.1:7. Involuntary admission and treatment; preliminary conference.— A. A preliminary conference shall be held before a judge within twenty-four hours of the issuance of a summons pursuant to § 37.1-67.1:3 if the respondent is in protective or temporary protective custody or within a reasonable time if the respondent is not in custody.

B. At the preliminary conference, the judge shall inform the respondent, orally and in writing, of the rights and procedures enumerated in paragraph C of this section. The judge shall ascertain if the respondent is represented by an attorney and, if not, shall appoint an attorney to represent him.

C. Every respondent shall be informed of the following:

1. His right to be represented by an attorney of the respondent's own choice or to have the court appoint an attorney for him.

2. The basis for an order for protective custody, temporary protective custody, or emergency placement.

3. His right to a commitment hearing pursuant to § 37.1-67.1:11 within ninety-six hours of the time the respondent is taken into protective custody pursuant to § 37.1-67.1:4.

4. The commitment criteria set forth in § 37.1-67.3:1.

5. The place, time, and date of the commitment hearing.

6. His right to obtain, at the respondent's own expense, an independent evaluation of his mental condition.

7. The procedures for a court-ordered independent clinical evaluation.

8. His right to use the processes of the court to summon witnesses on the respondent's behalf and to be confronted by and cross-examine witnesses against him.

9. His right to be present at the commitment hearing and to have the hearing closed to the public at his request.

10. His right to appeal a commitment order to the circuit court within thirty days from the date of the order.

11. His right to a trial by jury on appeal.

D. At the preliminary conference, the judge shall determine whether there is probable cause to believe that the respondent meets the commitment criteria set forth in § 37.1-67.3:1. Such determination shall be made on the basis of (i) testimony from the petitioner or another responsible person familiar with the respondent's condition or behavior or the circumstances precipitating the petition; (ii) a review of the preadmission screening report if available; (iii) a review of other relevant information and records which may be available; and (iv) testimony, if any, offered by the respondent or others.

E. At the preliminary conference, upon a finding of probable cause pursuant to paragraph D of this section, the judge shall inform the respondent of his right to apply for either voluntary admission and treatment or other treatment. In order to determine the respondent's eligibility for such voluntary treatment, the judge shall ascertain if the respondent is able to make an informed decision concerning his need for hospitalization or other treatment, if the respondent has consented in good faith to such hospitalization or treatment, and if an appropriate facility or program has agreed to accept him for treatment. If an eligible respondent makes application for treatment other than hospitalization and if the judge determines that such treatment is appropriate, the judge shall order the respondent to accept such treatment and he shall terminate the proceedings. If an eligible respondent makes application for voluntary hospitalization, the judge shall order the respondent to accept voluntary admission for a minimum period of hospitalization, not to exceed seventy-two hours, and after such minimum period to give the hospital forty-eight hours' notice prior to leaving the hospital, unless sooner discharged pursuant to § 37.1-98 or § 37.1-99. The judge shall then terminate the proceedings. Such person shall be subject to the transportation provisions as provided in § 37.1-71.

F. If the judge determines that probable cause does not exist to believe that the respondent meets the commitment criteria, he shall dismiss the petition and release the respondent if the respondent is in protective custody. If the judge determines that there is probable cause to believe that the respondent meets the commitment criteria, and the respondent does not elect voluntary admission, he shall schedule a commitment hearing to be held no later than ninety-six hours from the time the respondent is ordered into protective custody pursuant to § 37.1-67.1:4, and he shall order an independent clinical evaluation conducted pursuant to § 37.1-67.1:9. If the respondent is not held pursuant to an emergency placement order under paragraph G of this section, the commitment hearing shall be scheduled to be held within a reasonable time.

G. If the judge determines that there is probable cause to believe that the respondent meets the commitment criteria, the judge shall further determine whether there is probable cause to believe that custody of the respondent is necessary to prevent harm to the respondent or others pending the commitment hearing. If the judge determines that custody is necessary, he shall issue an emergency placement order which shall expire at the end of seventy-two hours or at the conclusion of the commitment hearing, whichever occurs first. If the judge determines that emergency placement is unnecessary, he shall order the respondent released, if in protective custody, pending further proceedings on the petition and shall make such further orders as may be required by this chapter.

H. If the petitioner does not appear for the preliminary conference, the judge shall dismiss the petition unless a responsible person familiar with the respondent's condition or behavior or the circumstances precipitating the petition appears in support of the petition. If the respondent is not in custody and does not appear for the preliminary conference, the judge may determine, based on the evidence before the court, whether or not probable cause exists to believe that the respondent meets the criteria set forth in § 37.1-67.3:1. If the judge is unable to make the necessary determination in the respondent's absence, the judge may reschedule the preliminary conference and may issue an order requiring that the respondent be taken into custody for the purpose of being brought before the court for the conference, if no other reasonable method exists for ensuring his presence.

I. Availability of judges — The chief judge of each general district court and of each juvenile and domestic relations district court shall establish and require that a judge, as defined in § 37.1-1, be available seven days a week, twenty-four hours a day, for the purpose of performing the duties set forth in this section and in §§ 37.1-67.1:3 and 37.1-67.5.

