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Ake v. Oklahoma: New Directions for Forensic Evaluation

by W. Lawrence Fitch*

In an opinion announced in February, the United States Supreme Court ruled that an indigent criminal defendant is entitled to "psychiatric assistance" at the government's expense in at least two situations: (1) where the defendant makes a preliminary showing that his or her "sanity" at the time of the offense is likely to be a significant factor at trial and (2) where the defendant's mental condition is relevant to sentencing in a capital case, at least where the government produces psychiatric evidence of the defendant's future dangerousness in support of the death penalty.[1] *Ake v. Oklahoma*, 53 U.S.L.W. 4179 (February 26, 1985).

The assistance the Court said the defendant is due in these cases includes not only the opportunity for a clinical examination but also help in evaluating, preparing, and presenting a defense. Although the Court's opinion provides that the defendant has no right to select a clinician of his or her "personal liking" or to receive funds to retain such a clinician, the tenor of the opinion is that the indigent defendant is entitled to the kind of expert assistance he or she might expect from a clinician who was privately retained: broad-based assistance within the context of the attorney-client relationship.

In support of the proposition that providing this kind of expert assistance would entail no great financial burden for the states (and implying, perhaps, that extending the right to such assistance would require little or no change in law or practice in the majority of states), the Court noted that more that forty states already guarantee the criminal defendant the right to expert assistance under certain circumstances. What the Court failed to recognize, however, is that this guarantee, where it appears, typically is stated in somewhat general terms as a feature of the defendant's broad statutory right to the assistance of counsel. In most states, procedures governing the provision of clinical assistance in cases in which the defendant's mental state is at issue are set forth in some detail in the law of criminal procedure, and these procedures often do not contemplate the kind of comprehensive, partisan assistance envisioned in *Ake*.

In many states, a defendant's request for clinical assistance on the sanity issue results in the appointment of a neutral expert to conduct an evaluation for the court. Copies of the evaluator's report are sent to the state's attorney, the defendant's attorney, and the court. While, of course, the defendant may call the evaluator as a witness at the trial, no right to consultation or other assistance is recognized. Whether such a procedure satisfies the requirements of *Ake* is highly doubtful.

Continued on page 2

Also in this issue...

*W. Lawrence Fitch is Director of the Forensic Evaluation Training and Research Center at the Institute of Law, Psychiatry and Public Policy.

Continued from page 1

Factual Context of the Court's Opinion

The defendant in this case, Glen Burton Ake, was charged in Oklahoma with two counts of capital murder and two counts of shooting with intent to kill. At his arraignment on these charges, Ake's behavior was "so bizarre" that the judge, on his own accord, ordered Ake evaluated by a psychiatrist. The psychiatrist who evaluated Ake diagnosed "probable paranoid schizophrenia" and recommended further evaluation to determine Ake's competency to stand trial.

The judge ordered a competency evaluation at Eastern State Hospital in Vinita, Olkahoma. After twenty-six days of evaluation and observation, the chief forensic psychiatrist at the hospital reported to the court that Ake was incompetent to stand trial. Following a hearing on the issue of Ake's competency, the court ordered Ake retained at the hospital for treatment. Six weeks later, Ake was found to have regained his competency and the criminal proceedings resumed.

At a pre-trial hearing, Ake's attorney notified the court of his intent to raise the defense of insanity at Ake's trial and requested that the court order an evaluation of Ake's mental state at the time of the offense. The court denied this request, and the case proceeded to trial without such an evaluation having been performed. Ake's sole defense at his trial was that he was legally insane at the time of the offense. Ake's attorney called as witnesses each of the clinicans who had examined him at Eastern State Hospital, but, because these clinicians had not evaluated the issue of Ake's mental state at the time of the offense, no clinical testimony on this issue was presented at Ake's trial. The clinicians, however, did testify that Ake was dangerous to society.

At the close of the trial, the judge instructed the jurors on the law of insanity in Oklahoma, advising them that unless they determined that Ake had presented evidence sufficient to raise a reasonable doubt about his sanity at the time of the offense they need not consider the sanity question in their deliberations. The jury found Ake guilty on all counts.

At the sentencing hearing, held before the same jury later the same day, the prosecutor asked for the death sentence, arguing that the clinical testimony presented at the trial established the likelihood of Ake's future dangerousness. Dangerousness is recognized by Oklahoma law as an "aggravating factor," which, if established, provides a basis for imposing the death penalty. The defense presented no evidence in rebuttal. The jury sentenced Ake to death on each of the two murder counts and to 500 years imprisonment on each count of shooting with intent to kill.

Ake appealed to the Oklahoma Court of Criminal Appeals, claiming that he had been denied access to psychiatric assistance in violation of the Fourteenth Amendment to the Constitution. The court rejected this claim and affirmed the convictions and sentences. Ake appealed this decision to the United States Supreme Court.

Constitutional Underpinnings of the Court's Decision

In his appeal to the Supreme Court, Ake again argued that the trial court's denial of his request for psychiatric assistance deprived him of his Fourteenth Amendment right to a fair trial. The Supreme Court agreed and, in an 8 to 1 decision, reversed and remanded the case for a new trial.

Writing for the majority, Justice Marshall observed that the Fourteenth Amendment's due process guarantee of fundamental fairness entitles indigent defendants to "an adequate opportunity to present their claim fairly within the adversary system." "We recognized long ago that mere access to the courthouse doors does not by itself assure proper functioning of the adversary process, and that a criminal trial is fundamentally unfair if the state proceeds against an indigent defendant without making certain that he has access to the raw materials integral to the building of an effective defense."

Whether "psychiatric assistance" is an essential "raw material" or "basic tool of an adequate defense," Marshall reasoned, depends on the relative weight of three factors: (1) the interests of the defendant that will be affected by the action of the state in providing or denying the assistance; (2) the governmental interest that will be affected if the assistance is provided; and (3) the probable value of the assistance and the risk of an erroneous deprivation of the affected interests if the assistance is not provided. Applying this standard to the issues in *Ake*, the Court concluded that: (1) the defendant's interest in the accuracy of a criminal proceeding

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Guest Contributors
Frank M. Feibelman
W. Lawrence Fitch
Paul A. Lombardo
Michael A. Solomon

Continued from page 2

in which his or her life or liberty is placed at risk is "almost uniquely compelling;" (2) the only legitimate governmental interest—paying for the assistance provided—"is not substantial, in light of the compelling interest of both the state and the individual in accurate disposition;" and (3) the kinds of questions the jury must resolve where the defendant's mental state is at issue "inevitably are complex and foreign," may be the subject of legitimate disagreement among psychiatrists, and, thus, can be accurately assessed by the jury only if both parties have the opportunity to develop and present pertinent psychiatric opinion testimony.[2]

The kinds of questions the jury must resolve- . . . can be accurately assessed by the jury only if both parties have the opportunity to develop and present pertinent psychiatric opinion testimony.

With regard to the defendant's right to expert assistance where the state produces clinical evidence of the defendant's future dangerousness in the capital sentencing context, Justice Marshall observed that such a right was implied by the Court's controversial decision two years ago in *Barefoot v. Estelle*, 463 U.S. 800 (1983). In *Barefoot*, the Court held that, despite its demonstrated unreliability, psychiatric testimony elicited by the prosecution on the issue of a defendant's future dangerousness was not constitutionally inadmissable in a capital sentencing proceeding because the defendant in such a proceeding would always have the opportunity to expose the shortcomings of such testimony through the rebuttal testimony of his or her own expert. If the defendant has no access to independent expertise, of course, the basis for the holding in *Barefoot* is absent. Accordingly, in order to justify admitting the testimony of a prosecution expert on the issue of the defendant's future dangerousness, the judge must grant the defendant access to independent expert assistance on this issue.

Whether the right to psychiatric assistance for capital sentencing purposes attaches where the dangerousness issue is not raised is unclear. Justice Marshall observed in Ake that the state has a "profound interest in assuring that its ultimate sanction [the death penalty] is not erroneously imposed" and that "monetary considerations should not be more persuasive in this context [capital sentencing] than at trial." Given these statements, together with the Court's demonstrated willingness to recognize mental disorder as potentially mitigating in the capital sentencing context[3], it is reasonable to infer that the Court would recognize a constitutional right to psychiatric assistance for capital sentencing purposes where there was reason to believe that the defendant's mental condition was relevant to sentencing, whether or not the defendant's future dangerousness had been raised as an issue. The facts of the *Ake* case did not present this question, however, and, thus, whether such a right exists remains unsettled.

Implications for Law and Practice

The *Ake* decision is likely to have a significant impact on the manner in which forensic services are provided. Exactly how current practices will change, however, is not yet clear, as the Court chose to leave questions of implementation to the states.

Questions raised, but left open, by the *Ake* decision include:

- whether clinicians other than psychiatrists may provide *Ake* assistance;
- whether public-sector clinicians may serve as *Ake* experts;
- what roles and functions the *Ake* expert should perform and what level of assistance the defendant is due;
- whether communications between the *Ake* expert and the defense are privileged; and
- how *Ake* assistance should be compensated.

Attorneys general and other public officials throughout the country report persistent pressure since the Court's opinion was announced to address these questions and develop policies for the provision of psychiatric assistance in accord with the opinion.

Less than three weeks after the *Ake* decision was announced, Donald C. J. Gehring, Deputy Attorney General for the Criminal Law Enforcment Division of the Office of the Attorney General in Virginia, issued an advisory opinion[4] for the benefit of prosecutors in the state in which he concluded that:

- Where a defendant makes a "threshold showing concerning his mental condition at the time of the offense...he should be evaluated by a psychiatrist appointed by the court."
- The psychiatrist appointed to evaluate the defendant "should be one who would have no ethical problem or conflict of interest in assisting in the defense in accordance with *Ake*."
- "[T]he defendant should not be sent to Central State Hospital [the facility in which Virginia's maximum security forensic unit is located] for an evaluation by a state psychiatrist unless the evaluation by the appointed psychiatrist [raises the insanity issue]."
- "In all capital cases [the prosecutor should] recommend to defense counsel that a psychiatric evaluation be requested to assist the defendant with presenting evidence in mitigation."
- Where defense counsel requests an evaluation for capital sentencing purposes, "the trial court should appoint a psychiatrist to evaluate the defendant for aggravating and mitigating circumstances, and the court should require the doctor to report the results of

Continued on page 4

Continued from page 3

the evaluation in the manner prescribed by Section 19.2-169.5 D and E [provisions relating to the reporting of conclusions concerning a defendant's mental state at the time of the offense]. If the appointed psychiatrist's evaluation discloses either the presence of mitigating circumstances or the affirmative absence of aggravating circumstances, the defendant should be sent to Central State for an evaluation by a state psychiatrist on these issues."

- "Funds for the employment of psychiatrists are authorized by current statutes. See Sections 19.2-163 and 19.2-332, Code of Virginia."

Qualifications of the Expert

Although Mr. Gehring's conclusions for the most part comport with both the letter and the spirit of the *Ake* decision, whether the procedures he recommends are entirely necessary or feasible is open to question. To begin with, while the *Ake* opinion makes consistent reference to the defendant's right to "psychiatric assistance," it is not clear that the Court intended to limit the pool of potential *Ake* experts to clinicians trained in psychiatry. Rather, it is likely that the Court used the term "psychiatrist" to refer generically to the kinds of mental health professionals otherwise qualified under the law to provide forensic evaluation services. Indeed, one of the clinicians who testified at Ake's trial, whom Justice Marshall referred to in the opinion as a psychiatrist, was a physician without psychiatric training.

In recent years, a number of states have recognized psychologists as qualified to provide opinion testimony on the issue of a defendant's mental state at the time of the offense. Many states allow such testimony by non-psychiatrist physicians as well. The American Bar Association, in its recently promulgated Mental Health/Criminal Justice Standards, recognizes several classes of mental health professionals as potentially qualified to address this issue.[5]

To summarily exclude all non-psychiatrist clinicians from consideration as *Ake* experts—as some prosecutors in Virginia reportedly have read Mr. Gehring's opinion to require—seems unnecessary and unwise. Such an exclusion also would be difficult to implement in practice, given the scarcity of psychiatrists in some communities and the reluctance of many psychiatrists to participate in forensic work. Accordingly, a more reasonable interpretation of the *Ake* opinion is that it guarantees the defendant access to the assistance of a clinician otherwise qualified by law to evaluate and present opinion testimony on the relevant issues.[6]

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Use of Public-Sector Clinicians

Given the Court's concern that the defendant have access to independent expert assistance in cases where the prosecution relies on a "state psychiatrist," it is understandable that *Ake* will be read by some to bar the use of state-employed clinicians as defense experts. Such a reading seems unduly rigid, however. While it is clear that the expert assigned to assist the defense must be independent of the prosecution, nothing in the opinion suggests that clinicians employed by the state are, per se, beholden to the prosecution and, therefore, ineligible to serve the defense.

It is possible, of course, that a particular group of clinicians with a long history of serving the prosecution would be so clearly identified with the prosecution that it would, at least, appear unfair to assign them to serve the defense. And it is possible that this accounts for Virginia Deputy Attorney General Gehring's recommendation that clinicians from Virginia's maximum security forensic unit not be employed to provide *Ake* assistance. More likely, however, Mr. Gehring's concern is more a practical one: if clinicians from this unit are assigned to assist the defense, who will be available to assist the prosecution? Prosecutors in Virginia traditionally have looked to the Forensic Unit at Central State Hospital for assistance when forensic issues arise; if Central State is unavailable because its clinicians have been assigned to assist the defense, the prosecution may feel vulnerable.

Of course, it might be argued that, assuming their objectivity, state forensic unit clinicians would be no more helpful to the defense as *Ake* experts than as experts for the prosecution, and, therefore, it should not matter which side they are assigned to serve. However, to the extent that these clinicians are more experienced in forensic matters than their colleagues in the community — and, consequently, are capable of providing more effective assistance in these cases — the defense may be at a distinct advantage in a contested case having clinicians from the state's forensic unit on its side. On the other hand, if it is true—as is often alleged—that state hospital forensic unit clinicians have a "prosecution bias," the defense may prefer its experts assigned from another pool.

In any event, it may not be feasible from a practical standpoint to exclude state hospital clinicians from the class of experts available to provide *Ake* assistance. Even in states like Virginia, where the majority of forensic evaluations are conducted on an outpatient basis in the community[7], many evaluations continue to be conducted in state hospitals, either because the defendant must be hospitalized for treatment pending trial or because special evaluation procedures are necessary that require that the defendant be hospitalized. Given the reluctance of many private hospitals to admit persons under criminal charge (particularly persons charged with violent offenses), the state

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Continued from page 4

hospital may be the only location in which some defendants may be evaluated.

With regard to the use of other public-sector mental health professionals as *Ake* experts (e.g., staff of locally operated community mental health centers), the issues are little different. Barring actual or perceived alignment with the prosecution, nothing in the *Ake* opinion would require the disqualification of any otherwise qualified public-sector mental health professional from serving as an *Ake* expert. The only imaginable circumstance under which such a professional might be ineligible for a defense assignment would be where a selected group of clinicians were designated to provide assistance for the prosecution and a different group were designated to provide assistance for the the defense. Presumably, under such a model, clinicians from one group would be ineligible for assignment to serve the other's constituency. But nothing in the *Ake* opinion would suggest that such a model is either required or in any way desirable.

The Expert's Role

The roles and functions of the expert assigned to assist the defense are not clearly defined in Justice Marshall's opinion. The opinion does provide that the expert should be available to examine the defendant and assist in evaluating, preparing, and presenting the defense. Somewhat more specifically, Justice Marshall indicated that the expert's consultative role should include advising the defense on the viability of the insanity defense and preparing the cross-examination of expert witnesses produced by the state.

Acknowledging both the "widespread reliance on psychiatrists" in criminal cases and the "inexact[ness]" of psychiatry as a science, Justice Marshall reasoned that, in cases where the defendant's mental state is at issue, "the jury [will] make its most accurate determination of the truth on the issue before them" only if both the prosecution and the defense have the opportunity to develop and present their views of the clinical evidence. Accordingly, the expert assigned to assist the defense should not view himself or herself as a neutral examiner designated to advise the court—the role traditionally assumed by the court-appointed expert. Rather, the expert should serve as though he or she were employed to assist the defense in presenting its case in the best possible light.

The expert's opinion, of course, should not be affected by this change of role, but the manner in which the expert works with the defense attorney to present his or her opinion is likely to be affected. For example, the expert should be prepared to discuss with the defense attorney the strengths and weaknesses of his or her opinion as well as that of any expert to be produced by the prosecution. Moreover, the expert should advise the attorney how to elicit testimony of all the experts in such a manner as to provide the maximum advantage for the defense—all within ethical bounds, of course.[8]

In non-capital cases in which the expert, after evaluating the defendant, reaches the opinion that the defendant was sane at the time of the offense, further consultation with the defense attorney ordinarily will not be necessary. There may be cases, however, in which the defense will wish to pursue an insanity defense despite the negative opinion of the expert. In such a case, the consultative role of the expert is unclear: should the expert advise the attorney how the attorney might most effectively make a case for insanity, or should the expert restrict his or her assistance to issues other than insanity (e.g., mens rea or sentencing issues)? Nothing in Justice Marshall's opinion directly addresses this question.