§ 37.1-67.1:8. Involuntary admission and treatment; emergency placement and treatment.—A. A respondent who is subject to an emergency placement order shall be taken to a willing facility designated by the community services board. Such respondent shall not be detained in a jail or other place of confinement for persons charged with criminal offenses unless such confinement is specifically authorized by the chief judge of the appropriate circuit court pursuant to regulations duly adopted by the Board. Such regulations shall specify the conditions under which emergency placement in a jail or similar facility is permissible and in which counties and cities such emergency placement is authorized.

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Continued from page 33

B. A facility to which a respondent is admitted pursuant to an emergency placement order may administer appropriate emergency treatment within its capabilities, including medications, which the director of the facility or his designee determines to be necessary to protect the health or safety of the person or the safety of others. Such treatment may be administered only in conformance with the human rights regulations promulgated by the Board and may be administered without the informed consent of the respondent only if a psychiatrist has determined, upon personal examination, that the respondent is likely to cause serious harm to himself or others unless the proposed treatment is immediately administered.

§ 37.1-67.1:9. Involuntary admission and treatment; independent clinical evaluation.—A. Upon a finding of probable cause pursuant to paragraph F of § 37.1-67.1:7, the judge shall direct the community services board to conduct, or to arrange to have conducted, an independent clinical evaluation for the purpose of evaluating the respondent's mental condition and his need for hospitalization or treatment.

B. The independent clinical evaluation shall be conducted by a psychiatrist licensed in Virginia, or, if a psychiatrist is not available, by either a qualified psychologist or by a physician who is licensed in Virginia and who is qualified by training and experience in the diagnosis of mental illness. The evaluator shall not be the petitioner, shall not be related to the respondent, and shall not be substantially involved in the respondent's treatment as to be unable to reach an independent judgment. The evaluator, pursuant to regulations adopted by the Board, may utilize qualified mental health professionals designated by the community services board to assist in conducting such evaluation.

C. The evaluation shall include, but not be limited to, a review of the petition and the respondent's relevant and available medical and psychological records; social history; interviews with the petitioner, if available, and with any person currently responsible for the respondent's treatment; and a personal examination of the respondent. The evaluator shall complete the evaluation and shall provide a report of the evaluation to the court and to the respondent's attorney as soon as possible but in no event later than forty-eight hours after the issuance by the court of the order for evaluation. The report shall contain the certification required by § 37.1-67.1:10 and, in addition, shall supplement and update the information contained in the preadmission screening report and include recommendations for the respondent's care and treatment.

D. In any case in which the respondent is not in custody, the judge shall issue an order requiring the respondent to appear and submit to the evaluation described in this section. Such evaluation shall be conducted in a manner to be determined by the community services board. If the respondent fails to comply with the court's order, the judge, upon request of the community services board, may issue an order requiring the respondent to be taken into custody and brought to the evaluation facility.

§ 37.1-67.1:10. Involuntary admission and treatment; evaluator's certification.—The independent clinical evaluator, on the basis of the evaluation conducted pursuant to § 37.1-67.1:9, shall certify to the court as to one of the following:

1. The respondent needs hospitalization or other treatment for mental illness, is able to make an informed decision concerning his need for hospitalization or treatment, has consented in good faith to voluntary hospitalization or other treatment and has been accepted for treatment by an appropriate facility. Certification for voluntary admission may be given at any time prior to the commitment hearing. Upon such certification, the respondent may be admitted to any hospital as a voluntary patient or may, if appropriate, be admitted to any outpatient treatment program licensed by the Department or approved by a community services board, and the petition shall be dismissed by the court.

2. There is no substantial evidence that the respondent meets the commitment criteria set forth in § 37.1-67.3:1. If the respondent is being held pursuant to an emergency placement order he shall be released. The court shall dismiss the petition.

3. There is substantial evidence that the respondent meets the commitment criteria set forth in § 37.1-67.3:1, and the respondent either objects to hospitalization or treatment or is unable to make an informed decision concerning his need for hospitalization or treatment. Upon such certification, the commitment hearing pursuant to § 37.1-67.1:11 shall take place.

§ 37.1-67.1:11. Involuntary admission and treatment; commitment hearing.—A. Upon receipt of the evaluator's certification pursuant to paragraph 3 of § 37.1-67.1:10, the court shall proceed with the commitment hearing scheduled pursuant to paragraph F of § 37.1-67.1:7. The judge, at the request of the respondent and for good cause shown, may grant one continuance. If the respondent is subject to an emergency placement order, the continuance shall not exceed, in the absence of extraordinary circumstances, twenty-four hours and the emergency placement order may be extended for the period of continuance.

B. The petitioner shall be afforded the opportunity to be represented by counsel at the commitment hearing. If, upon consideration of the totality of the circumstances, the judge determines that the interests of justice will be furthered thereby, he may exercise his discretion to appoint counsel to represent the petitioner.

C. As far in advance of the hearing as possible, the attorney for the respondent shall interview the respondent; shall examine all relevant diagnostic and other reports, including those prepared pursuant to this chapter; and shall take reasonable steps to interview the petitioner and all material witnesses.