Applicability of the Attorney-Client Privilege

While Justice Marshall seems clearly to envision the expert serving at the behest and for the benefit of the defense, nowhere does he discuss whether the prosecution may have access to the expert's findings. It is universally accepted that communications between an attorney and his or her client made in the course of the attorney-client relationship and in professional confidence are privileged and may not be disclosed without the client's consent. Many courts have held that, where a forensic examination is initiated by the defense, the examiner is to be seen as an agent of the defense, serving within the context of the attorney-client relationship; thus, communications between the examiner and the defendant are protected by the attorney-client privilege and may not be disclosed without the defendant's consent unless the defendant places his or her mental state at issue in the case and gives notice of an intent to present expert testimony at the trial.[9] Accordingly, to the extent that the *Ake* expert is viewed as an agent of the defense, serving within the context of the attorney-client relationship—the role Justice Marshall appears to prescribe—communications between the expert and the defendant would be protected by the attorney-client privilege, and copies of evaluation reports prepared by the expert would not be automatically accessible to the prosecution or the court. Given that the procedure in most states is for reports resulting from court-ordered evaluations to be shared at least in part with all of the parties, significant changes in law and practice should be expected throughout the country.

"Psychiatric Assistance" at Sentencing in Capital Cases

With regard to the defendant's right to expert assistance in the context of capital sentencing, the Court held that access to such assistance must be provided in cases where the state produces testimony of a mental health expert concerning the defendant's future dangerousness. Virginia Deputy Attorney General Gehring's recommendation that access to such assistance be

Continued on page 6

Continued from page 5

provided in every capital case—whether the issue of dangerousness is raised or not—is a sound one, nonetheless. Indeed, applying the analysis Justice Marshall used to determine whether such assistance is required in insanity cases and in cases where the defendant's dangerousness is raised in the capital context (i.e., whether the risk of error in the proceeding is enhanced if such assistance is not provided, etc.), it would seem that clinical assistance would be necessary whenever the defendant's mental condition is relevant to whether he or she should be sentenced to death. Given the law's clear recognition of mental or emotional disturbance as potentially mitigating at capital sentencing, clinical opinion on these issues always would be relevant, and, therefore, it seems, expert assistance always should be available.

Mr. Gerhing's recommendation that procedures be established for conducting evaluations in capital cases which simply track existing procedures for the provision of pretrial evaluation services raises problems, however. Indeed, if the assistance provided by the *Ake* expert is to be accorded a privileged status, any requirement that the expert's findings be disclosed automatically to the prosecutor or the court—a requirement featured in most states' insanity evaluation procedures—would be inappropriate, whether the issue were future dangerousness or mental state at the time of the offense.

The issue of disclosure is particularly significant with respect to the expert's assessment of dangerousness, as few states impose any restriction on the use of the expert's findings at the capital sentencing hearing once these findings are disclosed. The courts consistently have held that the Fifth Amendment protects against the prosecution using statements the defendant makes during a pre-trial, "insanity" evaluation to establish whether, in fact, the defendant committed the offense with which he is charged[10]. By analogy, it would seem that statements the defendant makes during an evaluation to assess mitigating mental abnormality for capital sentencing purposes would be protected from use by the prosecution to establish the defendant's future dangerousness, where such a factor may provide the basis for imposing the death penalty. Without such protection, the defendant would be placed in the untenable position of having to waive his or her right not to testify against himself or herself (on the issue of dangerousness) in order to exercise his or her right to a meaningful evaluation on the issue of mitigating mental abnormality. This issue, however, has not yet been resolved by the courts. Accordingly, so long as the prosecution has access to the findings of the *Ake* expert, there is little to prevent the prosecution from using these findings to form the basis for its case in chief at the capital sentencing hearing.

Compensation of the Expert

Finally, the question arises how the *Ake* expert will be compensated for the service he or she provides. Depending on the level of assistance the courts decide the defendant is due and whether non-psychiatrist clinicians will be permitted to provide this assistance, the cost of providing forensic services may rise considerably over current levels. Whether the courts will be willing to ignore current fee schedules for the compensation of court-appointed evaluators and invoke less restrictive provisions in the law relating to the reimbursement of general defense expenses remains to be seen.

Continued on page 21

Federal Insanity Law Revised

In October 1984, President Reagan signed into law the Comprehensive Crime Control Act of 1984. Included in the Act is a chapter entitled "Offenders With Mental Disease or Defect." This chapter, also known as the Insanity Defense Reform Act of 1984, sets forth the standards and procedures that apply where a defendant charged in federal court with a violation of the federal criminal law raises the issue of his or her competency to stand trial or mental state at the time of the offense. In addition, the chapter prescribes procedures for the hospitalization of insanity acquittees and other criminal defendants and offenders suffering from a mental disease or defect.

With the regard to the defense of insanity, the new law provides (in 19 U.S.C. § 20)

> it is an affirmative defense to a prosecution under any federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his act. Mental disease or defect does not otherwise constitute a defense.... The defendant has the burden of proving the defense of insanity by clear and convincing evidence.

The law further provides that "[n]o expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto. Such ultimate issues are matters for the trier of fact alone." This new law is contained in Federal Rules of Evidence, Rule 704 (b).

With regard to the commitment and release of insanity acquittees, the law provides in 18 U.S.C. § 4243 (d) that,

> a person found not guilty by reason of insanity of an offense involving bodily injury to, or serious damage to the property of, another person, or involving a substantial risk of such injury or damage, has the burden of proving by clear and convincing evidence that his release would not create a substantial risk of bodily injury to another person or serious damage of property of another due to a present mental disease or defect. With respect to any other offense, the person has the burden of such proof by a perponderance of the evidence." U.S. Code, Title 18, chapter 313, section 4243 (d).

— W. Lawrence Fitch

In the Virginia General Assembly — 1985

The Virginians with Disabilities Act

First introduced in the 1984 General Assembly, H.B. 817, "The Virginians with Disabilities Act," was this year enacted in drastically amended form. The Act, which in its original draft is described in *4 Developments in Mental Health Law 19* (July-December 1984), barely passed the state Senate after opposition to it was mounted by business lobbyists.

The opposition focused on the proposal to extend employment rights to persons with mental disabilities, and succeeded in imposing several restrictions on these and other rights in the Act in the version finally signed into law.

- To meet the definition of a "person with a disability" (and therefore to be protected by the law) a person with a mental disorder first must either be mentally retarded or suffering from a mental illness severe enough to have substantial adverse effects on an individual's cognitive or volitional functions." But such an individual's mental disorder must also be so mild as to be "unrelated" in any way to employment to be covered by the employment rights section of the Act, "unrelated" to education to be covered by the post-secondary education rights section of the Act, etc.
- Active substance abusers are excluded by definition from the "persons with disabilities" covered by chapter 9 of the Act.
- Persons who have successfully asserted mental disability as a defense to a crime are also excluded by definition from the coverage of chapter 9.
- Only "otherwise qualified" persons with disabilities are covered by key sections of chapter 9. An "otherwise qualified" is defined to mean that the person with a disability can be qualified without any accommodation whatsoever.
- A surfeit of defenses to claims of employment discrimination by persons who manage to meet the definition of "otherwise qualified person with a disability" is offered by § 51.01-41. Assuming that any obligation at all is imposed to make accommodations, the employer is exempted from making accommodations which amount to an "undue burden" on the employer. Accommodations costing over $500 are presumed under the Act to create an "undue burden" on employers with fewer than fifty employees. Employers can also successfully defend discrimination against "otherwise qualified persons with disabilities" who are "unable to adequately perform his duties, or cannot perform his duties in a manner which would not endanger his health or safety or the health or safety of others," although by definition such employees would neither be "otherwise qualified" or, for that matter, a "person with a disability."
- Handicapped persons (whether or not they meet the narrow definition of "otherwise qualified person with a disability") continue to be exempted from the protection of the state Minimum Wage Act, § 40.1-28.9 of the Code of Virginia.
- The Act does not apply if the employer is covered by either § 503 or § 504 of the federal Rehabilitation Act. A private right of action is currently unavailable in Virginia for violations of § 503 by federal contractors.
- Employers who hire a person because of the requirements of the Act are given immunity from tort action based on negligent employment.
- Private actions for violations of the Act cannot recover compensatory damages for pain and suffering or punitive damages. The plaintiff has a duty to mitigate damages.
- While successful private plaintiffs can recover attorney fees, defendants can also recover attorney fees in some unsuccessful claims.
- The statute of limitations for claims under the Act is one year with the additional requirement that a written notice of the claim must be mailed to the defendant within 180 days of the alleged violation of the Act.
- The Office for the Rights of the Disabled is barred from recovering attorney fees, filing class actions, or, without specific gubernatorial approval, bringing individual actions under the Act.

In light of provisions such as these, which nearly negate the practical significance of chapter 9 of the Act, the continued opposition of some legislators to the Act and the fanfare which accompanied its passage are testaments to the symbolic value of extending state statutory protection to the rights of persons with mental disabilities. Prior Virginia law provided comparable protection, but only to persons with physical disabilities.

The Virginians with Disabilities Act, which forms a new title, 51.01, of the Virginia Code, resulted in several other changes in state law, more substantive, if less controversial, than those in chapter 9:

- All state agencies serving persons with disabilities are required by chapter 1 to formulate and annually update a plan of cooperation to eliminate gaps and duplications of services.
- A thirty-eight member Board for the Rights of the Disabled is created by chapter 7. This Board monitors the interagency plan of cooperation, conducts needs assessments, and makes budgetary recommendations for the Governor. The Board also has the authority to promulgate regulations to "implement" the rights provisions of chapter 9, although most of the pro-

Continued on page 8

Continued from page 7

visions are self-implementing, and require legislative revisions more than administrative regulations. The Board also assumes the functions of the former State Developmental Disabilities Planning Council.

- A new Department for the Rights of the Disabled is created by chapter 8. The Department assumes the functions of the former State Developmental Disabilities Protection and Advocacy Agency and the Client Assistance Program of the Department of Rehabilitative Services. The Department is charged additionally with enforcing the rights provisions, although its authority in this area is somewhat limited. The Department cannot hire counsel without the express approval of the Attorney General. The Department cannot file an action in court without the express, personal approval of the Governor, who may designate the Attorney General to handle the case (and under other statutes the Attorney General may assign the matter to a private attorney). State agencies, such as the Department of Mental Health and Mental Retardation with established internal advocacy programs, may continue to operate those programs. In addition to these advocacy functions, the Department provides some staffing assistance to the Board for the Rights of the Disabled. The Board monitors the Department as it would any other agency which serves persons with disabilities. The Board is not charged directly with making policy for the Department for the Rights of the Disabled, although the Board's power to make regulations relative to chapter 9, in effect gives it considerable authority over the Department.
- The remainder of the Act concerns the Department of Rehabilitative Services and the Board of Rehabilitative Services. The Act restores to the Board its authority to promulgate regulations. In recent years the role of the the Board had been diminished to that of a mere advisory board. The duties of the Department of Rehabilitative Services are set forth comprehensively in the Act. The nature of several federally funded services of the Department, such as vocational rehabilitation, independent living services, and projects with employers are set forth in the Act in language which basically tracks applicable federal law.
- H.B. 817 also repealed §§ 20-46 and 20-47 which had prohibited marriages of persons declared incompetent, where the woman was under the age of forty-five years. These Code provisions were vestiges of eugenics legislation. Marriages of parties who lack capacity to consent to marriage continue to be voidable from the time they are so declared by a court.

H.B. 817; 1985 Va. Acts. ch. 421; enacting title 51.01; repealing §§ 20-46 and 20-47.

Handicapped Voters

Provisions for selection of vote registration sites and polling places were amended slightly this year. The new provisions mandate that "consideration" be given to facilities accessible to the handicapped and the elderly, for registration sites, and that after January 1, 1986, all polling places must be accessible to those groups except where the State Board of Elections determines that an "emergency" exists, or that no accessible polling place is available.

H.B. 1242; 1985 Va. Acts ch. 197; amending §§ 24.1-43, 24.1-97 and 24.1-129.

Supervision of Education and Curriculum Guidelines for State Facilities

House Bill 1351 authorized the Department of Education to develop curriculum guidelines for education programs serving school age residents of state mental health and mental retardation facilities. The guidelines are to be designed with the particular academic, physical and affective educational needs of various age ranges of facility residents in mind, are to be reviewed and approved by the Board of Education prior to implementation. Supervision of educational programs conducted in state facilities, including setting of standards and regulations, is the responsibility of the Board of Education. Though the Department of Mental Health and Mental Retardation holds ultimate responsibility for programs offered in its facilities, House Bill 1334 further clarified the scope of "supervision" to be exercised by the Board of Education over these programs. According to new § 22.1-214.2, "supervision" includes "constant direct contact" between the Department of Mental Health and Mental Retardation and the Board, "consistent oversight" by the Board; guidelines for performance evaluation of educational staff, and technical assistance from the Board.

H.B. 1351; 1985 Va. Acts ch. 350; amending § 22.1-7, 22.1-214 and 37.1-10 and adding § 22.1-214.2 and 37.1-10.01.

Special Education For Residents of State Mental Health and Mental Retardation Facilities

State law was amended to require local school divisions to provide special education to eligible handicapped children of school age who reside in state mental health and mental retardation facilities, foster-care homes, or group homes located with the school division.

The Board of Education is charged with adopting regulations which define which school age residents of state mental health or mental retardation facilities are eligible for placement in public school. The Department of Mental Health and Mental Retardation is assigned responsibility for the cost of education, even if the resident attends public school.

S.B. 650; 1985 Va. Acts ch. 158; amending §§ 22.1-215 and 37.1-42.1.

State Plan for Medical Assistance (Medicaid Eligibility)

House Bill 387 amended the provisions of Virginia Law that require a state

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Continued from page 8

plan for medical assistance to be prepared for submission to the Secretary of Health and Human Services as a precondition to receipt of federal funds under Title XIX of the Social Security Act (Medicaid). The payment of medical assistance for minors up to the age of twenty-one who have been placed in foster homes or private institutions by nonprofit private agencies licensed a child-placing agencies by the Department of Social Services was mandated in the amendment. House Bill 426 amended the Code further requiring the disregard of irrevocable trusts (not to exceed $1500 in value), as an asset to be considered when determining eligibility for Medicaid.

H.B. 426; 1985 Va. Acts ch. 535; amending § 32.1-325.

Personal Damage Claims of Disabled Plaintiffs

Circuit courts now have the authority to approve "structured settlements" of lawsuits brought on behalf of minors and mentally disabled adults. These settlements involve one or more payments to be made in the future. To be approved, the payments must either be secured by a bond or made by an approved insurance company. Where the annual payments are $4000 or less, they may be paid into the court while the plaintiff is under a disability. Larger payments must be paid to a guardian.

H.B. 1259; 1985 Va. Acts ch. 499; amending § 8.01-424.

Parental Admission to Child Care Facilities

Custodial parents or guardians are now specifically authorized to visit their children in "child-care centers, homes or facilities" regardless of whether such institutions are licensed by the state. This new part of the Virginia Code was offered as a response to the national awareness of potential child abuse in any care centers.

H.B. 1694; 1985 Va. Acts ch. 251; adding § 63.1-210.1.

Civil Commitment Appeals

Civil commitment hearings in Virginia are held in courts not of record before General District Court Judges, Juvenile and Domestic Relations District Court Judges, or Special Justices. Special Justices are attorneys appointed by the senior Circuit Court Judge to serve only in commitments and a few related matters. Like most proceedings in Virginia initiated at this level, civil commitment can be appealed de novo to the court of record, the Circuit Court. Unlike other District Court proceedings, civil commitments engendered confusion over the issues to be tried on appeal to the Circuit Court.

While it was clear that the opinion of the original court which entered the commitment order was not entitled to any weight on appeal, and that a full trial was required at the Circuit Court on appeal, practices differed throughout the state as to the relevant time period when the defendant's mental state was assessed against the standards of commitability. Some defendants on appeal have reportedly been committed by the Circuit Court, not because they met the standards for commitment at the time of the Circuit Court hearing, but because the evidence adduced by the Circuit Court established that they met the standards for several weeks earlier at the initial commitment hearing.

The confusion was exacerbated by delays in hearing commitment appeals before the Circuit Court of sufficient length to permit remission of whatever mental disorder the defendant might have had when initially detained.

And while the defendant was routinely represented by court-appointed counsel in the Circuit Court, often before a jury, the petitioner was not.

Other problems with appeals included selection of venue. Appeals are permitted to be heard in a Circuit Court serving either the jurisdiction in which the defendant was committed or the jurisdiction in which he is hospitalized. And in some state hospitals where on appeal the Circuit Court ordered commitment the hospital would calculate the 180 day limit on the term of commitment from the date of the Circuit Court order, rather than the initial commitment.

In response to these problems with commitment appeals, the 1985 legislature made the following changes to § 37.1-67.6:

- The Circuit Court order of commitment must be based on a finding that the defendant meets the commitment criteria at the time of the Circuit Court hearing.
- The Circuit Court order "continues" the commitment. This implies that the time limit on commitment is measured from the time of the initial commitment, not the Circuit Court order "continuing" that commitment.
- The defendant may choose venue, but the court has the authority to transfer the court to the other venue, if it finds it to be "more convenient."
- The local prosecutor is required to "defend" the initial order of commitment.
- The process for scheduling the Circuit Court hearing is accelerated.
- The defendant is exempted from posting an appeal bond or paying a writ tax in pursuing his appeal in the Circuit Court.

This amendment, effective July 1, 1985, leave intact provisions which require the court to appoint counsel for any defendant who is not represented, limit counsel's fee to $75.00, and in effect prohibit petitioners from appealing to the Circuit Court the District Court's refusal to commit.

The appeals provisions apply as well to certifications of eligibility for admission to state mental retardation facilities.

H.B. 1393; 1985 Va. Acts ch. 106; amending § 37.1-67.6.

Court-Appointed Experts in Commitments

The basic statute governing civil commitment in Virginia, § 37.1-67.3, has been amended to encourage the appointment of licensed clinical psychologist in these hearings.

Continued on page 10

Continued from page 9

Immediately prior to the 1982 amendments to the state commitment law, the court was directed to appoint a physician skilled in the diagnosis of mental illness. This physician, for a fee of $25.00 was required to certify that he had "personally examined the individual and has probable cause to believe that he is or is not mentally ill, that such person does or does not present an imminent danger to himself or others, and requires or does not require involuntary hospitalization."

In 1982 the General Assembly responded to conflicting demands that community mental health programs be given a statutory role in commitment, and that private psychiatrists be permitted to pursue commitment of their patients without interference by the community mental health professionals. The 1982 amendments directed the court to appoint a psychiatrist to make the necessary certification. If a psychiatrist was not available, the court was given the choice of appointing either a qualified physician or clinical psychologist.

Under the 1982 amendment the court was required to obtain from the community services board providing mental health services to defendant's area of residence a pre-admission screening report. This report was not required, however, where the defendant had been "examined" by a psychiatrist (e.g., pursuant to a court-appointed examination or prior treatment).

The 1985 amendment gives licensed clinical psychologists parity with psychiatrists in commitment proceedings. The court has the alternative of appointing either a psychiatrist or a clinical psychologist, and if neither is available a physician skilled in the diagnosis of mental illness.

And now the court need not obtain a pre-admission screening report where the defendant has been examined by a psychiatrist, or by a clinical psychologist prior to the hearing. The practical significance of this provision is slight since it is the policy of the state hospitals and many local courts to require pre-admission screening reports in all cases prior to the commitment hearing. These reports are intended to provide a better survey of available community alternatives to hospitalization than the certification by the court-appointed expert.

Clinical psychologists in Virginia have doctorates; they are licensed by the state Board of Medicine.

H.B. 1418; 1985 Va. Acts ch. 261; amending § 37.1-67.3.

Predischarge Planning

An amendment enacted this year to § 37.1-98 and the enactment of a new § 37.1-98.2 will improve the quality of predischarge planning in the state hospital's with little or no reduction of patient privacy. The new law will permit the state mental health and mental retardation facilities to involve local community mental health clinics in preparation of the predischarge plan, even where the patient or the patient's guardian has refused to authorize disclosure of information to the community mental health clinics. Community mental health clinics and other local public mental health, mental retardation and substance abuse facilities are operated in Virginia by forty regional "community services boards" or CSB's.

For many years the state hospitals and training centers have notified localities of patient discharges, contingent on the consent to disclosure of that information by the patient, or, if the patient lacked the capacity to consent, his guardian. In 1980 the General Assembly attempted to integrate state and local mental health services by mandating joint efforts at predischarge planning. But the state legislature refused to permit this joint planning in the absence of the consent of the patient or the patient's guardian. It was argued then that, if consent were sought, it would be obtained in most cases. The few refusals would reflect legitimate concerns about stigma on the part of patients returning to small communities.

Consent to joint predischarge planning has proved to be more difficult to obtain, however. Many patients have been considered incapable of consenting to disclosure of information to CSB's because of facility determinations that they were incapable of consenting to medication. For many patients there has been noone available to serve as guardian for the purpose of consenting to predischarge planning. Some patients have had guardians opposed to discharge who have impeded discharge by declining to consent to predischarge planning.

State and local mental health and mental retardation professionals intent on joint predischarge planning have resorted to a number of circumventions of the law, varying in degrees of ingenuity and effectiveness. In some areas CSB employees have become nominal employees of the state hospital to permit regular state hospital employees to share patient information with them. State policy in recent years has encouraged CSB's to obtain patient consent to predischarge planning at the earliest stages of preadmission screening.

The 1985 amendment accomplishes five major changes:

- Disclosure of state hospital information occurs at two tiers. At the first tier an exchange between the state hospital and the CSB is permitted for predischarge planning. Consent must be sought from the patient, but if he refuses, the exchange may nonetheless go forward. All discharges from state facilities are conditional on the development of a predischarge plan by the state facility and the CSB responsible for the area from which the patient comes or to which he wishes to be discharged.
- At the second tier, the CSB may disclose information to other local agencies or providers identified in the plan. This disclosure may occur notwithstanding the refusal of the patient or his guardian to authorize disclosure, but consent from the patient or his guardian must first be sought by the CSB.
- While § 37.1-98.2 is chiefly concerned with discharges from state facilities, the new amendment is worded broadly enough to authorize noncon-

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Continued from page 10

sensual exchanges of patient information between the CSB and the state hosptial at the preadmission stage, and during hospital treatment.

- The contents of the mandatory predischarge plan have been expanded to address more specifically "needs for treatment, housing, nutrition, physical care and safe." Planners are directed to consider not only the local human service agencies, but to (public or private) "service providers" as well.
- Disclosures unrelated to predischarge planning remain subject to state and federal regulations concerning the confidentiality of patient records. Whether this provision is intended to implicitly exempt predischarge planning from existing state regulations is unclear. Predischarge planning will in any event continue to require execution of a qualified service organization agreement for some client, to satisfy the demands of federal substance abuse confidentiality regulations in 42 C.F.R. § 2.

S.B. 704; 1985 Va. Acts ch. 87; amending § 37.1-98; repealing § 37.1-98.1; enacting § 37.1-98.2.

Guardianship Venue

The venue in which guardianship petitions may be filed on behalf of persons in long-term care placements was clarified by 1985 amendments to §§ 37.1-128.1 and 37.1-132. Prior law permitted the petition to be filed in the circuit court in which the person "resided" or "is located." Because of uncertainty as to the current legal residence of someone in a long-term care facility, these two statutes were revised to make it clear that the petition can be filed both in the area of the facility or the area in which the patient resided immediately prior to entering the facility, regardless of the current legal residence of the patient.

The two statutes amended this year both permit partial guardianships, based on a finding of "incapacity." The amendments track existing language in the traditional, plenary guardianship statute, § 37.1-128.02.

H.B. 1370; 1985 Va. Acts ch. 390; amending §§ 37.1-128.1 and 37.1-132.

Board of Psychology

The 1985 General Assembly restructured the Board of Psychology to include five members: two clinical psychologists, one licensed school psychologist, one licensed psychlogist specializing in counseling psychology and one licensed psychologist in any speciality. At least one of these members must be a faculty member at an accredited college or university. These changes increase the representation of licensed clinical psychology and decrease the representation of academic psychologists.

S.B. 653; 1985 Va. Acts ch. 159; amending § 54-937.

Licensure of Professional Counselors

Senate Bill 535 allows for provisional licensure to be granted to persons holding doctoral degrees in professional counseling from accredited institutions. The provisional status would allow for practice, under the supervision of a licensed or certified counselor, after completion of course work until the counselor-in-training completes experiential requirements for full licensure by the Board of Professional Counselors.

S.B. 535; 1985 Va. Acts ch. 274; adding § 54-933.1.

Raising the Competency Issue

The General Assembly clarified who may raise the issue of competency to plead or stand trial. Earlier Code language had directed courts to entertain "representations of counsel" as to possible incompetency of defendants. The amended language allows for either counsel "for the defendant or the attorney for the Commonwealth" to raise the competency issue in court.

H.B. 1286; 1985 Va. Acts ch. 307; amending § 19.2-169.1.

Regional Health Planning Fund

New legislation authorized the creation of a fund to award grants for health planning on a regional basis. The fund is to be administered by the Department of Health, and will make awards that must be matched by local funds. The amount of money available to any specific health systems agency will be limited by a formula that takes into account the size of the population served in the local area. Grants made from the fund, if any, will ultimately depend upon the size of appropriation made to implement the planning fund.

H.B. 229; 1985 Va. Acts ch. 288; adding § 32.1-121.1.

Congenital Anomalies Reporting and Education System

The General Assembly established the Virginia Congenital Anomalies Reporting and Education System this year. The system is designed to collect data that will aid in diagnosis, evaluation and treatment of birth defects and inform parents and physicians of the health resources available to aid children with birth defects. The law gives the State Health Commissioner authority to establish an advisory committee to assist in design and implementation of the system, and directs the Board of Health to promulgate rules and regulations to define the disorder which must be reporting, reporting procedures, etc. The new law mandates the confidentiality of data collected through the system, while permitting the parents of children to be contacted to offer education and collect further information.

S.B. 533; 1985 Va. Acts ch. 273; adding §§ 32.1-69.1 and 32.1-19.2. ■

The Virginians with Disabilities Act: A Bill of Rights for the Handicapped or a Cruel Hoax?

by Frank M. Feibelman*

On February 18, 1985 the Virginia General Assembly passed and on March 21, 1985, Governor Robb signed into law House Bill 817 known as the Virginians with Disabilities Act. House Bill 817 was introduced in the 1984 General Assembly by its chief patron Delegate Warren Stambaugh. It passed in the House of Delegates in the 1984 session with nary a whimper of opposition. When it reached the Senate and was assigned to the Senate Rehabilitation and Social Services Committee, a flurry of opposition erupted from Virginia's business community.

The Virginians with Disabilities Act originally was the product of some work done by the rehabilitation committee of the Governor's Overall Advisory Council on the Needs of Handicapped Persons. The committee set about to draft an act that would perform two functions: bolstering the state code provisions for Virginia's Department of Rehabilitative Services and expanding the civil rights of persons with disabilities from their meager protections in the Virginia Code to something with considerably more meat on its bones.

Two sections of the act were trumpeted by advocates for persons with disabilities as being efficacious. Those two sections are the employment rights section, Section 51.0l-41 of the Code of Virginia, and the creation of a Department of Rights of the Disabled, Section 51.01-36, *et seq.* of the Code of Virginia. These two provisions deserve careful examination.

Employment Rights

Prior to the passage of House Bill 817 the sole protection for persons with disabilities from employment discrimination was Section 40.1-28.7 of the Code of Virginia, which in pertinent part stated:

> No employer shall discriminate in employment or promotion practices against any person on account of a physical handicap which is unrelated to the person's qualifications and ability to perform the job.

Section 51.01-41 (A) of the Act states:

> No employer shall discriminate in employment or promotion practices against an otherwise qualified person with a disability solely because of such disability. (emphasis added)

Two modifications were made to Section 40.1-28.7 in its transformation to Section 51.01-41 (A) of the Act. In the first modification, the addition of the term "solely" burdens the discriminated employee with the Herculean burden of proving that the employer's discriminatory action was solely on the basis of disability which forecloses all those actions in which discrimination was based not only on disability but also for any other reason.

The second difference between Section 40.1-28.7 and Section 51.01-41 (A) of the Act is the inclusion in the Act of the term, "otherwise qualified person with a disability." "Otherwise qualified person with a disability" is defined for purposes of the employment discrimination section to mean a person with a disability who is qualified without accommodation to perform the duties of a particular job or position. Subsequent subsections of Section 51.01-41 mandate that employers make reasonable accommodations for persons with disabilities, but these further requirements for employers' reasonable accommodations only apply if a person with a disability meets the definitional thresholds for coverage under the Act. Section 51.01-3 of the Act also defines a person with a disability to mean any person who has a physical or mental impairment which substantially limits one or more of his major life activities or has a record of such impairment and which for purposes of the employment discrimination section is unrelated to the individual's ability to perform the duties of a particular job or position, or is unrelated to the individual's qualifications for employment or promotion.

To show a violation of the Act, a person with a disability must be able to prove that his or her disability impacts not at all on the ability to perform the job. The query then is when would reasonable accommodations ever be required of an employer. Under the Act, it appears that a person with a disability must by definition be able to perform the job without any accommodations and his disability must be unrelated to his ability to perform the job.

Creation of Department for Rights of the Disabled

The other much ballyhooed provision of House Bill 817 that is supposed to advance the cause of civil rights for persons with disabilities is the establishment by statute of the Department for Rights of the Disabled, Section 51.01-36 *et seq.* of the Act. There previously existed in state government pursuant to Section 37.1-239 *et seq.* of the Code of Virginia, an Advocacy Department for the Developmentally Disabled which was empowered to pursue administrative remedies with appropriate state officials and to exercise other powers and perform other duties conferred on

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*Staff Attorney,
Virginia Poverty Law Center
Richmond, Virginia

Continued from page 12

imposed by the law. Since the Advocacy Department for the Developmentally Disabled received federal funding under the Developmental Disabilities Bill of Rights and Assistance Act, 42 USC Section 6000 *et seq.*, it was specifically authorized and mandated to have the authority to pursue legal, administrative and other appropriate remedies to insure the protection of the rights of such persons (developmentally disabled persons) who are receiving treatment, services, or habilitation within the state, 42 USC Section 6012 (a) (2) (A).

What is new in the transition from the Advocacy Department for the Developmentally Disabled to the Department for Rights of the Disabled is this language in Section 51.0l-37(5):

> ...the Department may file an action in any court only upon the express approval of the Governor, whose authority to act under this provision shall not be delegated.

The provision granting the Governor the authority to authorize or veto the initiation of litigation poses an ethical dilemma for the Department's attorney. The act of filing suit by the Department obviously can only be implemented by the attorney authorized by the act to be employed by the department who obviously must be a member of the Virginia State Bar. The department's attorney, like all attorneys licensed to practice law in Virginia is governed by the Virginia Code of Professional Responsibility.

Disciplinary Rule 5-106(B) of the Virginia Code of Professional Responsibility provides that:

> A lawyer shall not permit a person who recommends, employs, or pays him to render legal services for another to direct or regulate his professional judgment in rendering such legal services (emphasis added).

The decision whether or not to litigate a potential cause of action is obviously one which is solely within the judgment of a professional licensed to do so, i.e. an attorney. In making a decision on litigation, the attorney has an ethical duty to decide what is in the best interest of his client and not let political considerations affect his judgment. By giving the Governor, who may or may not be an attorney, the non-delegable duty to either approve or disapprove the filing of suit, the Virginians with Disabilities Act has imposed on the attorney employed by the Department for the Rights of the Disabled an unconscionable dilemma. The attorney may either practice law in obvious non-compliance with the Code of Professional Responsibility or advise every potential client who asks for the attorney's services that the attorney cannot enter into an attorney-client relationship because he is not able to practice law in conformance with the Code of Professional Responsibility. If the Department's attorney takes the latter course of action any communication from his non-client "client" will not have the protections of privileged communications between attorney and client. The advocacy efforts of an attorney working for the Department for Rights of the Disabled would be severely limited if he or she cannot fully practice law in compliance with the Virginia Code of Professional Responsibility.

The drafters of House Bill 817 had the intention of expanding the civil rights protections for persons with disabilities. The Act obviously fell far short of accomplishing this goal. Hopefully latter sessions of the Virginia General Assembly will fulfill the currently empty promise of the Virginians with Disabilities Act. ■

Social Security Mental Disability Evaluation Training for Clinicians

The Mental Disability Evaluation Project of the Institute of Law, Psychiatry and Public Policy, pursuant to a contract with the Virginia Department of Mental Health and Mental Retardation, will provide two series of Social Security Training sessions during fiscal year 1985-86.

The clinical sessions are designed for state facility and community services board clinicians (counselors, psychiatrists, psychologists, social workers, therapists, etc.) who are now or in the future will be providing medical/clinical evaluation reports to the Social Security Administration. This training will focus on production of a relevant, complete, and accurate report which addresses the specific legal and administrative requirements of the Social Security Administration. Clinical sessions will be offered in single day and two-day formats. Two single day sessions will be provided in Charlottesville on September 23 and 24. The two-day sessions will be scheduled at a later date and will occur during the period of January to March, 1986. **Clinicians desiring to participate in the 1986 sessions should contact Cooper Geraty at Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia, 22901, (804) 924-5435. Spaces are limited.** Training and materials will be provided at no cost, but participants are responsible for travel and other expenses.