D. The hearing shall be attended by the respondent; by the petitioner; and, if the respondent is a patient in a treatment facility pursuant to a prior involuntary commitment order, by a representative of the facility who is qualified to testify as to the respondent's current and anticipated response to treatment, reasonable treatment alternatives less restrictive than institutional confinement, and family and community resources available to the person. The evaluator, or a qualified mental health professional who conducted the preadmission screening or who participated in the independent clinical evaluation, shall be present and may be called as a witness by the respondent, by the petitioner, or by the court. Notwithstanding the admissibility of any report prepared for the court, the respondent shall be given a fair opportunity to confront and cross-examine the persons who prepared any such reports or whose opinions are therein expressed.

E. Prescreening, diagnostic and other written reports relevant to these proceedings and prepared pursuant to or independently of this chapter shall be received in evidence when signed by the preparer. The independent clinical evaluator, a qualified mental health professional who participated in the evaluation, or any other expert witness may testify at the hearing as to the information upon which he has based his opinion, if the information is of a type ordinarily relied upon by mental health professionals in forming opinions about a person's mental or emotional condition. Any information obtained from or disclosed by the respondent in the course of the evaluation conducted pursuant to § 37.1-67.1:9 is admissible in any hearing provided by this chapter without regard to whether it would otherwise be privileged; however, no disclosure made by the person during the course of evaluation or treatment or in any proceeding conducted under this chapter, and no opinion testimony based on such disclosures, may be admitted against the person on the issue of guilt in a criminal proceeding unless he places his mental condition in issue in such proceeding, and the disclosure or opinion is relevant to such an issue raised by him.

The hearing shall be open to the public unless the respondent or his attorney requests that it be closed.

§ 37.1-67.3:1. Involuntary admission and treatment; commitment criteria.— In order for the respondent to be involuntarily committed for a period of hospitalization or to be subject to other court-ordered treatment, the court must find, based on clear and convincing evidence, that the respondent, as a result of mental illness, (i) presents an imminent danger to himself or others as evidenced by a recent overt act or threat; or (ii) is substantially unable to provide for himself, or secure from others, his minimum needs for food, clothing, shelter or physical safety. The court shall specify in its findings the behaviors or symptoms which provide the evidentiary basis for its determination.

§ 37.1-67.3:2. Involuntary admission and treatment; disposition following commitment hearing. —A. If the court finds that the respondent does not meet the criteria specified in § 37.1-67.3:1, the petition shall be dismissed and the respondent, if in custody, shall be released immediately, unless continued detention is otherwise authorized by law.

B. If the court finds, based on clear and convincing evidence, that the respondent meets the criteria specified in § 37.1-67.3:1, the court shall consider placement in less restrictive treatment environments than hospitalization. If the court determines, based on clear and

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Continued from page 34

convincing evidence, that no less restrictive treatment environment is appropriate and specifies the basis for this determination in its findings, the respondent may be ordered involuntarily admitted for a period of hospitalization and treatment, the maximum duration of such period to be determined by the court but not to exceed ninety days from the date of the court order.

C. If the court finds, based upon clear and convincing evidence, that the respondent meets the criteria specified in § 37.1-67.3:1, but also finds that hospitalization is unduly restrictive, the judge may order the respondent to accept outpatient treatment, day treatment in a hospital, night treatment in a hospital, treatment in a community mental health clinic, or such other treatment modalities as may be necessary to meet his needs and are located within a reasonable distance from the respondent's area of residence. The judge shall consult with the community services board to ascertain that such treatment is appropriate and available. In such cases, the proceedings shall be continued to a date set at the time of disposition, such continuance not to exceed ninety days, during which period the court may require the facility to report periodically concerning the respondent's progress and his compliance with the conditions of treatment. An order for treatment pursuant to this paragraph shall be transmitted to the treatment facility and the community services board for the locality in which treatment is ordered. Whenever the court is notified by the person responsible for the respondent's treatment or by the community services board that the respondent who is the subject of the order has not complied with the conditions specified in the order for treatment, the judge may summons the respondent to court and hold a commitment hearing pursuant to § 37.1-67.1:11. If the judge determines that there is probable cause to believe that immediate custody is necessary to prevent harm to the respondent or others or if the respondent fails to comply with the summons, the court may issue an order requiring the person to be taken into protective custody and brought before the court. If the respondent is in custody, the hearing shall occur within forty-eight hours of the time the respondent was taken into protective custody. If, after the hearing, the court finds, based upon clear and convincing evidence, that the person meets the criteria set out in § 37.1-67.3:1, and that the person has not complied with the conditions of treatment specified in the order, the court may infer that more restrictive conditions of treatment are required and shall enter an appropriate disposition authorized by this section.