Advocacy sessions are designed for persons who assist patients/clients through the complex Social Security application and appeals process. This training will focus on solutions to the procedural problems and on accumulation and presentation of necessary clinical data to decision-makers. The single day advocacy sessions will be scheduled at a later date. Additional information regarding the advocacy sessions may be obtained from Cooper Geraty.

Both of these training sessions are offered in an effort to minimize the inappropriate denial and termination of benefits for Virginians who are vocationally impaired. The Social Security Administration will soon begin again its Continuing Disability Review program, which has been under a nation-wide moratorium for approximately two years due to public response to improper terminations. In addition, new federal criteria will be used to determine the disability of mentally impaired persons. The training will address these recent changes and will suggest appropriate methods for securing Social Security benefits for Virginians who are vocationally disabled by reason of mental impairment.

Virginia Supreme Court Considers Role of Psychiatry in Criminal Cases

Clarifies Insanity Defenses

In an opinion announced on November 30, 1984, the Virginia Supreme Court resolved a question that has confounded Virginia judges for more than one hundred years: whether the two parts of the cognitive prong of Virginia's insanity defense (i.e., lack of understanding of the nature, character, and consequences of the act; inability to distinquish right from wrong) are to be read conjunctively (i.e., both necessary for acquittal) or disjunctively (i.e., either sufficient).

The insanity defense in Virginia derives from the Virginia Supreme Court's decision in *Dejarnette v. Commonwealth*, 74 Va. 867 (1881). In this case, the Court stated in dictum that, although a defendant may be suffering from a mental disorder, "if he still understands the nature and character of his act and its consequences, and has a knowledge that it is wrong and criminal... such [mental disorder] is not sufficient to exempt him from responsibility to the law for his crimes." (The irresistible impulse defense also was recognized in this decision.)

If, as *Dejarnette* provides, the defendant who both understands the nature, character, and consequences of his or her act and has a knowledge that the act is wrong and criminal is sane, logic would dictate, the defendant who either does not understand the nature, character, and consequences of his or her act, or has no knowledge that the act is wrong and criminal would be insane (assuming such cognitive impairment were due to a mental disorder). Subsequent Virginia Supreme Court decisions, however, have upheld convictions in cases where the jury was instructed that the defendant was to be acquitted by reason of insanity only if he or she both lacked an understanding of the nature, character, and consequences of the act and was unable to distinquish right from wrong. See, for example, *Thompson v. Commonwealth*, 193 Va. 704 (1952). Indeed, for years, Virginia's Model Jury Instructions — used by many Virginia judges to instruct jurors on the law to be applied in a given case — defined insanity in these conjunctive terms. In 1983, however, the Jury Instructions were amended to reflect the disjunctive view.

Finally, the Virginia Supreme Court has laid the matter to rest with its decision in *Price v. Commonwealth*, 228 Va. ____, 1 VRR 480 (Nov. 30, 1984): "the defendant was insane if he did not understand the nature, character, and consequences of his act, or he was unable to distinquish right from wrong."

Rejects Expert Testimony on *Mens Rea*

In an opinion announced in January, the Virginia Supreme Court ruled that "evidence of a criminal defendant's mental state at the time of the offense is, in the absence of an insanity defense, irrelevant to the issue of guilt." *Stamper v. Commonwealth*, 228 Va. ____, 1 VLR 749 (1985).

The defendant in the case, Walter R.C. Stamper, was charged with possession of marijuana with intent to distribute. At his trial, Stamper called as an expert witness a psychiatrist who was prepared to testify that Stamper "was manic-depressive, in a manic state on the date of the offense, and consequently incapable of forming the intent to distribute." The trial court refused to admit the psychiatrist's testimony because Stamper had not interposed an insanity defense.

The Supreme Court affirmed the trial court's decision, declaring that:

- "diminished capacity" "represents a 'fundamental change in the common law theory of [criminal] responsibility [quoting from *Fisher v. United States*, 328 U.S.463, 476 (1946)]...and we decline to adopt it;"
- psychiatric testimony on "specific intent" represents an "inappropriate invasion, by expert opinion on the ultimate fact in issue, of the province of the factfinder;" and
- "[t]he state of knowledge in the fields of medicine and psychiatry is subject to constant advance and change...[and] [t]he courts cannot, and should not, become dependent upon these subtle and shifting graduations for the resolution of each specific case."

The Court's opinion raises significant constitutional and evidentiary issues and, therefore, will be the subject of a more detailed analysis in the next issue of ***Developments in Mental Health Law***.

— W. Lawrence Fitch

Recent Supreme Court Decisions

In addition to the *Ake* decision discussed on page 1 of this issue, during the recently ended October 1984 term the United States Supreme Court handed down opinions of critical significance to Section 504 jurisprudence, Medicaid, private health insurance coverage of mental health care, special education, and group homes for mentally retarded persons.

State Immune From Section 504 Actions

In *Atascadero State Hospital v. Scanlon*, ___ U.S. ___, 53 U.S.L.W. 4985 (June 28, 1985) a five-member majority of the Court ruled that states cannot be sued in federal courts for violating Section 504. Section 504 of the federal Rehabilitation Act of 1973 prohibits recipients of federal aid from discriminating against handicapped persons. That section has been widely interpreted by the courts including the Supreme Court, to permit victims of alleged discrimination to bring actions in federal court. See ***4 Developments in Mental Health Law** 5 (January-June 1984).* The majority broadly read the Eleventh Amendment to render the state immune to such actions, in the absence of a clear waiver of sovereign immunity by the state, or an express abrogation of that immunity by Congress (pursuant to its authority to enforce the Fourteenth Amendment) in the enactment of Section 504. The majority found that there had been neither a waiver nor an express Congressional restriction of state sovereign immunity.

The dissenters in a lengthy exposition of the history of the Eleventh Amendment concluded that the intent of the Eleventh Amendment was no more than to preserve state sovereign immunity in state law causes of action against states in federal courts. The dissenters also would have ruled that the state had waived its immunity to suit in federal court by accepting federal funds and that Congress had abrogated any state immunity in enacting Section 504.

The Court's ruling will have the practical effect of diminishing access by handicap persons to state employment, facilities and services. Congress has the power under Section 5 of the Fourteenth Amendment to overturn the decision, and may consider doing so as part of S. 431 and H.R. 700. Those bills were initially introduced to "restore" the applicability of Section 504 and other civil rights legislation to what it was prior to the *Grove City College v. Bell* decision.

Medicaid Limitations Survive Section 504 Challenge

In *Alexander v. Choate*, ___ U.S. ___, 53 U.S.L.W. 4072 (Jan. 9, 1985), the Court unanimously turned aside a challenge to a state Medicaid plan which contained an annual 14-day limitation of inpatient hospital coverage. The plaintiffs had alleged that the 14-day limitation, or for that matter any fixed limitation that was unrelated to diagnosis, had a disparate impact on handicapped persons. This disparate impact, the plaintiffs argued, was discrimination proscribed by Section 504 of the federal Rehabilitation Act of 1973.

Justice Marshall, speaking for the Court, steered a tortuous course between two conflicting interpretations of Section 504. On the one hand the legislative history of Section 504 did not support the state's contention that Section 504 only prohibited intentional discrimination. Congress clearly had concluded that "discrimination against the handicapped is primarily the result of apathetic attitudes rather than affirmative animus."

On the other hand the Court was concerned with keeping Section 504 claims "within manageable bounds." While Justice Marshall suggested that if Congress had wanted to prevent all forms of governmental activity with a disparately disadvantageous impact on handicapped persons, it would have demanded the preparation of "Handicapped Impact Statements" before a recipient of federal assistance took any action, his real concern with circumscribing the disparate impact claims cognizable under Section 504 seems to have been a practical one.

The touchstone of compliance with Section 504, the Court concluded, is "meaningful access" to the benefit which the recipient of federal support offers; if necessary, "reasonable accommodations" to handicaps must be made to assure "meaningful access" to the benefit. Having said this much, the Court was forced to consider the nature of the benefit underlying Medicaid and the extent to which the principle of reasonable accommodation required a redefinition of that benefit.

The Court found that the benefit offered by Medicaid was a package of services, including 14 days of inpatient care per year. As a group the handicapped had access to this benefit which was both equal in the sense that it was offered on an even-handed basis and meaningful in the sense that at least during the 14 days of inpatient care handicapped persons would receive treatment as effective as a non-handicapped person would receive.

The plaintiffs had urged the Court to define the relevant benefit as "health," so that if, as a consequence of the state Medicaid plan, the health of handicapped persons was augmented less than that of non-handicapped persons, the plan was discriminatory in violation of Section 504.

Alternatively the plaintiffs argued that

Continued from page 16

Continued from page 15

if, at no cost to non-handicapped persons or the state the Medicaid plan could be written in such a way as to increase the ultimate benefit received by handicapped persons, then the principle of reasonable accommodation required that.

The Court's rejection of the plaintiffs' arguments defies simple analysis. Certainly Justice Marshall viewed the kind of redistribution of Medicaid benefits demanded by the plaintiffs to be unworkable. What might increase benefits to persons with one kind of handicap, might decrease those benefits to someone with a different handicap, or a non-handicapped persons protected by other civil rights laws banning disparate impact discrimination. The administrative costs of the kind of planning exceed what might be required by way of reasonable accommodation.

Medicaid, the Court noted, was a particularly unsuitable government program on which to impose a mandate of redistribution. Section 504 had targeted employment, education, and the elimination of physical barriers, but not Medicaid. The legislative history of Medicaid, by contrast, affirmed "the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid." The Court's drawing a distinction between Medicaid and, for example, employment, suggests an at least theoretical possibility that the Court would be more receptive to disparate impact claims that sought a redistribution of employment opportunity which furthered the vocational rehabilitation aims of the Rehabilitation Act.

The decision to interpret Section 504 to require only that the state offer "meaningful access" rather than an equality of result is reminiscent of the Court's approach to the *Education for All Handicapped Children Act in Board of Education v. Rowley* (see 2 ***Developments*** 27 (July-Sept. 1982). The *Rowley* opinion read EAHCA's mandate of an "appropriate education" to be synonomous with "meaningful access" to an education. While this substantively this may demand less of the states by way of increasing opportunities for handicapped persons, it invites case-by-case consideration of what is "meaningful access" in the context of a particular government program and a particular handicap.

The summary dismissal of the plaintiff's Section 504 challenge of a state Medicaid plan is probably of less general significance than the Court's holding that discriminatory animus need not be alleged or proved in a Section 504 action, at least where, as in this case, damages are not an issue.

State May Require Mental Health Benefits in Health Insurance

Massachusetts state law requires that any health insurance policy include generous array of inpatient and outpatient mental health benefits. Two insurance companies challenged the legality of this statutory requirement, as it applied to group health insurance sold to Massachusetts employers or unions. The Supreme Court upheld the Massachusetts law in a 8-0 ruling, *Metropolitan Life Insurance Company v. Massachusetts*, ___ U.S. ___, 53 U.S.L.W. 4616 (June 3, 1985).

The Court's ruling was a narrow one. The insurance companies contended that two federal statutes regulating employment pre-empted the state's authority to enact mandatory benefit statutes. The federal statutes, the Employee Retirement Security Act of 1974 (ERISA) and the National Labor Relations Act (NLRA) regulate pension plans and collective bargaining, respectively.

The Court ruled that § 514 (b) (2) (A) of ERISA permits states to engage in broad regulation of insurance benefits. The Court then determined the state mandated benefit law did not alter the bargaining power of employers and employees or limit the rights of collective bargaining. Therefore, it was not pre-empted by the NLRA.

The Court noted that

> Massachusetts' mandated benefit law is an insurance regulation designed to implement the Commonwealth's policy on mental health care, and as such is a valid and unexceptional exercise of the Commonwealth's police power. It was designed in part to ensure that the less wealthy residents of the Commonwealth would be provided adequate mental health treatment should they require it.

The legislation's aims included, in effect, assuring that mental health insurance was sold to more low risk customers so that the individual cost of coverage was reduced. The state was also hopeful that low income, high risk individuals would receive mental health insurance as part of their employment compensation, and thus increase reimbursement for any public sector mental health services that those persons might seek.

Parents Entitled to Reimbursement for Private Special Educational Placement During Dispute with School Board

Parents have a right to reimbursement for private educational placements they make for their child pending their challenge of the local educational agency's refusal to make that placement, if the parents ultimately prevail. In *School Committee of the Town of Burlington v. Department of Education of Massachusetts*, ___ U.S. ___, 53 U.S.L.W. 4509 (April 29, 1985), the Court ruled that the father of a learning disabled child was entitled under the provisions of the federal Education for All Handicapped Children Act to reimbursement for private educational costs incurred during his dispute with the school district over the appropriate educational placement for his son.

The fact that the father had acted unlilaterally in taking his son out of public school did not matter, said Justice Rehnquist on behalf of the entire Court. The review process was so lengthy that if parents were forced to accept an inappropriate placement until the completion of the process, a significant part of the child's opportunity

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Continued from page 16

to benefit from a free and appropriate public education would be lost. The parents, of course, are not entitled to reimbursement if the local educational agency ultimately prevails.

Zoning Ordinance Restricting Group Homes Found Discriminatory

All nine members of the Court agreed that the City of Cleburne, Texas, had acted unconstitutionally in requiring a group home for mentally retarded persons to obtain an annual special use permit. The group home which had been planned as an ICF-MR (Intermediate Care Facility qualifying for Medicaid reimbursement) was denied the special use permit by the city council. The Court concluded, in *City of Cleburne, Texas v. Cleburne Living Center*, ___ U.S. ___, 53 U.S.L.W. 5022 (July 1, 1985), that the city, in requiring the group home to obtain a special use permit in zoning district where similar homes could locate without a permit violated the Equal Protection Clause of the Fourteenth Amendment. The zoning district was designated as "R-3," an "Apartment House District."

The Court was divided 6-3 on the rationale underlying this result. The majority, led by Justice White, rejected the approach of the Fifth Circuit Court of Appeals. The Fifth Circuit has found that mental retardation was a "quasi-suspect classification" and that the validity of the Cleburne zoning ordinance should be assessed under "intermediate-level scrutiny." To pass constitutional muster under this heightened level of scrutiny the ordinance had to substantially further an important government function. The Fifth Circuit found that it did not, and declared the ordinance invalid on its face and as applied to the group home in this case.

The six-member majority of the Supreme Court declined for two reasons to apply intermediate level scrutiny to the Cleburne ordinance. The Fifth Circuit had been impressed by what it saw as a history of mistreatment and prejudice against mentally retarded persons. The Court of Appeals also viewed community living in a group home as a fundamental right of mentally retarded persons. Without it they had little hope of joining open society.

The Supreme Court had a more optimistic perspective on the legislative treatment of mentally retarded persons. Not only did the Court applaud past state and federal legislation affecting mentally retarded persons, but it expressed concern that if legislation which made distinctions based on mental retardation were subjected to a higher level of scrutiny, legislation intended to benefit mentally retarded persons might be invalidated. Legislation affecting "this large and diversified group" of mentally retarded persons, the Court said, "is a difficult and often a technical matter, very much a task for legislators guided by qualified professionals and not by the perhaps ill-informed opinions of the judiciary."

But the majority rejected the Fifth Circuit's use of intermediate level scrutiny for reasons less related to its assessment of society's treatment of mentally retarded members, than to its view of the limited role of the federal judiciary in Equal Protection cases. The practice of applying one of two or three levels of scrutiny depending on the nature of the classification (e.g. race or sex) or the nature of the right affected to some members of the majority was doctrinally confusing and likely to lead to subjective and inconsistent judicial responses to state legislative action. It also discourages the kind of state-by-state legislative experimentation which it is the function of a federal system of government to promote.

The Supreme Court's majority had no difficulty finding the ordinance, as applied to the group home, invalid under the lowest level of scrutiny. Under this level of scrutiny a law survives an Equal Protection challenge if the court finds it is "rationally related to a legitimate government purpose." The Court examined and declared irrational the factors on which the City Council based its insistence on a special permit.

Most importantly, the Court found that the "negative attitude of the majority of property owners... and the fears of elderly residents of the neighborhood" were impermissible bases for treating the group home differently than apartment houses and other multiple dwellings which could locate as a matter of right in the district. (The Court had no occasion in this case to consider the issues that might have arisen if the group home had sought to locate in a "single-family" district.)

Three Justices, while concurring in the result, would have applied a heightened level of scrutiny, and would have invalidated the ordinance on its face. One of their concerns was that while the majority purported to apply the lowest level of scrutiny, in fact it had conducted the kind of demanding investigation of the ordinance usually permitted only in cases involving suspect classifications or fundamental rights. This could lead, the dissenters warned, to judicial invalidation of virtually any state legislation on the grounds that it was "irrational."

ICF Residents Ineligible for Medicaid

In *Connecticut Department of Income Maintenance v. Heckler*, ___ U.S. ___, 53 U.S.L.W. 4558 (May 20, 1985), a unanimous Court ruled that Middletown Haven Rest Home in Connecticut could not receive Medicaid reimbursement. Although the 180-bed facility was an Intermediate Care Facility (ICF), a federal audit had concluded that it was also an Institution for Mental Diseases (IMD). Services in an IMD are not covered by Medicaid, except with respect to patients under twenty-one or over sixty-four in states which have adopted services in IMD's to those age groups as part of their Medicaid plans.

At issue was the meaning of the term, "IMD," services in which are generally not covered by Medicaid, specifically

Continued on page 18

Settlement of *Poe v. Lynchburg* Ends "Sterilization Era"

Attorneys for patients who had been sexually sterilized during residence in Virginia state mental health facilities recently settled their case against the state after more than four years of litigation. *Poe v. Lynchburg Training School and Hospital*, the class action suit that challenged the practice of "eugenical sterilization" under laws originally passed in the 1920's [see *Involuntary Sterilization in Virginia: From Buck v. Bell to Poe v. Lynchburg" 3* ***Developments in Mental Health Law*** *13 (1983)*] was dismissed by an order of United States District Judge James Turk under the terms of the settlement.

While the original suit attacked both the substance of the sterilization law and the procedures under which it was applied for almost fifty years and had sought a declaratory judgment as an unconstitutionality of the law, the settlement provided more modest relief. The state agreed to initiate a two month media campaign, including radio and television announcements, that would serve to inform the public generally of the discontinued sterilization program, with the hope that patients who had been sterilized would hear the announcements. A toll-free "sterilization hotline", already in service, is advertised as part of the media campaign and maintained to handle inquires from former patients concerning their medical histories. The plaintiff had initially sought individual notice to each person sterilized in a state facility.

The plaintiffs had also demanded earlier in the suit that free medical and psychological counseling for all those sterilized and, where feasible, surgical reversal operations at state expense. The settlement terms, however, require the state merely to post a notice in all community services board offices announcing the availability of services such as counseling to persons who have been sterilized. Such counseling would be provided, as it always had been, at a cost, based on the client's ability to pay. The state also agreed, as part of the ongoing community services board training program, to train counselors to address the unique problems of sterilized clients. The settlement does not otherwise significantly increase the services available or decrease their cost to members of the plaintiff class.

These settlement terms were made binding upon all potential class plaintiffs, that is, anyone who may have been involuntarily sterilized in a Virginia institution under the provisions of state law. Two unnamed plaintiffs who wish to pursue reversal operations refused consent to the settlement terms and were thus exempted from the order. They are probably free to bring suit as individuals or seek other remedies from state agencies.

The dismissal of *Poe v. Lynchburg Training School and Hospital* represents what may be the official legal conclusion to what has been known as Virginia's "Sterilization Era", a period from 1927 to 1972 during which an estimated seven thousand to eight thousand persons were sterilized in state institutions. Although laws that mandated sterilization of the poor, handicapped, mentally ill or others who the Virginia Code once characterized as "socially inadequate" have been repealed, the constitutional precedent for such laws remains intact. Judge Turk's earlier opinion in the *Poe v. Lynchburg* case, 581 F. Supp. 789 (1981) confirmed that the Supreme Court's decision in *Buck v. Bell*, 274 U.S. 200 (1927), the case that upheld Virginia's 1924 sterilization law, continues to represent the constitutional standard against which sterilization laws will be measured. Thus, while there is no evidence of a legislative inclination to reenact laws impairing the reproductive freedom of society's least favored members, it is worth recalling that Justice Holmes's parting comment in *Buck*, "Three generations of imbeciles are enough", survives as the last legal word for the *Poe v. Lynchburg* plaintiffs and their counterparts in other states.

— Paul A. Lombardo

Continued from page 17

whether that term referred only to traditional public mental health hospitals, or whether it included ICF's and other facilities which arose as alternatives to the hospitals.

The Court supported the approach of the Secretary of Health and Human Services, which was to appraise the "overall character" of the facility to determine whether it was "primarily engaged" in the treatment of mental diseases. By this test public or private ICF's and SNF's (Skilled Nursing Facilities) could be found to be IMD's and therefore ineligible for Medicaid reimbursement.

In determining that the ICF in this case was also an IMD the audit team used the following criteria:

1. That a facility is licensed as a mental institution;
2. That it advertises or holds itself out as a mental institution;
3. That more than 50% of the patients have a disability in mental functioning;
4. That it is used by mental hospitals for alternative care;
5. That patients who may have entered a mental institution are accepted directly from the community;
6. That the facility is in proximity to a state mental institution (within a 25-mile radius);

Continued on back cover

The Mentally Ill in Virginia's Jails*

by Michael A. Solomon**

In Virginia last year, there were over 12,000 admissions of severely mentally ill persons to our local jails. Widespread jailing of the mentally ill can be understood only within the larger context of public policy toward the chronically mentally ill in our communities. I will be discussing the findings and recommendations of our Joint Task Force on the Mentally Ill in Virginia's jails in light of the pressing need for more comprehensive community programs for the chronically mentally ill.

The Task Force

Last year, Dr. Joseph Belivacqua, Commissioner of the Department of Mental Health and Mental Retardation, and the Director of the Department of Corrections appointed a Joint Task Force to assess the needs of the mentally ill within Virginia's jails and to make recommendations. Among the members of the task force were a sheriff, a judge, a prosecutor, a legislator, a jail administrator, DOC officials, and clinicians who have worked in jails.

The Task Force visited jail sites throughout Virginia. We interviewed law enforcement officials community mental health workers, correctional officers, jail nurses, physicians, and inmates. We conducted a survey of all of the state's jails and reviewed pertinent literature.

We found that over 6% of the inmates admitted to Virginia jails each year are psychotic. This figure translates into 12,000 admissions per year. Psychiatrists use the term "psychotic" for the most severe form of mental illness in which an individual's thinking is so disordered that he loses touch with reality. A psychotic person's thoughts are grossly disorganized. He may be actively hallucinating.

The figure of 1,000 (6%) represents only the most severely disturbed persons. Approximately 25% of jail inmates need to be seen and evaluated by a mental health service. The problems of these inmates range from depression and massive anxiety to self injury and suicide attempts. The suicide rate among jail inmates is sixteen times that of the non-incarcerated population.

In many jails, over half of the inmates have significant alcohol or drug problems. Newly admitted intoxicated inmates are at particularly high risk for suicide. Acute withdrawal from alcohol or drugs can present as a medical emergency with potentially fatal consequences.

The prevalance of epilepsy or seizure disorders among jail inmates is several times that of the general population. National studies place the proportion of mentally retarded inmates in prisons at around 10%. The number of retarded persons who are currently within Virginia's jails is unknown.

Jailing The Mentally Ill

We found that a substantial proportion of the sickest group that gets jailed — the psychotic inmates — often face only minor misdemeanor charges such as trespassing, failure to identify, or disorderly conduct. What comes to mind is the young man who is picked up by police as he wanders down the median strip of an interstate partially clothed and talking to himself, while gesticulating wildly; or the disheveled elderly "bag lady" who, frightened and paranoid, refuses to leave McDonalds at closing time.

Who are these people and why do they get jailed rather than taken to get help? They are often young people who suffer from the major mental diseases: schizophenia or manic depressive illness. In an earlier era, less than a generation ago, they would have spent their lives in the old state hospitals. They have been called "the young chronics" or, to use a more apt phrase, "veterans of the mental health wars". Dr. Richard Lamb, a psychiatrist who has worked with this group of individuals for the past twenty five years, has written with regard to the chronically mentally ill in the Los Angeles County jail: "...the lives of a large proportion of these inmates are characterized by chaos, dysphoria and deprivation in a world for which they are ill prepared. They cry out for control and structure, as do their families and neighbors, but who listens or wants to believe?"

This group of young people who suffer from chronic mental illness are not necessarily poor. Many come from middle class families. In late adolescence or in their early twenties, they are hospitalized in private facilities. But after several relapses the insurance money runs out and from then on when they disturb their families or neighbors, they enter the state hospital system or get jailed.

There are many popular misconceptions about psychotic illness. Despite what you may have seen in the movies or on television, it is not caused by faulty upbringing. Rather, these biological diseases that involve subtle disturbances in brain function.

Continued on page 20

*Presentation made by the author to the Public Safety Subcommittee, Senate Finance Committee, of the Virginia General Assembly on July 19, 1985.

**Director of the Forensic Treatment Program, Western State Hospital, Staunton, Virginia; Assistant Professor of Psychiatry and Behavioral Medicine, University of Virginia, Charlottesville, Virgin-

Continued from page 19

Recommendations

The question of what we can do for the mentally ill in our jails has to be viewed as part of the question of what we can do for the chronically mentally ill; this very needy, dependant, vulnerable, and sometimes troublesome group of people.

1) **Diversion**: When possible, we need to keep the psychotic trespasser from going to jail in the first place. The legislature should grant police explicit authority to take overtly sick people for help without having to arrest them. Perhaps magistrates should also play a part in the process of diversion, suspending very minor charges on the condition that the sick person get treatment. The Community Services Boards (CSB's) should work actively with police, sheriff's deputies, and magistrates in seeking alternate dispositions for psychotic persons who get picked up for minor nuisance violations.

2) **Provisions of Mental Health Services Within the Jails**: While the mentally ill persons who commit very minor violations can be diverted from jail, there will continue to be other inmates who are in need of mental health services but who are not suitable candidates for diversion. This includes inmates who face serious charges and inmates who have suffered mental breakdowns while in jail.

Such individuals need to be assessed and treated within the local jails. Occasionally, psychiatric hospitalization will also be required. Jails in Richmond, Fairfax, Augusta, and Albemarle Counties, among others, currently have mental health programs. Often the CSB is the best provider of such services. Our Task Force reviewed a variety of funding arrangements through which jail mental health services can be established. The particular funding setup depends upon a variety of local factors.

Jails also need to have the capacity to screen inmates for suicide risk and to develop specific written protocols for the management of suicidal inmates. This requires training for both jail staff and mental health clinicians. The interagency committee which is implementing the Task Force recommendations is currently working on the development of jail mental health training programs.

3) **The Role of the State Hospital**: Occasionally, mentally ill jail inmates and the chronically mentally ill need to be hospitalized. The hospital stay usually can be quite brief. (The NIMH Collaborative Study of Schizophenia which was conducted with several thousand patients found that with proper drug treatment, 65% of patients had psychotic symptoms eliminated within six weeks, 30% showed some improvement, while 5% showed no change or got worse). Hospital treatment for a psychotic person should involve careful administration of antipsychotic medications plus caring human contact, which is essential. Hospitalization, in most cases, need last no longer than a couple of months.

At the present time, there is not a need for more hospital beds in Virginia's state system. To the contrary, there are presently a substantial number of patients in our state hospitals whose mental conditions have stabilized. They no longer need to remain in the hospital; they could be safely discharged but the communities won't take them back.

Current funding arrangements work against incentives for community treatment for the chronically mentally ill. Rather, they favor prolonged hospitalization. This is costly, inefficient, and wasteful. Since adequate community programs are generally not being made available to the chronically mentally ill upon discharge, this sets many individuals up for a return to the jail or the state hospital.

4) **Community Treatment For The Chronically Mentally Ill**: If we want to get some of the chronically mentally ill out of the jails, and prolonged hospitalization doesn't serve anyone's interest, what can we do? It just doesn't have to be so. First, we need to acknowledge that what passes for traditional community treatment; a weekly or monthly visit to the clinic to pick up medications and receive counseling, just does not constitute adequate service to many of the chronically mentally ill. There is a desperate need for supervised housing and for innovative programs in which to keep people active during the day.

Such programs exist in Virginia. In a number of areas (for example: Abingdon, Staunton, Charlottesville, and Buena Vista) there are now innovative programs that do very well for the chronically mentally ill and keep them from getting into trouble.

One example of this type of program is the psychosocial clubhouse. These are large renovated older houses where ex-patients or "members" spend the day. They prepare meals, do clerical work, or provide janitorial services. Some of the members just sit around. But they have a place to go and they don't bother anyone. Many individuals who, in the past, cycled through hospitals and jails, are very successful members of clubhouse programs.

The problem is that there are not enough of these programs and the ones that we have are unevenly distributed throughout the state. It is clear that we could do much better for these individuals and the results would be less costly both in human and financial terms. Our current policies are shortsighted. We need to alter the economic incentives which currently favor prolonged hospitalization and inadequate community support programs which set people up for failure after discharge from the hospital. Only when we upgrade our community programs for the chronically mentally ill will be begin to seriously address the problem of the mentally ill within our local jails. ■

Continued from page 6

Conclusion

How the *Ake* decision will be implemented in law and practice is by no means clear. Virginia Deputy Attorney General Gehring has provided valuable guidance for prosecutors in Virginia who must address these issues in current cases. But, before these issues finally are resolved, a serious debate should be expected at the public policy level, and, ultimately, legislative amendment may be necessary.

Postscript: Recent Progeny of *Ake*

The United States Supreme Court recently issued rulings in two Virginia cases in which the right of a capital defendant to independent "psychiatric assistance" was at issue. In one case, the Court let stand a conviction and sentence of death where access to psychiatric assistance was limited to the provision of a pretrial evaluation by neutral clinicians. In the other case, where access to psychiatric assistance was similarly limited and the prosecution called one of the evaluators to testify concerning the defendant's future dangerousness, the Court ordered the Virginia Supreme Court to reconsider the defendant's appeal in light of *Ake v. Oklahoma*.

The defendant in the first case, Morris Odell Mason, was charged with capital murder in Northhampton County, Virginia. Prior to trial, Mason's attorneys requested an evaluation of Mason's competency to stand trial and mental state at the time of the offense. Following a preliminary evaluation by a psychiatrist at the Eastern Shore Mental Health Center, Mason was admitted to Virginia's maximum security Forensic Unit at Central State Hospital, where he was evaluated by James C. Dimitris, M.D., Medical Director of the Forensic Unit, and William M. Lee, Ph.D., Chief Psychologist of the Unit. Dr. Dimitris reported that Mason was both competent to stand trial and sane at the time of the offense.

Mason's attorneys then requested funds with which to retain an "independent psychiatrist" to evaluate Mason's competency and sanity. The court denied this request. Against the advice of his attorneys, Mason pleaded guilty to the capital murder charge. At this time, Mason's attorneys orally renewed their request for funds for additional psychiatric evaluation. Again, the request was denied.

The assistance the Court said the defendant is due... includes help in evaluating, preparing, and presenting a defense.

At the sentencing hearing, the pretrial evaluation reports were admitted into evidence, but no psychiatric or psychological testimony or other clinical evidence was presented. Observing that these "documents themselves do not tell me very much" without "supporting evidence," the court sentenced Mason to death.

The Virginia Supreme Court affirmed Mason's conviction and sentence of death, rejecting defense arguments that the trial court had erred in refusing Mason's request for funds for an independent psychiatric examination. The United State Supreme Court denied certiorari (i.e., refused to accept the case for review).

The case reached the United States Supreme Court twice more on habeas corpus appeals, most recently during the Court's October 1984 term. The petition for a writ of certiorari in October argued that (1) Mason had been denied his constitutional right to the assistance of an independent mental health expert and (2) the failure of Mason's trial attorneys to request an evaluation for capital sentencing purposes amounted to ineffective assistance of counsel. On April 1, the Supreme Court denied certiorari for the third time. *Mason v. Sielaff*, 53 U.S.L.W. 3702 (April 1, 1985). On June 25, Mason was executed.

The defendant in the second case, Lem Davis Tuggle, Jr., was charged with capital murder in Smythe County, Virginia. Like Mason, Tuggle requested an evaluation of his competency to stand trial and mental state at the time of the offense and was admitted to the Forensic Unit at Central State Hospital. Arthur Centor, Ph.D., and Miller Ryans, M.D., evaluated Tuggle and reported that he was both competent and sane. In addition, they reported that they had assessed Tuggle's future dangerousness and offered to discuss the evaluation with either the defense or the prosecution.

In most states, procedures governing the provision of clinical assistance... do not contemplate the kind of comprehensive, partisan assistance envisioned in *Ake*.

Tuggle's attorneys subsequently arranged for an independent psychiatrist to examine Tuggle and assist the defense in preparing for trial. The cost of this service was to be borne by the defendant. Their request of the court to order Tuggle transported to Charlottesville, Virginia, for an evaluation by the independent psychiatrist, however, was denied. Consequently, the independent evaluation was never performed.