§ 37.1-67.3:3. Release and recommitment.—A respondent committed pursuant to § 37.1-67.3:2 shall be released at the expiration of the period of commitment unless he is released sooner pursuant to §§ 37.1-84.2, 37.1-98 or 37.1-99, or if, during his commitment or at its expiration, he is accepted for admission on a voluntary basis as provided for in § 37.1-65, or he is involuntarily committed by further petition. The first recommitment shall be for a period of up to ninety days. Subsequent recommitment may be for a period of up to 180 days. Any recommitment shall be by the procedures set forth herein for commitment, except that if the respondent is in a facility at the time the petition for recommitment is filed, the evaluation and certification required by §§ 37.1-67.1:9 and 37.1-67.1:10 may be conducted by authorized members of the facility staff not directly responsible for the patient's treatment, and the preliminary conference required by § 37.1-67.1:7 shall not be required. However, the director of every facility shall ensure that every such patient shall be informed, orally and in writing, of the rights and procedures enumerated in paragraph C of § 37.1-67.7 at least forty-eight hours in advance of any recommitment hearing held pursuant to this section.

[§§ 37.1-67.4, 37.1-67.5, 37.1-67.6, and 37.1-70 omitted here]

§ 37.1-70.1. Immunity.—Notwithstanding any other provision of this chapter, the person performing the preadmission screenings, evaluations, or certification provided for in §§ 37.1-67.1:1 through 37.1-67.1:10 and § 37.1-70 shall be immune from civil liability for any act performed or omission in the course of his duties pursuant to those sections of this chapter, unless it is proven that such person acted with malicious intent, gross negligence or outside the scope of his employment.

[§ 37.1-71 omitted here]

§ 37.1-78.2. Use of physical restraints.—Any person transported or confined pursuant to the provisions of this article shall not be physically restrained unless necessary for the safety of the person or the transporting officer as determined by the transporting officer on the basis of the person's recent or current behavior.

§ 37.1-78.3. Transportation upon dismissal of petition or upon release pending commitment hearing.—Upon dismissal of a petition for involuntary commitment of a person who is held in protective custody or pursuant to an emergency placement order in a community other than his own or who is the subject of a hearing held in a community other than his own, the facility shall arrange to transport such person to his community of residence or to the locality in which the petition was initiated. If the person is unable to arrange for his own transportation, transportation shall be provided by the sheriff of the city or county in which he was held, by an attendant from the hospital in which he was held, or by some suitable person appointed by the director of such hospital for this purpose. The sheriff, hospital attendant or other person appointed for this purpose shall receive only his necessary expenses for conveying such person. Expenses authorized herein shall be paid by the Department.

[§§ 37.1-88 and 37.1-89 omitted here]

§ 37.1-89.1. Fees and expenses in involuntary commitment proceedings.—A. Special justices and substitute judges.— The fees and expenses of any special justice as defined in § 37.1-88 and of any district court substitute judge who presides over hearings pursuant to the provisions of §§ 37.1-67.1:1 through 37.1-67.3:3 shall be established by the Supreme Court of Virginia based on reasonable criteria. The Supreme Court, as it deems appropriate and notwithstanding the provisions of Chapter 4.1 of Title 16.1, may pay any such special justice or substitute judge an annual salary in an amount to be determined by the Supreme Court in lieu of fees and expenses.

B. Attorneys. — The fees and expenses of any attorney appointed to represent either the respondent or the petitioner shall be established by the Supreme Court of Virginia based on reasonable criteria but shall not be less than established by law for the defense of indigents charged with misdemeanors. The Supreme Court, in appropriate cases, may enter into agreements with local legal aid societies, law firms, or other legal organizations to provide attorneys for petitioners and respondents.

C. Interpreters. — The fees and expenses of any interpreters appointed to represent the respondent shall be established by the Supreme Court of Virginia based on reasonable criteria.

D. Cost of custody and emergency placement.—The costs of protective and temporary protective custody and emergency placement pursuant to §§ 37.1-67.1:4, 37.1-67.1:5, and 37.1-67.1:7 and of preadmission screening and the independent clinical evaluation shall be paid by the Department to the service provider upon authorization of the community services boards. Funds paid by the Department for these costs shall not be included in calculating local match pursuant to § 37.1-199. The community services board shall have the authority to designate willing facilities where respondents may be held in custody pursuant to a protective custody order or an emergency placement order. Such facilities may be those operated by the Department if located in or near the respondent's community or if the respondent's community is without appropriate facilities. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the Board based on reasonable criteria.

Where coverage by a third-party payor exists, the facility seeking reimbursement under this secton shall first seek reimbursement from the third-party payor. The Commonwealth shall reimburse the providers only for the balance of costs remaining after the allowances covered by the third-party payor have been received.

§ 37.1-89.2. Payment and recovery of fees and expenses.—Except as hereinafter provided, all expenses incurred, including the fees, attendance and mileage specified in this article, shall be paid by the Commonwealth. Any such fees, costs and expenses incurred in connection with an examination or hearing for an admission pursuant to § 37.1-65.1 or §§ 37.1-67.1:1 through 37.1-67.3:2 in carrying out the provisions of this chapter or in connection with a proceeding under § 37.1-134.2, when paid by the Commonwealth, shall be recoverable by the Commonwealth from the person who is the subject of the examination, hearing or proceeding, or from his estate. Such collection or recovery may be undertaken by the Department. All such fees, costs and expenses, if collected or recovered by the Department, shall be refunded to the Commonwealth. No such fees or costs shall be recovered, however, from the person who is the subject of the examination or his estate when no good cause for his admission exists or when the recovery would create an undue financial hardship. □

Continued from page 31

held or the respondent released. Continued detention during the period between the preliminary conference and the commitment hearing may be ordered by the court at the preliminary conference only if the respondent meets the emergency placement criteria, which are:

> *. . .probable cause to believe that the respondent meets the [general] commitment criteria. . .and probable cause to believe that custody of the respondent is necessary to prevent harm to the respondent or others pending the commitment hearing.*

H.B. 4 § 37.1-67.1:7G. This standard focuses judicial inquiry on the question of whether the respondent will do harm to himself or others in the brief period until the hearing. It is expected that sufficient clinical data will have been produced through the pre-admission screening procedure to allow a reasonably complete inquiry into this issue. Emergency placement should be ordered only when less intrusive methods of protecting personal safety are inadequate.