Tuggle was tried and convicted of capital murder. At the sentencing hearing, the prosecution called Dr. Centor to testify. Over objections from the defense, Dr. Centor was permitted to testify that, based on his earlier evaluation of Tuggle, Tuggle "shows a high probability of future dangerousness." Virginia law provides that a defendent convicted of a capital offense may be sentenced to death only upon a finding beyond a reasonable doubt either (1)

Continued on page 22

Continued from page 21

"that there is a probability... that he would commit criminal acts of violence that would constitute a continuing serious threat to society" or (2) "that his conduct in committing the offense was outrageously or wantonly vile, horrible or inhuman, in that it involved torture, depravity of mind or aggravated battery to the victim."[11] The jury found both of these "aggravating factors" and sentenced Tuggle to death.

The Virginia Supreme Court affirmed the conviction and the sentence of death. The defense appealed this decision to the United States Supreme Court, arguing that (1) the trial court's refusal to provide Tuggle with access to independent psychiatric assistance violated his constitutional right to due process as well as his right to effectively present his defense, and (2) introduction of the testimony of Dr. Center on behalf of the prosecution at the sentencing hearing violated Tuggle's Sixth Amendment right to the effective assistance of counsel (because the assessment of dangerousness was performed without notice to Tuggle's attorney) and his Fifth Amendment right not to testify against himself. On May 13, 1985, the Supreme Court vacated the judgment and remanded the case to the Virginia Supreme Court for further consideration in light of *Ake v. Olkahoma. Tuggle v. Virginia*, 53 U.S.L.W. 3807 (May 13, 1985).

After re-hearing the matter, the Virginia Supreme Court on September 6, 1985, again affirmed Tuggle's conviction and sentence to death, reasoning that (1) because neither Tuggle nor his attorney made the "requisite threshold demonstration" that Tuggle's sanity at the time of the offense was likely to be a significant factor at trial (and nothing about Tuggle's behavior during the course of the criminal proceedings indicated that he was suffering from a significant mental abnormality), no right to independent psychiatric assistance on this issue attached, and (2) because at the sentencing phase the jury found that Tuggle's "conduct in committing the offense was outrageously or wantonly vile, horrible or inhuman" — a factor which by itself may provide the basis for a sentence of death — the failure of the court to provide Tuggle with independent psychiatric assistance on the dangerousness issue was harmless error. *Tuggle v. Virginia*, No. 840486, ___Va. ___(Sept. 6, 1985).

Notes

1. In a separate, concurring opinion, Chief Justice Burger observed that the facts of the case confine the actual holding of the

Continued on page 23

State's Failure to Deliver Evidence Bearing on Defendant's Sanity Violates Defendant's Rights Under *Ake v. Oklahoma*

Relying on the United States Supreme Court's recent decision in *Ake v. Oklahoma*, 53 U.S.L.W. 4179 (February 26, 1985) (see article elsewhere in this issue), the United States Court of Appeals for the 11th Circuit has ruled that the failure of the state to deliver to the defense information in its possession which could be used by the defense to question the defendant's sanity at the time of the offense violates the defendant's constitutional rights to psychiatric assistance and to the effective assistance of counsel. *Blake v. Kemp*, 37 CrL 2131 (11th Cir., No. 81-7417, March 29, 1985).

The defendant in this case, Joseph Blake, was charged with capital murder in the killing of Tiffany Loury, age two. Blake confessed to the police that, following an argument with Loury's mother, he asked Loury whether she would like to go with him to "another world" where they would not be bothered; when she answered, "yes," he dropped her from a bridge, telling her he would join her later. He stated to the police, "all I know is I did wrong and in another way I did right.... She is in a better place now." Two or three days later, Blake wrote a suicide letter to the jailer, stating, "she [Loury] came to me and said she wanted me now."

Two weeks later, the court ordered Blake evaluated by a psychiatrist. The psychiatrist was given a copy of the police report describing the offense but not Blake's taped confession or the suicide letter. These items were withheld from Blake's attorney as well.

During the psychiatric evaluation, Blake was unable or unwilling to relate the circumstances surrounding the offense. Accordingly, the psychiatrist reported that he was unable to form an opinion about Blake's sanity at the time of the offense, and the case proceeded to trial without any psychiatric testimony on this issue. Blake was convicted and sentenced to death.

A federal district court granted habeas corpus relief, ruling that where the defendant's sanity is "fairly in question" the defendant has "at a minimum the constitutional right to at least one psychiatric examination and opinion developed in a manner reasonably calculated to allow adequate review of relevant, available information, and at such a time as will permit counsel reasonable opportunity to utilize the analysis in preparation and conduct of the defense." The Court of Appeals agreed, adding that, "under these circumstances, we do not hesitate to find that the State so materially interfered with the defendant's ability to test the prosecution's case as to raise a presumption that the defendant's counsel could not have been able to provide effective assistance."

The District Court also ruled that the defense attorney's failure to present any mitigating evidence at Blake's capital sentencing hearing amounted to ineffective assistance of counsel. The Court of Appeals again agreed, observing that "such failure in a capital trial falls below any objective standard of reasonableness."

— W. Lawrence Fitch

Continued from page 22

Court to capital cases. "In capital cases the finality of the sentence imposed warrants protections that may or may not be required in other cases. Nothing in the Court's opinion reaches non-capital cases." The majority opinion, however, appears quite clearly to recognize the right of a defendant to psychiatric assistance on the issue of his or her "sanity" at the time of the offense without regard for the nature of the offense charged. Moreover—and ironically—Justice Rehnquist, the lone dissenter in the case, gives support to this interpretation by objecting to the broad constitutional rule established by the majority as unwarranted by the facts of the case. "I would limit the rule to capital cases...."

2. Interestingly, other recent Supreme Court cases in which this familiar, three-pronged standard has been applied have held that, where the issue to be resolved concerns the mental state of one of the parties, greater deference may be given the judgment of a "neutral" mental health professional and less concern need be shown for adversarial due process. So, for example, in *Parham v. J.R.*, 442 U.S. 584 (1979), where the issue was whether an adversarial hearing need be held before a juvenile could be committed involuntarily to a psychiatric hospital, the Court held that the judgment of the mental health professional recommending hospitalization (which is concurred in by the juvenile's parents) satisfies the requirements of due process without the need for any adversarial safeguard. Of course, in a proceeding for the commitment of a juvenile, the purposes of which are beneficent and the parents' interest in which weigh heavily, the concern for accuracy may not be as "uniquely compelling" as in a criminal case. Nevertheless, the *Ake* decision may be read to signal a growing skepticism among the Justices about the reliability of psychiatric assessment; thus, it may not be unreasonable to expect that, in future decisions, the Court will extend to other kinds of cases—such as those involving civil commitment—the right of a party at risk to independent "psychiatric assistance."
3. Lockett v. Ohio, 438 U.S. 586 (1978); Eddings v. Oklahoma, 455 U.S. 104 (1982).
4. Letter from Donald C.J. Gehring, Deputy Attorney General (Virginia), to James W. Updike, Attorney for the Commonwealth (Bedford County, Virginia), dated March 18, 1985.
5. American Bar Association Standing Committee on Association Standard for Criminal Justice, *Criminal Justice Mental Health Standards* (1984).
6. This view was adopted, but then, for all practical purposes, rejected, by Jane D. Hickey, Assistant Attorney General for the Human and Natural Resources Division of the Office of the Attorney General in Virginia, in an advisory opinion she rendered on April 16, 1985, for the director of one of Virginia's state psychiatric hospitals. Ms. Hickey wrote: "while [q]ualified clinical psychologists may continue to perform forensic evaluations in the Commonwealth and their testimony is admissible and competent evidence...the requirements of *Ake* would not be met if a clinical psychologist were appointed to evaluate and assist the defendant and later the state used a psychiatrist to perform the evaluation". [Letter from Jane D. Hickey, Assistant Attorney General (Virginia), to Olivia Garland, Director of Central State Hospital (Virginia), dated April 16, 1985.]

   Ms. Hickey apparently interprets *Ake* to require that the defense be assigned an expert who is at least as well qualifed as the expert employed by the prosecution. And she assumes that psychiatrists are better qualified than psychologists — or, at least, that "juries may believe that greater weight is accorded to the testimony of a psychiatrist than to the testimony of a clinical psychologist" and that "[t]he clinical psychologist... may not be as effective as a psychiatrist in helping the defense to prepare for cross-examination of the prosecution's psychiatrist."

   While it is understandable that the Attorney General's Office would interpret *Ake's* "psychiatric assistance" requirement conservatively, the conclusions Ms. Hickey reaches seem unnecessarily restrictive. To begin with, nothing in the Court's opinion requires that the defense be provided access to an expert whose credentials are equal to those of the prosecution's expert. If the prosecution's expert were board-certified in forensic psychiatry and an author of twenty articles and four books on evaluating criminal defendants, would the defendant's expert have to be similarly qualified? Suppose the prosecution's expert were an experienced forensic psychologist whose findings were based at least in part on extensive psychological testing. Would the defense be entitled to the assistance of an equally qualified psychologist? Would the assistance of a psychiatrist — who likely would be less adept at assisting the defense in cross-examining the prosecution's psychologist on the testing performed — be inadequate? There may be cases in which it will be necessary to provide the defense with access to an expert having a particular kind of specialized training resembling that of the prosecution's expert—for example, where the prosecution intends to use its expert to address a technical issue outside of the expertise of the defendant's expert—but these cases should be the exception rather than the rule.

   While Ms. Hickey may be correct that juries attach more credibility to the testimony of a psychiatrist than to that of a psychologist, this is simply Ms. Hickey's opinion — an assumption she makes based on her own experience. The Virginia legislature has addressed this issue and has decided that doctoral-level psychologists and psychiatrists are equally qualified by education to perform forensic evaluations in the state. The Virginia Supreme Court in one case went even further and approved admitting the testimony of a masters-level psychologist on the issue of a defendant's mental state at the time of the offense. *Rollins v. Commonwealth*, 207 Va. 575 (1966). Similarly, the United States Congress and the legislatures of many states have recognized the qualification of psychologists to serve on an equal basis with psychiatrists in insanity cases. If there remains a concern that juries will place disproportionate reliance on the testimony of psychiatrists, it seems an instruction from the judge concerning the legislature's judgment on this issue would be the appropriate remedy, not rejection of that judgment as incorrect.
7. Virginia law provides that all pretrial forensic evaluations must be conducted on an outpatient basis unless outpatient services are unavailable or the court determines, based on the findings of an outpatient examination, that inpatient evaluation is necessary. Va. Code Ann. §§ 19.2-169.1 and 19.2-169.5 (Supp. 1982). In most Virginia communities, these outpatient evaluations are conducted by community mental health professionals who have completed a 50-hour program of training in forensic evaluation at the University of Virginia's Institute of Law, Psychiatry and Public Policy.
8. For a discussion of the ethical boundaries of forensic psychiatry, see *Bulletin of the American Academy of Psychiatry and the Law*, Volume 12, Number 3 (1984), which is devoted in its entirety to this topic.
9. United States v. Alvarez, 519 F. 2d 1036 (3d Cir. 1975); State v. Pratt, 284 Md. 516 (1979); Houston v. State, 602 P. 2d 784 (Alaska 1979); Pouncey v. State; 353 So. 2d 640 (Fla. App. 1977). See, American Bar Association, supra note 5, Standard 7-3.3.
10. Gibson v. Zahradnick, 581 F. 2d 75 (4th Cir. 1978); U.S. v. Reifsteck, 535 F. 2d 1030 (8th Cir. 1976); U.S. v. Alvarez, 519 F. 2d 1036 (3rd Cir. 1975); Collins v. Auger, 428 F. Supp. 1079 (S.D. Iowa 1977); State v. Lapham, 377 A. 2d, 249 (Vt. 1977).
11. Va. Code Ann. § 19.2-264.4 (Repl. Vol. 1983). ■

Continued from page 18

7. That the age distribution is uncharacteristic of nursing home patients;
8. That the basis of Medicaid eligibility for patients under 65 is due to a mental disability, exclusive of services in an institution for mental disease;
9. That the facility hires staff specialized in the care of the mentally ill; and
10. That independent professional reviews conducted by state teams report a preponderance of mental patients in the facility.

Relevant to these criteria it was found that over 77% of the residents of Middletown Haven suffered from a major mental disorder and over 50% had been transferred from the state hospital. The size of the facility was not taken into consideration.

The state had argued unsuccessfully that the Medicaid Act should be interpreted to encourage movement of patients out of traditional state custodial hospitals and into less restrictive ICF's. But the Court insisted that it was the intent of Congress to exclude coverage of IMD's regardless of the form of the IMD, and regardless of whether that represented enlightened policy. ■

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Box 100
Blue Ridge Hospital
Charlottesville, VA. 22901

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Psychic Trauma: Putting the Proposed Revisions to DSM-III in Perspective

by Robert S. Brown, Jr., M.D.*

There is widespread disagreement within the legal community on the question of whether compensation should be paid to a person who suffers significant mental impairment after experiencing stress, or "psychic trauma," attributable to another's wrongdoing.

Traditionally courts have not permitted recovery for psychic trauma unless the plaintiff proved either that it was accompanied by physical trauma (the "impact rule"), or that some type of physical disorder (often nominal), resulted from the psychic trauma.

Recent advances in psychiatric theory and practice, however, have shown that serious mental disorder can occur just as surely as a result of the patient's having witnessed the physical injury of another, as having personally suffered the injury. And this psychic trauma and other kinds can lead to mental disorder that is unaccompanied by real physical illness. For this reason there has been some relaxation of the technical requirements necessary to prove compensable injury in a minority of American jurisdictions.[1]

The gap between psychiatric and legal views of mental impairment caused by psychic trauma, nonetheless, remains wide. This is partly due to fears of a flood of fraudulent claims and of a massive increase in societal costs as a result of greatly expanded defendant liability. These are at least the traditional judicial rationales for restricting recovery for psychic trauma. But it is also partly due to a longstanding disagreement among clinicians as to what constitutes a post-traumatic stress disorder (PTSD), a common mental impairment caused by severe psychic trauma. This lack of consensus among psychiatrists, psychologists, and others adds fuel to the skepticism of many lawyers about the usefulness of the behavioral sciences in general, and consequently has discouraged courts from allowing full recovery in psychic trauma cases.

The American Psychiatric Association is now considering a proposed revision of DSM-III,[2] which embodies several important alterations to the diagnostic category of post-traumatic stress disorder. An amended set of diagnostic criteria has been proposed with the aim of more precisely defining and clarifying both the causes and symptoms of the disorder. These changes, if adopted, will add to the credibility and usefulness of the PTSD diagnosis in legal settings.

To put the proposed revisions of the PTSD diagnosis in perspective, this article will give a brief account of the development of PTSD from its physiological beginnings in the Nineteenth Century to its present

Continued on page 26

*Forensic Psychiatry Fellow, Institute of Law, Psychiatry and Public Policy and Senior Resident, Department of Internal Medicine, University of Virginia Hospital. The author acknwledges with gratitude the research assistance of Colin M. Dunham, J.D.

Also in this issue . . .

Continued from page 25

status as a clinically verifiable mental disorder. Some of the reasons for the proposed revisions to DSM-III, and the consequences of their adoption, should then be apparent.

Historical Development

An early case of psychic trauma was noted by a Dr. Maty in 1766. In 1761 a French officer, the Count de Lordat, overturned his carriage and received injuries to his neck, shoulder, arm, and head. Although he apparently escaped without serious harm at the time (he walked some miles for assistance), Dr. Maty described a series of dramatic changes that befell the Count in the next six months.

> A more melancholy object I never beheld. The patient, naturally a handsome middle aged, sanguine man, of a cheerful disposition and active mind, appeared much emaciated, stooping, and dejected. He walked with a cane but with much difficulty and in a tottering manner. By this time it seemed his left hand and arm were paralyzed but also his right was somewhat benumbed and he could scarcely lift it to his head.[3]

This case is one of many reported from the mid-Eighteenth Century onwards. The pattern consisted of an accident causing varying degrees of physiological injury followed by neurological symptoms seemingly unconnected to the accident itself.

The spread of industrialization and the onset of the "Railway Age" were accompanied by an increase in the number of reported cases of this type. A leading hypothesis at the time was that a relatively minor trauma, by disrupting the minute organization of the spinal cord's nerves, could cause an alteration in the spinal cord's ability to receive adequate nutrition. By the late 1800's this idea had caused physicians to label symptoms like those of the Count's, "spinal concussion." An influential theorist, Dr. John Erichsen, drawing on the large number of well documented cases of railway accidents, published in 1882 a series of lectures entitled, *Concussion of the Spine, Nervous Shock, and Other Obscure Injuries of the Nervous System.*[4]

Despite continued skepticism within the English medical community as to whether relatively trivial physical traumata could cause severe mental disorders (and even doubt as to the severity of the psychiatric symptoms themselves), litigation increasingly involved claims of "spinal concussion," of which claims of "shock," "spinal anemia" and meningitis were variants. A recent historian of psychic trauma, Dr. Michael Trimble, reports that, following the dissemination of the spinal concussion theory in books such as Erichsen's "The disorder and its accomanying pathology was seized upon by litigants and their friends. They 'were appraised of clinical and pathological possibilities that were before this undreamed of' . . . and few cases were taken to court without the above book appearing and being quoted."[5]

Freud and Psychic Trauma

By the late Nineteenth Century the accumulation of numerous well verified cases of severe post-accident, non-physiological symptoms convinced even the skeptics that the phenomenon was real even if the explanation of spinal injury seemed implausible.

A turning point in the development of the PTSD nomenclature came with the publication of Freud's and Breuer's *"On the Theory of Hysterical Attacks."*[6] In describing the psyche's responses to threat, they emphasized the symbolic and disguised repetiton of a previously experienced trauma in women. (Later they would find this hysteria in both sexes.) In their view, psychic trauma could bring about diverse symptoms which might only appear gradually and long after the event itself.

It is this concept of psychic trauma that underlies current views on PTSD. The theory held that, following a traumatic event, the patient experiences a repetition of the incident in the form of recurrent mental images, dreams, nightmares, or obsessive thinking. The traumatic event may also produce palpitations, sweating, tremors, and other symptoms related to the autonomic nervous system, all common symptoms of anxiety. The theory that compulsive tendencies develop after the occurrence of a traumatic event was subsequently validated in a number of clinical studies.[7]

Shell Shock and Battle Fatigue

War gave clinicians the opportunity to observe a segment of the population under severe stress situations. In the American Civil

Continued on page 41

Developments in Mental Health Law

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Social Security Notes

The Social Security Disability Benefits Reform Act of 1984 made a number of important changes in disability law, including requiring the Social Security Administration (SSA) to promulgate new mental impairment criteria and a new standard of review for termination of disability benefits. P.L. 98-460, 98 Stat. 1794 (1984). For a summary of the Act, *see* "Social Security Notes" 4 **Developments in Mental Health Law** 13 (1984). Final mental impairment and standard of review regulations have now been published. These two sets of regulations will affect greatly the millions of Americans who apply for or are receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits by reason of mental impairment.

On August 28, 1985, final regulations providing updated mental disability criteria were published. Listings of Impairments — Mental Disorders, 50 Fed. Reg. 35,038 (1985) (to be codified at 20 C.F.R. § 404, subpt. P, App. 1, (hereinafter *"Listings"*). A copy of the criteria component of the new *Listings* follows this article. The new *Listings* are in large part the product of a SSA work group comprising representatives of national mental health professional organizations and SSA personnel. There are substantial changes contained in both the approach to and structure of the regulations.

The major change in approach involves the differing role assumed by clinical signs, symptoms, and laboratory findings (sometimes known as "Part A" criteria), compared to the role assumed by functional limitations criteria (sometimes known as "Part B" criteria). Data pertinent to the former group are used to establish the *existence* of a medically determinable mental impairment recognized by the Social Security Administration. However, in a departure from past practice, no effort is made to evaluate the *severity* of an impairment by use of clinical signs or other data from this group. Rather, severity is usually assessed through data documenting the existence of the four Part B functional limitations criteria: activities of daily living; social functioning; concentration, persistence, and pace; and deterioration or decompensation in work or work-like settings. Compared to the old regulations, these four functional criteria are improved, but still not always highly predictive indicators of severity of vocational impairment. For a further explanation of the roles of each of these two groups, *see Listings* 12.00 (C) 1-4.

A set of secondary changes in approach is also included in the new *Listings*. First, there is a recognition that the results of a single mental status examination may not adequately describe the clinical condition of persons with chronic mental impairments. Review of a wide range of longitudinal data is necessary to obtain a better picture of the person's abilities and limitations. *Listings* 12.00 (E).

Second, the ameliorative effect of structured settings on overt symptomatology is discussed. The ability of a person to function outside of such a structured setting must be determined before proper evaluation of that person's work capacity can occur. *Listings* 12.00 (F).

Finally, attention is given to the complex influence of medication on vocational capacity. While psychotropic medications may attenuate overt symptomatology, they may or may not affect the functional limitations imposed by the underlying mental disorder. Furthermore, any possible negative side effects of medication must be considered in the disability determination.

The structure of the new *Listings* is much improved, but rather more complex than the old regulations. The number of *Listings* categories is increased from four to eight, and they are organized in diagnostic groups: Organic Mental Disorders; Schizophrenic, Paranoid and Other Psychotic Disorders; Affective Disorders; Mental Retardation and Autism; Anxiety Related Disorders; Somatoform Disorders; Personality Disorders and Substance Addiction Disorders. *Listings* 12.02-.09. Excluding the Mental Retardation and Autism Disorders and the Substance Addiction Disorders, the remaining six categories share a common structure, with relatively minor variations.

Each of these six categories contains Part A, describing the particular clinical signs the continuous or intermittent existence of which is necessary to establish an impairment in the category; and Part B, describing functional limitations used to evaluate the severity of the impairment. The Part A segments of each of these categories closely follow DSM-III terminology and more accurately reflect current thinking about the clinical signs associated with each diagnostic group. As noted above, the four Part B criteria are used to assess the severity of the limitations imposed by the disorder. The same four functional criteria are used across the six diagnostic related categories. However, it is important to note that different categories require the existence of a different number of functional limitations in Part B in order to meet the severity of the particular category. For example, documentation of two of the four Part B criteria satisfies the Schizophrenic, Paranoid and Other Psychotic Disorders listing, while three of the four are necessary to satisfy the Somatoform Disorders and Personality Disorders. *Listings* 12.03,.07,.08.

The other minor variation is that two of the six categories (Schizophrenic, Paranoid and Other Psychotic Disorders, and Anxiety Related Disorders) have a third criteria group, Part C. *Listings*

Continued on page 28

Continued from page 27

12.03,.06. The Part C group is an alternative or supplemental set of historical and/or functional criteria which is designed to address particular impaired populations.

While the *Listings* are rather complex, attorneys and clinicians familiar with the DSM-III structure and terminology should not have serious difficulty using them. However, specific reference to several of them may prove helpful.

- **Schizophrenic, Paranoid and Other Psychotic Disorders** -*Listings* 12.03. This category is a good example of the usual approach and structure of the majority of the listing categories. It contains a representative Part A group of clinical signs appropriate to the diagnostic category as well as the normal Part B group of the four functional limitations (the existence of two of which provide the requisite severity level to meet this listing). In a major advance, the category also contains a Part C, designed to accommodate persons who have a history of psychosis, but whose acute symptomatology is now attenuated by medication and/or psychosocial support. In the past, these persons frequently were denied or terminated from benefits because few acute clinical signs were present, even though many of them were very functionally limited and could not reasonably be expected to maintain competitive work. If these persons meet the primarily historical requirements of Part C, they now would be determined to be eligible for disability benefits.

- **Mental Retardation and Autism** — *Listings* 12.05. This category is atypical. It has four alternative criteria (Parts A, B, C, and D), the satisfaction of any of which is sufficient to establish eligibility. However, these criteria do not follow the pattern of most of the other categories. Rather, they are a mix of I.Q. test scores or the inability to take I.Q. tests, and/or functional limitations. This category is relatively unchanged from the old regulations, probably because the old regulations in this area were considered generally acceptable. However, the new *Listings* do add Part D to encompass autism and to provide alternative and more specific functional limitations criteria for some mentally retarded persons.

- **Substance Addiction Disorders** — *Listings* 12.09. This category is also atypical. The work group which was responsible for creating the new *Listings* recommended criteria in this category that were generally consistent with the approach and structure of the majority of the other categories. The recommendation had specific clinical signs and functional limitations which were believed to be predictive of inability to work. However, the Social Security Administration declined to accept the work group's suggestion and instead merely adopted a reference criteria approach. That is, this category does not acknowledge that substance addiction disorders can be vocationally disabling in and of themselves, but rather requires reference to other diagnostic categories to establish disability. These other categories include physical *e.g.*, liver damage) or other mental *e.g.*, depressive syndrome) conditions and must be evaluated pursuant to the listing category of the particular physical or mental manifestation. This reference approach is consistent with long standing Social Security Administration internal policy not to allow substance addiction eligibility in the absence of organ damage or more "acceptable" mental impairment. This policy has met with repeated strong disapproval by virtually all federal courts which have addressed the issue.

Although the new *Listings* were published as final regulations and became legally effective August 28, 1985, full implementation has not yet occurred. The SSA has been providing substantial internal training and quality control review of

Social Security Mental Disability Evaluation Training for Clinicians

The Mental Disability Evaluation Project of the Institute of Law, Psychiatry and Public Policy, pursuant to a contract with the Virginia Department of Mental Health and Mental Retardation, will provide two series of Social Security Training sessions during fiscal year 1985-86.

The clinical sessions are designed for state facility and community services board clinicians (counselors, psychiatrists, psychologists, social workers, therapists, etc.) who are now or in the future will be providing medical/clinical evaluation reports to the Social Security Administration. This training will focus on production of a relevant, complete, and accurate report which addresses the specific legal and administrative requirements of the Social Security Administration. Two clinical sessions have been tentatively scheduled for January 13 and 14, in Richmond and January 27 and 28, in Petersburg. **Clinicians desiring to participate in the 1986 sessions should contact Cooper Geraty at Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia, 22901, (804) 924-5435. Spaces for these two-day sessions are limited. The provision of possible additional clinical sessions at different sites may depend on the level of expressed clinician interest.** Training and materials will be provided at no cost, but participants are responsible for travel and other expenses.

Advocacy sessions are designed for persons who assist patients/clients through the complex Social Security application and appeals process. This training will focus on solutions to the procedural problems and on accumulation and presentation of necessary clinical data to decision-makers. The single day advocacy sessions will be scheduled at a later date. Additional information regarding the advocacy sessons may be obtained from Cooper Geraty.

Both of these training sessions are offered in an effort to minimize the inappropriate denial and termination of benefits for Virginians who are vocationally impaired. The Social Security Administration recently resumed its Continuing Disability Review program, which has been under a nation-wide moratorium for approximately two years due to public response to improper terminations. In addition, new federal criteria will be used to determine the disability of mentally impaired persons. The training will address these recent changes and will suggest appropriate methods for securing Social Security benefits for Virginians who are vocationally disabled by reason of mental impairment.

tentative decisions before making final decisions under the regulations. SSA's desire to train adequately is proper; however, the attendant delay has resulted in hardship for many claimants whose applications have been awaiting action for months. It is expected that SSA will begin in December or January to issue decisions in many of these long-delayed cases.

Part of the impetus behind Congress' requirement for mental criteria revision was the belief that the old regulations were insufficient and out of date, and resulted in an unacceptably high number of improper denials. While the new *Listings* do appear to reflect more closely current clinical thought regarding mental disorders, it is not clear how large an impact they will have on the award/denial rate. Estimates from authoritative SSA sources indicate that an increase in the award rate of only approximately five (5) percent is expected. Advocates and clinicians involved with Social Security claimants should monitor closely the results of implementation and should be especially careful to consider appeal of denials which may be incorrect.

The Social Security Disability Benefits Reform Act of 1984 also established a new standard of review to be used in determining whether benefits of a currently eligible disabled person should be terminated. The key concept in the new standard is that persons who have been determined by SSA to be disabled and who are currently receiving disability benefits ordinarily should not be cut off from benefits unless there has been some medical improvement in their condition. This so called *"medical improvement standard"* had previously been adopted by the vast majority of federal courts which had considered the issue. Final regulations implementing this standard were issued December 6, 1985. Supplemental Security Income; Disability and Blindness Determinations, 50 F.R. 50, 118 (1985) (to be codified at 20 C.F.R pt. 404, 416) (hereinafter *"Medical Improvement Regulations"* or *"Regulations"*). Before termination of current disability benefits can occur, the *Regulations* require that the person's medical condition must have improved and the person can now work, or that an exception to the medical improvement requirement exists.

The key components of the *Medical Improvement Regulations* involve the definition of medical improvement and exceptions to the requirement that medical improvement be present in order to terminate benefits.

- **Medical Improvement Definition** — *Regulations*, 50 F.R. 50, 131, § 404.1594(b). Medical improvement is defined as any decrease in the medical severity of the recipient's impairment(s) which was present at the time of the most recent disability determination. This decrease must be based on improvement in the symptoms, signs, and/or laboratory findings associated with the disorder. Furthermore, the improvement must result in an increase in the person's functional capacity to do basic work activities. In comparing the person's current condition to his/her previous condition to determine if a decrease in severity has occurred, only the impairments which were documented at the earlier determination are evaluated. Additional or previously undocumented impairments are considered prior to the ultimate disability decision, but are not during the medical improvement determination.

- **Exceptions to the Medical Improvement Requirement.** There are a number of exceptions to the general rule that medical improvement must have occurred before a termination determination can be made. There are two groups of exceptions. One group addresses factors which are not directly involved with the evaluation of impairment severity and which are relatively straightforward. The factors are: a prior determination was fraudulently obtained; the recipient, without good cause, fails to cooperate with the termination review; the Social Security Administration cannot locate the recipient; the recipient, without good cause, fails to follow prescribed treatment which would be expected to restore the ability to work; and the recipient is currently working.

Ninth Circuit Strikes Down "Severity" Policy

In *Yuckert v. Heckler*, No. 84-4432, ___ F.2d ___ (9th Cir. 1985), the Court of Appeals for the Ninth Circuit recently struck down the so-called "severity" regulation, 20 C.F.R. § 404 1520(c), which permitted the Social Security Administration to find a claimant not disabled based solely on medical evidence, without regard to such vocational factors as age, education, work experience and ability to perform past work. The invalidated regulation established a five step sequential evaluation procedure for determining disability, the second step of which states:

> You [claimant] must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not have a severe impairment.

In deciding that this formulation violates the Social Security Act by ignoring the express statutory requirement that both medical and vocational factors be considered when determining disability, the Ninth Circuit joins the Third and Seventh Circuits in invalidating the sequential evaluation procedure because it does not permit the individualized assessment of disability mandated by the SSA.

The SSA has recently revised its severity policy in SSR 80-28 (Oct. 1985). Under this ruling a denial or termination of disability benefits can be supported by a finding of "not severe" only where alleged impairment is no more than a "slight abnormality" which would have minimal effect on work ability even if the person were of advanced age, had minimal education and limited work experience. This finding must be clearly established by medical evidence.

Continued on page 29

The other group contains four exceptions, some of which are more problematic. First, the recipient is the beneficiary of advances in medical or vocational therapy or technology and these advances have favorably affected the severity of the impairment or the ability to do basic work activities. Because these advances *usually* will result in a decrease in severity as shown by symptoms, signs, and laboratory findings so as to meet the medical improvement definition, this exception will have very limited application.

Second, the recipient has received vocational therapy which has increased his/her ability to work. Often this therapy will be additional education, training, or work experience that improves the recipient's job skills without necessarily affecting the level of severity of the underlying condition.

Third, new or improved diagnostic evaluative techniques demonstrate that the recipient's impairment(s) was not as disabling as it was thought to be at the time of the most recent grant of benefits. The techniques must have become generally available after the date of the most recent grant of benefits. The Social Security Administration will provide notice concerning such techniques and when they are considered to have become generally available.

Fourth, the prior disability decision granting benefits was "in error." A simple substitution of current judgment regarding the correctness of the prior determination will not satisfy the "in error" test. The erroneous decision must fall into certain enumerated categories: the decision in question is incorrect on its face *e.g.,* evidence in the file was misread or an adjudicative standard was misapplied); material evidence was missing at the earlier decision, is now available, and demonstrates that a prior decision of no disability would have been correct; and new evidence relating to the prior determination refutes conclusions based on prior evidence *e.g.,* a tumor thought to be malignant was later shown actually to be benign). □

— C. Cooper Geraty, III

12.01 Category of Impairments—Mental

12.02 Organic Mental Disorders

(Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or

2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Dementia involving loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on the Luria-Nebraska or Halstead-Reitan; and

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning: or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms.

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders* (Characterized by the onset of psychotic features with detioration from a previous level of functioning.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or,

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation; and

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms; or

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations described in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated deterioration with increased mental demands requiring substantial increases in mental health services and withdrawal from the stressful environment; or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders* (Characterized by disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not realized; or

3. Bipolar syndrome with episodic periods manifested by the full symptomatic picture of either or both manic and depressive syndromes; and

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms.

12.05 *Mental Retardation* (Developmental disorders characterized by a life-long pattern of below average intellectual functioning and a failure to develop adaptive behaviors.)

The required level of severity for this disorder is met when the requirements in A, B, or C are satisfied.

A. Severe and profound mental retardation as manifested by a failure to develop even the most primitive of self-help skills (e.g., toilet training, dressing, washing, etc.) and requiring custodial care or

B. A valid performance, verbal or full scale IQ of 59 or less; or

C. A valid performance, verbal, or full scale IQ of 60 to 69 inclusive with two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms.