In contrast to the existing vague criteria of "mentally ill and in need of hospitalization," the bill's pre-hearing detention criteria require that the respondent be released unless affirmative evidence indicates that the person is likely to suffer or cause harm. This change shifts the presumption from one of continued detention if there is evidence the respondent is seriously ill, to one of termination of detention unless there is evidence of potential harm. This shift reduces inappropriate detentions while continuing to provide a focused basis for appropriate detentions.

Increased Responsibilities of the Community Services Boards

One of the major changes proposed by House Bill No. 4 is the central, enlarged role it establishes for the community services boards. Substantial obligations are placed on the boards to identify clinical resources and to assure the provision of clinical services within a limited time frame. However, corresponding authority to coordinate and control the commitment process is also provided to the boards so that they may meet their obligations without undue burden.

Pre-Admission Screening

One major responsibility of the boards is to ensure an early pre-admission screening in all cases. The screening is required to take place as early in the process as possible, is authorized to occur prior to the filing of a petition, and the results are expected to be available at the preliminary conference. In order to meet this responsibility, the boards are empowered to designate the persons qualified to conduct the screenings **(H.B. 4 § 37.1-63.1, 67.1:2),** to designate the willing facilities to which respondents are taken for detention and screening **(H.B. 4 § 37.1-67.1:6),** and to require that the screening be completed before a petition is accepted for filing by a judge or magistrate **(H.B. 4 § 37.1-67.1:3).** If the board chooses not to exercise this last power, a copy of the petition must be promptly provided to the board in any case in which a summons is issued. **H.B. 4 § 37.1-67.1:3.** Furthermore, the courts are required to cooperate with the boards in coordinating compliance with all requirements placed on the boards by the bill. **H.B. 4 § 37.1-67.1:1.**

Independent Clinical Evaluation

The other major board responsibility is to conduct, or arrange to have conducted, the independent clinical evaluation. The evaluator must be a licensed psychiatrist or, if one is not available, psychologist or physician with certain qualifications. However, in recognition of the lack of clinical resources in some areas of Virginia, the boards may designate other mental health professionals to assist in the evaluation. **H.B. 4 § 37.1-67.1:9B.**

As these two major responsibility areas indicate, the bill places the boards in an important position as a major link between community and hospital treatment in the commitment process. Their increased duties will obviously require additional funding. These costs will be paid by the Department of Mental Health and Mental Retardation to the service provider upon authorization of the appropriate board, and will not be included in calculating the board's local match for the purpose of making state grants for other local mental health services. **H.B. 4 § 37.1-89.1D.** □

Notes

1. The patron of this bill (House Bill No. 119) was Del. Warren Stambaugh, who also chaired the Joint Subcommittee on Mental Health and who is one of the patrons of House Bill No. 4.
2. There are a number of important changes effected by the bill which are not addressed herein. These include: a new definition for mental illness, **H.B. 4 § 37.1-1;** new definitions for least restrictive treatment environment, qualified psychologist, and qualified mental health professional, **H.B. 4 § 37.1-63.1;** a changed length of commitment, **H.B. 4 § 37.1-67.3:2B;** new provisions for enforcement of required non-hospital treatment, **H.B. 4 § 37.1-67.3:2C;** specific requirements for recommitment, **H.B. 4 § 37.1-67.3:3;** more specific appeal procedures, **H.B. 4 § 37.1-67.6;** a grant of limited immunity for clinical decision-makers, **H.B. 4 § 37.1-70.1;** limitations on the use of physical restraints, **H.B. 4 § 37.1-78.2;** transportation provisions for the respondent upon dismissal of the petitions or release pending hearing, **H.B. 4 § 37.1-78.3;** mandatory training for special justices, judges, and magistrates, **H.B. 4 § 37.1-88;** and new fee provisions for special justices and judges, attorneys, and interpreters, **H.B. 4 § 37.1-89.1A,B,C.**

   Also not addressed is the probable increased cost of the new commitment process. The staff of the House of Delegates Appropriations Committee in January 1983, prepared a preliminary fiscal impact statement on the bill (H.B. 119) **which was submitted to the 1983 session.** That statement projected an annual net incremental cost of approximately $4 to $6 million. Because the commitment and detention criteria in House Bill No. 4 are tighter than those in the earlier bill and because the maximum period of pre-hearing detention in the earlier bill was longer than that in House Bill No. 4, it would not be unreasonable to expect the additional costs of the new bill to be slightly less than those projected in the impact statement for the earlier bill.
3. If a summons is issued, the judge must also ascertain, if possible, whether the respondent is represented by an attorney and, if not, must appoint an attorney to represent the respondent at the preliminary conference. **H.B. 4 § 37.1-67.1:3.**
4. During all periods of pre-hearing detention, emergency treatment in conformance with the Human Rights Regulations promulgated by the State Mental Health and Mental Retardation Board may be provided to the respondent if the director or the director's designee determines such treatment is necessary to protect the health or safety of the respondent or others. This treatment may be administered without the informed consent of the respondent only if a psychiatrist, upon examination, has determined that the person is likely to cause or suffer serious harm to himself or others. **H.B. 4 § 37.1-67.1:6B,8B.**
5. Detention is not permitted for the purpose of obtaining screening of a respondent or of a person against whom the filing of a petition is being considered, but rather it is permitted only as authorized by the specific detention procedures identified in the bill. **H.B. 4 § 37.1-67.1:2.**
6. As noted in Secton D, **infra,** the community services boards are given the responsibility of ensuring that appropriate screening procedures are established.
7. The procedures for recommitment are very similar to those for the initial commitment hearing. The differences are: (1) if the respondent is in a facility at the time the recommitment petition is filed, the evaluator may be a member of the facility staff; (2) the preliminary conference is not required; (3) the explanation of rights pertaining to the commitment process must be ensured by the facility director, rather than the judge at the preliminary conference; and (4) after an initial maximum recommitment period of ninety days, subsequent recommitments may be for a maximum of one hundred eighty days. **H.B. 4 § 37.1-67.3:3.**
8. **Va. Code § 37.1-67.3 (Supp. 1982).**
9. **Id.**
10. Among these suggested was a criterion adopted by the American Psychiatric Association in its *Guidelines for the Civil Commitment of Adults.* That criterion allows commitment grounded upon likely substantial mental or emotional deterioration and was included in the bill considered by the 1983 General Assembly. The APA Guidelines also require a finding of incompetency as an incident to commitment. H.B. 4 contains neither the substantial deterioration standard nor a finding of incompetency. □

How It Might Work*

Monday, 10 A.M. Bill H., an outpatient at R. Mental Health Center, has not taken his medication for several weeks and has become assaultive toward a neighbor. The police and the crisis intervention center are called. Based upon Bill's behavior as observed by the police, he is detained by the police and taken to RMHC for emergency treatment and evaluation. No judicial order was necessary to place Bill in **temporary protective custody** at RMHC for 4 hours, because the police officer found that Bill presented **a demonstrable and immediate risk of inflicting serious harm on himself or others.**

Monday, 2 P.M. Bill's wife files a **petition** for Bill's commitment with a **magistrate.** After reviewing the **petition** and consulting with a **qualified mental health professional** (designated by RMHC), the **magistrate** first decides that there is **probable cause** to believe that Bill meets the **commitment criteria.** The **magistrate** issues a **summons** and a copy of the **petition,** notifying Bill that a **preliminary conference** will be held Tuesday at 10 A.M. The **magistrate** also notifies Bill that he has the right to an appointed defense counsel. Second, the **magistrate,** after consultation with the designated **qualified mental health professional** and Bill's wife and neighbor, decides that Bill should remain at RMHC in **protective custody** until the **preliminary conference** set for the next day, because of the **demonstrable and immediate risk of Bill's inflicting serious harm on himself and others.** RMHC is notified of the **petition** and begins to prepare a **preadmission screening report.**

Tuesday, 10 A.M. At the **preliminary conference** held before a **special justice** at RMHC's detention facility, RMHC submits its **preadmission screening report.** Bill is offered and refuses voluntary admission. The **special justice** decides that there is **probable cause** to believe that Bill meets the **commitment criteria** and appoints an attorney to represent Bill at the **commitment hearing.** The **special justice** schedules the **commitment hearing** 72 hours later, at 10 A.M. Friday. **The special justice** directs RMHC to conduct an **independent clinical evaluation** of Bill and to submit a report within 48 hours. RMHC selects a psychiatrist who is not involved in Bill's treatment to conduct the evaluation. The **special justice** exercises his discretion to appoint an attorney to represent the **petitioner,** Bill's wife, because in this case the interests of justice will be furthered. The **special justice** orders **emergency placement** for Bill pending the **commitment hearing** because there is **probable cause to believe that custody is necessary to prevent harm to the respondent or others pending the commitment hearing.**

Thursday, 10 A.M. A psychiatrist selected by RMHC submits a report of his **independent clinical evaluation** of Bill. The report finds that there is **substantial evidence** that Bill meets the **commitment criteria** and that he is unwilling or unable to consent to voluntary treatment. The report of the **independent clinical evaluation** also updates the **preadmission screening report.** Bill's attorney reviews both reports as they become available and continues to interview the witnesses to prepare for the **commitment hearing.**

Friday, 10 A.M. The **commitment hearing is conducted at the RMHC facility. The psychiatrist** who conducted **the independent clinical evaluation** does not attend, but the **qualified mental health professional** who prepared the **preadmission screening report** does attend and is cross-examined by Bill's attorney. Bill, Bill's wife, and a member of the RMHC staff, who has been treating Bill since Monday, attend the hearing, as they must, but are not called to testify, although they could have been. The **special justice** finds by **clear and convincing evidence** that Bill, as **a result of his mental illness, presents an imminent danger to himself or others as evidenced by a recent overt act or threat,** and the court specifies Bill's behavior and symptoms that led to that conclusion. The court then considers whether commitment to a hospital is the **least restrictive treatment environment** that is **appropriate.** On this question the court is not persuaded by **clear and convincing evidence** that outpatient treatment is inappropriate. So the court orders Bill to go to RMHC's outpatient clinic twice a week for the next 90 days to have medication administered and monitored. The court **continues the commitment hearing** for 90 days and directs RMHC to report to the court every 30 days on Bill's compliance with the order of outpatient treatment. Bill is then released.

Two weeks later. Bill has failed to go to the RMHC outpatient clinic and has begun to act in a threatening manner. A member of the RMHC staff responsible for Bill's treatment notifies the court. The court issues an order placing Bill in **protective custody** and appoints an attorney to defend Bill. Two days later the original **commitment hearing** is reconvened. The court now finds by **clear and convincing evidence** that Bill, **as a result of his mental illness, presents an imminent danger to himself or others as evidenced by a recent overt act or threat.** Because of Bill's failure to comply with the order of outpatient treatment, the court infers that a more restrictive setting is required for treatment and orders Bill **involuntarily admitted** to a state hospital for 90 days. □

**This hypothetical case is meant to be illustrative of some of the new features in the 1984 commitment proposal, but not necessarily representative of most of the cases to which the law would apply. In theory it would be the unusual case which justified confinement at all decision points in the process. In less serious cases the commitment proposal would encourage pre-hearing release and discourage the use of temporary protective custody, protective custody, and emergency placement.— Ed.*

Training Programs

The Institute of Law, Psychiatry and Public Policy continues to offer training programs designed for mental health professionals and other interested and qualified persons.

Training available through the Forensic Evaluation Training and Research Center focuses on acquainting mental health professionals with the Virginia criminal justic system and the types of evaluations requested by the criminal courts. The training consists of six days of instruction at the Institute in Charlottesville and one day of supervised evaluations at Central State Hospital in Petersburg. The training program director is Mr. W. Lawrence Fitch.

The Mental Disability Evaluation Training Project offers training for clinicians and advocates designed to ensure that comprehensive, accurate, and legally appropriate information is assembled for applications for Social Security benefits for mentally disabled persons. This training is aimed at creating disability evaluation teams in state and local facilities and consists of four days of instruction at the Institute. A series of one day training sessions for case managers; mental health, mental retardation, and substance abuse program administrators; and members of advocacy groups is also scheduled. Enrollment in both the four day and one day programs is limited. The director of the project is Mr. C. Cooper Geraty.

For further information on training programs sponsored by the Institute, contact:

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Rights for Adult Home Residents Proposed

In an effort to increase the protection of the rights of adult homes residents in Virginia, Delegate Mary Marshall is expected to introduce in the 1984 General Assembly a bill describing the "rights and responsibilities of residents of homes for adults." The text of an early draft of that bill is reproduced below.

The licensed "home for adults" in Virginia is a board and care residential facility for mentally or physically disabled adults who do not require nursing home care. With increasing frequency, it is utilized as a community placement, funded with the residents' Supplemental Security Income benefits, for persons who have been or are at risk of being placed in state mental health and mental retardation facilities.

Adult homes are currently subject to a formulation of residents' rights contained in the regulations of the state Department of Social Services, the agency responsible for licensing adult homes. The proposed legislation would reformulate these rights and express them as statutory provisions, rather than as regulations.

As noted elsewhere in this issue, the State Board of Mental Health and Mental Retardation is now considering extending to clients of community programs licensed or funded by DMHMR a level of protection of clients' rights comparable to that enjoyed by residents of state mental health and mental retardation facilities. If promulgated, however, these DMHMR community regulations will not serve former residents of DMHMR facilities who are placed in nursing homes (which are regulated by the Department of Health) or licensed adult homes (which are regulated by the Department of Social Services and are the subject of Delegate Marshall's bill).

Depending on how the community facility is characterized by state agencies, the rights of a recently discharged resident of a state facility might be governed by federal regulations, Department of Social Services regulations, Department of Health Regulations, or Department of Mental Health and Mental Retardation regulations. The rights of persons residing in these facilities vary significantly both in the descriptions of the substantive rights and the procedures established for enforcing those rights.

Some concern has been expressed that investment capital will favor facilities with the lowest level of rights protection and, consequently, that disabled persons, including former residents of state facilities, will tend to be placed in increasingly less protective settings.

The Proposed Legislation

A BILL to amend the Code of Virginia, by adding in Article 1 of Chapter 9 of Title 63.1 a section numbered 63.1-182.1, and to repeal § 63.1-173.1 of the Code of Virginia, relating to the rights and responsibilities of residents of homes for adults.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 9 of Title 63.1 a section numbered 63.1-182.1 as follows:

§63.1-182.1. Rights and responsibilities of residents of homes for adults; certification of licensure.—A. Any resident of a home for adults has the rights and responsibilities enumerated in this paragraph. The operator or administrator of a home for adults shall establish written policies and procedures to ensure that, at the

Continued on page 39

Clients' Rights in Community Programs Considered

by Gloria DeCuir*

In accordance with Title 37.1-84.1 of the Code of Virginia, the Virginia Department of Mental Health and Mental Retardation has proposed Rules and Regulations to Assure the Rights of Clients of Community Programs Licensed or Funded by the Department of Mental Health and Mental Retardation.

Earlier regulations adopted in compliance with Title 37.1-84.1 delineate rights of patients of psychiatric hospitals and other psychiatric facilities (1980), and residents of facilities operated by the Department of Mental Health and Mental Retardation (DMHMR) (1978 and 1983 revised). These earlier regulations do not apply to community programs.

A sixteen member task force, established by the DMHMR, has been working on the community rules and regulations for the past three years. The membership represents a wide variety of public and private professional and consumer interests in all three disability areas. The task force has focused its efforts on developing rules and regulations that would present the least burden on regulated programs while still ensuring the protection of client rights.

The proposed community rights regulations establish an administrative review process for review of allegations of rights violations. If the rules and regulations are not adopted, rights violations that could be handled quickly and fairly by means set forth in these rules and regulations might otherwise be handled by complicated, costly, and time consuming court procedures.

The proposed community regulations identify those fundamental rights which may not be restricted by the program. The regulations delineate other rights which may be limited for therapeutic reasons but subject those limitations to thorough review by the human rights system.

Following revision in response to December public hearings, the State Board for Mental Health and Mental Retardation will consider these regulations in February 1984. □

*Ms. DeCuir is the Coordinator of the Department of Mental Health and Mental Retardaton's Human Rights Program.

Continued from page 38

minimum, each person who becomes a resident of such home for adults:

1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgement of having been so informed, which shall be filed in his record;

2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the home and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;

3. Is free to manage his personal finances and funds regardless of source; is entitled at least monthly to personal account statements reflecting financial transactions made on his behalf by the home; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the home for any period of time in conformance with state law;

4. Is assured confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;

5. Is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;

6. Is, in the event a medical condition should arise while he is residing in the home, fully informed of his medical condition by a physician unless medically contraindicated, as documented by a physician in his medical record; is afforded the opportunity to participate in the planning of his program of care and medical treatment at the home;

7. Is not required to perform services for the home except as voluntarily contracted in the resident's agreement; any such agreement for services shall state the terms of consideration or remuneration and be documented in writing and retained in his record;

8. Is free to select health care services from reasonably available resources;

9. Is free to refuse to participate in human subject experimentation or to be party to research;

10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from any form of punishment, forced isolation, threats or other degrading or demeaning acts against him; and his needs are not neglected or ignored by personnel of the home;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

12. Is encouraged, and assisted with appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of restriction, interference, coercion, discrimination, threats or reprisal;

13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:

a. as necessary for the home to respond to unmanageable behavior in an emergency situation which threatens the immediate safety of the resident or others;

b. as medically necessary, as indicated by a physician, to provide physical support to a weakened resident;

16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician; to this end the owner or operator shall reasonably act as the resident's advocate in communicating with physicians about the needs of the resident;

17. Is accorded privacy in every aspect of daily living, including but not limited to the following:

a. in the care of his personal needs except as assistance may be needed;

b. in any medical examination or health related consultations the resident may have at the home;

c. in communications, in writing or by telephone;

d. during visitations with other persons;

e. in the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the State Board of Social Services;

f. in visits with his spouse; if both are residents of the home they are permitted but not required to share a room unless otherwise provided in the residents' agreements;

18. Is permitted to meet with and participate in activities of social, religious, and community groups at his discretion unless medically contraindicated as documented by his physician in his medical record.

B. If the resident is unable to fully understand and exercise the rights and responsibilities contained in this section, the home shall require that a responsible individual, of the resident's choice when possible, be made aware of each item in this section and the decisions which affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

C. The home shall post in a conspicuous place a copy of these rights and responsibilities and shall include in them the name and telephone number of the regional licensing supervisor of the Department of Social Services as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program.

D. The facility shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.

E. The provisions of this section shall not be construed to restrict or abridge any right which any resident has under law.

F. Each home shall provide appropriate staff training to implement each resident's rights included in subsections A through D hereof.

G. The State Board of Social Services shall adopt such regulations as necessary to carry out the full intent of this section.

H. It shall be the responsibility of the Commissioner of Social Services to ensure that the provisions of this section are observed and implemented by homes for adults as a condition to the issuance, renewal, or continuation of the license required by this article.

I. Nothing in this act shall be construed to prescribe, regulate or control the remedial care and treatment or nursing service provided to any resident in a home for adults conducted by and for those who rely on treatment in accordance with the tenents [sic] and practices of a recognized church or religious denomination.

2. That §63.1-173.1 of the Code of Virginia is repealed.

3. That this act shall become effective on January 1, 1985. □

Developments in Mental Health Law

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

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