12.06 *Anxiety Related Disorders* (In these disorders anxiety is either the predominate disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or

b. Automatic hyperactivity; or

c. Apprehensive expectation; or

d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress; and

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms; or

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders* (Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Psychogenic seizures; or

f. Coordination disturbance; or

g. Akinesia; or

h. Dyskinesia; or

i. Anesthesia; or

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury; and

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining sosocial functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms.

12.08 *Personality Disorders* (A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.)

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior; and

B. Resulting in three of the following;

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration and persistence resulting in frequent failure to complete tasks (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like situations which cause the individual to withdraw from that situation and/or to experience exacerbation of signs and symptoms.

12.09 *Substance Addiction Disorders* (Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.)

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Chronic brain damage. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04.

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

E. Peripheral neuropathies. Evaluate under 11.14.

F. Liver damage. Evaluate under 5.05.

G. Gastritis. Evaluate under 5.04.

H. Pancreatitis. Evaluate under 5.08.

I. Seizures. Evaluate under 11.02 or 11.03

Ninth Annual Symposium on Mental Health and the Law

Conference Center
Colonial Williamsburg, Virginia

May 29-30, 1986

Presented By

The University of Virginia
Institute of Law, Psychiatry and Public Policy
Division of Continuing Education, and
Office of Continuing Medical Education

Virginia Department of Mental Health and Mental Retardation

Program details will appear in the next issue of *Developments in Mental Health Law*

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Registration can be assured by completing the attached registration form and returning it with the appropriate fee. Please make checks payable to the Institute of Law, Psychiatry and Public Policy. Return registration to:

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Supreme Court Considers Voluntariness of Confessions

The "voluntariness" of confessions is a question of law requiring independent determination by the federal courts in habeas corpus proceedings, the Supreme Court ruled in *Miller v. Fenton*, ___ U.S. ___, *54 U.S.L.W. 4022 (Dec. 3, 1985).*

Justice O'Connor's opinion, in which the entire Court with the exception of Justice Rehnquist joined, overturned the decision of the Court of Appeals for the Third Circuit, reported at 741 F.2d 1456 (1984). The Third Circuit had ruled that, like competency to stand trial determinations and related controversies, the voluntariness of a confession was a question of fact. As such the federal court must accord the state court's finding on that question a presumption of correctness.

The Voluntariness Rubric

In reversing and remanding to the Third Circuit, Justice O'Connor stressed that the "voluntariness" of a confession was a "convenient shorthand" for the ultimate issue of conformity with due process. In reaching this ultimate question the federal courts might have to first consider such subsidiary questions of fact, as "whether a drug has the properties of a truth serum . . . or whether in fact the police engaged in the intimidation tactics alleged by the defendant." On these subsidiary questions the federal courts, pursuant to 28 U.S.C. § 2254(d), must presume the correctness of the state trial court's determination. But the federal courts have a unique responsibility independently to assure that confessions conform with the system of justice mandated by the due process clause.

This special abhorrence of convicting an individual through his coerced confession accounts in part for the Court's treating the "voluntariness" of a confession as a question of law, when, policy considerations aside, it is similar to competency to stand trial determinations, particularly if a "voluntary" confession is analyzed as a continuing, competent waiver of the *Miranda* right to terminate the interrogation and obtain counsel.

The "voluntariness" inquiry mandated by the *Miller* decision does not focus on the volitional attributes of the defendant. The particular susceptibility of the defendant to coercion may be one of the many subsidiary factual questions on which the state court determination is entitled to a presumption of correctness. But the ultimate question of whether the defendant was coerced to the extent that admission of the confession is unconstitutional is a matter of law for the federal habeas court independently to answer after examining the "totality of all the surrounding circumstances."

Miranda Waivers Not Considered

The Court, in footnote 3, declined to say whether the validity of a *Miranda* rights waiver was entitled to a presumption of correctness in a federal habeas proceeding. The Third Circuit had ruled in an earlier case that it was a question of fact entitled to the presumption. In *Miller* the defendant did not challenge the validity of the *Miranda* waivers which preceded his confession, but argued that in the subsequent interrogation his "will was overborne."

Because the Third Circuit's majority had indicated that they would have upheld the admission of the confession even on a more searching review, the Supreme Court remanded the case to the Third Circuit for reconsideration.

Other Supreme Court Actions

The Court has accepted for review a wide array of cases involving law and psychiatry, notably—

• *Galioto v. Department of Treasury*, No. 84-1904 *prob. juris. noted* 53 U.S.L.W. 2422 (Nov. 4, 1985). The court will review a decision by a federal district court in New Jersey which struck down a federal statute prohibiting the sale of guns to persons who have been adjudicated mentally defective or committed to a mental institution. C.f. 18 U.S.C. § 921 et. seq. While this statute also prohibits sales to persons convicted of certain crimes, it offers this class of persons an opportunity to apply for relief from the prohibition, an opportunity denied to persons who have been committed to mental institutions. The district court found violations of both the equal protection clause of the Fourteenth Amendment, in treating the two classes differently without a rational basis, and the due process clause, in irrebuttably presuming that persons once mentally ill were always too dangerous to be permitted to purchase firearms.

• *City of New York v. Heckler*, No. 84-1923, cert. granted ___ U.S.L.W. ___ (Oct. 7 1985). This case arose out of the Social Security Administration's policy of denying and ceasing benefits to individuals who failed to show that their impairments met the Listings. (Recent changes in the Listings are discussed on page 27 of this issue in "Social Security Notes.") The official purpose of the Listings is to "screen in" obviously eligible claims without consideration of vocational factors. But the Court of Appeals found that the SSA was using the Listings to "screen out" individuals whose impairments did not meet the Listings, without the individual assessments of residual functional capacity required by the regulations. The Supreme Court will not directly consider this misuse of the Listings which the SSA claims to have discontinued.

Continued on page 34

Continued from page 33

Instead the Court will look at the SSA's contention that the district court lacked jurisdiction over many of the plaintiff class members who failed to exhaust their administrative remedies and bring suit within sixty days of the final decision denying benefits.

• *Smith v. Sielaff*, No. 85-5487, *cert. granted* 106 S.Ct. 245 (1985). In this case the Court is asked to decide whether in the sentencing phase of a capital murder trial the prosecution can use expert testimony derived from a defense-requested psychiatric evaluation to prove aggravating circumstances. The defendant's attorney had decided that the testimony of a psychiatrist whom he had requested to perform a forensic evaluation would not assist his client and so did not call him as a witness to establish the presence of mitigating circumstances. The prosecution, over the objections of the defense, did call this psychiatrist and through his testimony may have persuaded the jury of the defendant's future dangerousness. The Court may also decide whether, if the prosecutorial use of the defense-requested evaluation is impermissible, a capital sentence can be affirmed on the basis of other "untainted" evidence of aggravating circumstances.

• *Wainwright v. Greenfield*, No. 84-1480, *argued* 38 Crim.L.Rep. 4106 (Nov. 13, 1985). Can the prosecution use the decision of the defendant to exercise his *Miranda* right to silence, two hours after the crime, to rebut an insanity defense? The Eleventh Circuit Court of Appeals found the use of the defendant's silence to be an abridgment of his fifth amendment privilege against self-incrimination and granted habeas corpus relief to a defendant who had unsuccessfully raised an insanity defense to charges of aggravated sexual battery. The case has been argued before the Supreme Court and now awaits decision.□

Protection and Advocacy of the Rights of the Mentally Ill: Congress Tries Again

Recently Congress has shown renewed interest in defining and protecting the rights of mentally ill patients in residential facilities. On July 31 the Senate passed the "Protection and Advocacy for Mentally Ill Persons Act" (S. 974) sponsored by Senator Weicker, while the House of Representatives referred a similar measure introduced by Congressmen Waxman and Bilirakis on October 3 to the Energy and Commerce Committee and reported out on November 21, 1985. (H.R. 3492)

Congressional action follows widespread disappointment with earlier federal attempts to ensure that mentally ill patients were afforded necessary minimum legal protections. Although § 501 of the Mental Health Systems Act of 1980, which contained a detailed enumeration of the rights of the mentally ill, survived the repeal of MHSA in 1981, its merely hortatory language has had small effect. Few states have actually "reviewed and revised" their laws "to ensure that mentally ill patients receive the protection and services they require" as recommended by § 501.[1] The Senate Act recommends that states take account of the bill of rights for the mentally ill outlined by the President's Commission on Mental Health, which it incorporates into the body of the Act's text; the House does not refer to a bill of rights as such but instead defines the terms "abuse" and "neglect" as they relate to mentally ill patients. Congress is now prepared to encourage state compliance by setting aside federal funds for the advocacy of the rights of the mentally ill.

House and Senate measures provide for an extension of the system of existing protection and advocacy agencies established under the Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103, 42 U.S.C. §6000 *et. seq.)*. States may apply for an allotment each year from the DHSS to protect and advocate the established rights of mentally ill persons and to investigate reported incidents of abuse and neglect.

The granting of federal funds is made conditional upon the protection and advocacy system meeting the following requirements. It must be "independent" of any agency that provides treatment services to the mentally ill; have the authority to pursue legal, administrative and other remedies to protect mentally ill persons; have reasonable access to residential facilities; be able to obtain access to records of a person who files a complaint; be provided with a copy of the state's annual survey report and plan of corrections for deficiencies in the state's residential facilities for the mentally ill; and establish a board, consisting of attorneys, mental health professionals, knowledgeable lay persons, mentally ill persons and members of their families, that advises the system on policies and priorities.

Both House and Senate bills agree on an appropriation of ten million dollars for fiscal year 1986, ten and a half million dollars for fiscal year 1987 and eleven and a quarter million dollars for 1988. Given the close similarity of the two bills, it seems likely that mentally ill patients in residential facilities may soon benefit from this Congressional action in states which apply for this support.

Notes

1. See 36 *Hospital and Community Psychiatry* 1008 (September 1985).

Virginia Legislative Proposals Concerning Forensic Psychiatry

Psychiatric Hospitalization of Jail Inmates

An interagency committee established by the Virginia Department of Mental Health and Mental Retardation and the Virginia Department of Corrections to implement the recommendations of the Joint Task Force on the Mentally Ill in Virginia's Jails (reported in the previous issue of **Developments in Mental Health Law**) recently announced its proposals for statutory reform. Chief among these is the following provision, which would amend the procedures for hospitalizing mentally ill jail inmates.

§ 19.2-169.6 Psychiatric hospitalization of jail inmates — A. An order for psychiatric hospitalization may be issued for any person who is incarcerated in a jail after a commitment proceeding conducted according to the procedures set forth in § 37.1-67.1 through § 37.1-70, as modified by the following provisions:

(i) in addition to the criteria for commitment specified in § 37.1-67.3, the judge must find that the person requires treatment in a hospital rather than in the jail;

(ii) if the person has not been tried and sentenced, his attorney, if available, shall be notified and given an opportunity to represent the person at the commitment hearing;

B. If any person hospitalized pursuant to this section has not been tried and sentenced, copies of the hospitalization order shall be provided to his attorney and to the court with jurisdiction over his case.

C. Upon issuance of a hospitalization order under this section, the person shall be presented for admission to a willing hospital designated by the Commissioner as appropriate for the treatment and evaluation of persons charged with or convicted of crime. Upon presentation of person under a hospitalization order issued under this section, a psychiatrist or a psychologist on the staff of the hospital shall conduct an evaluation of the person and determine whether he requires treatment in a hospital rather than in a jail. If the psychiatrist or psychologist determines that treatment in a hospital is not required, the person shall immediately be returned to jail.

D. Any person hospitalized pursuant to this section who has not completed service of his sentence or against whom criminal charges remain pending shall immediately be returned to the jail upon discharge.

E. In no event shall hospitalization ordered pursuant to this section be continued beyond the expiration date of the person's sentence, unless the person is committed pursuant to §§ 37.1-67.1 et. seq.; nor shall such hospitalization be grounds for a delay of trial, so long as the defendant remains competent to stand trial.

By consolidating and revising the various statutory provisions that presently govern the transfer of jail inmates to psychiatric hospitals, the proposed legislation aims at establishing a single, clear procedure that will expedite necessary transfers while protecting the due process rights of transferees. In particular, the new provision is designed to:

- Provide a uniform, consistent procedure for the hospitalization of jail inmates, whether pretrial, presentence, or postsentence. (Current § 19.2-169.6 applies only to pretrial jail detainees; procedures for the hospitalization of other inmates are derived from statutes governing civil commitment and forensic evaluation and treatment.)
- Facilitate the prompt placement (i.e., pre-hearing detention) of an inmate by eliminating the requirements of the current § 19.2-169.6 that the judge and defense attorney participate in the initial placement decision. (Under existing law, the hospitalization of a pretrial jail detainee may occur only if (1) the defendant's attorney is notified that hospitalization is under consideration and is given an opportunity to challenge the grounds for transfer and (2) the judge with criminal jurisdiction, or a judge designated by such judge, makes the requisite commitment findings.)
- Ensure that the judge with criminal jurisdiction and the inmate's attorney receive notice of the hospitalization.
- Provide for the return of the inmate to the jail upon discharge (unless his or her sentence has been completed or the charges have been dropped).
- Accommodate constitutional concerns by establishing involuntary admission procedures that differ from procedures governing the involuntary admission of persons not incarcerated *only* in those respects in which differential treatment is necessary to protect the Commonwealth's interest. The failure of the present § 19.2-169.6 to require a hearing prior to involuntary commitment may render it unconstitutional in light of *Vitek v. Jones*, 445 U.S. 480 (1980).

On November 4, 1985, Virginia's Attorney General issued an Official Opinion in which he concluded that § 19.2-169.6 provides the exclusive procedure for the psychiatric hospitalization of pretrial jail detainees (i.e., inmates awaiting trial). The requirement of current § 19.2-169.6 that the inmate's attorney and the criminal court judge participate in the hospitalization proceeding, however, frequently serves to frustrate the transfer process, particularly at night and during the weekends, when judges and attorneys may not be readily available. Accordingly, if the other transfer options (e.g., civil commitment pursuant to § 37.1-67.1), are not to be employed, the need to amend § 19.2-169.6 is compelling.

Continued on page 36

Continued from page 35

Ake Evaluations

In June, the Virginia Department of Mental and Mental Retardation established a task force to study the legislative and policy implications of the United States Supreme Court's opinion in *Ake v. Oklahoma*. (The *Ake* opinion is discussed in detail in the previous issue of **Developments in Mental Health Law.)** The task force consisted of representatives of the Attorney General's Office, Department of Mental Health and Mental Retardation administrative staff, a prosecutor, legal academics, and mental health professionals from the Forensic Unit at Central State Hospital as well as from the private sector.

The task force proposed revisions to several Virginia statutes dealing with the forensic evaluation process. These proposals were circulated for review by agencies and professional organizations throughout the Commonwealth. Subsequently, both the Attorney General's Office and the Criminal Law Committee of the Virginia Bar Association announced tentative legislative proposals patterned after those of the task force. Although important differences exist between these proposals, each would:

- make clear that the expert appointed to evaluate the defendant also is responsible for assisting in an insanity defense;
- establish a procedure for the provision of expert assistance at sentencing in capital cases;
- permit psychologists to provide expert assistance, as under current law;
- shield the results of an evaluation performed for the defense from the prosecution until the defendant gives notice of an intent to present expert testimony at the trial (and require that such notice be given at least 30 days before the trial); and
- eliminate the statutory limit on the amount of compensation that might be paid to mental health experts under §19.2-175 of the Virginia Code.

The statutory language tentatively proposed by the Virginia Bar Association's Criminal Law Committee is presented below.

§ 19.2-168. Notice to Commonwealth of intention to present evidence of insanity *or impaired mental condition;* continuance if notice not given. — In any case in which a ~~person charged with a crime~~ *defendant* ~~shall plan to present psychiatric evidence on his insanity or feeblemindedness~~ *intends (i) to put in issue his sanity or mental condition at the time of the crime charged and (ii) to present testimony of an expert to support his claim on such issue* at his trial, he, or his counsel, shall give notice in writing to the attorney for the Commonwealth, at least ~~ten~~ *thirty* days prior to his trial, of his intention to present such evidence. In the event that such notice is not given, and the ~~person~~ *defendant* ~~presents psychiatric~~ *proffers such* evidence at trial as a defense, then the ~~Commonwealth shall have the right of continuance for a reasonable period of time~~ *court shall require the defendant, or his counsel, to make disclosure of evaluation results pursuant to § 19.2-169.5 (E) and may allow the Commonwealth a continuance. The fact that the defendant, or his attorney, gave and later withdrew notice under this section shall not be admissible against the defendant at the trial.*

§ 19.2-168.1. Evaluation on motion of the Commonwealth after notice. — A. If the attorney for the defendant gives notice pursuant to § 19.2-168, and the Commonwealth thereafter seeks an evaluation of the defendant's ~~mental state~~ *sanity or mental condition* at the time of the offense, the court shall ~~order such evaluation to be performed by one or more mental health professionals, one of whom is either a psychiatrist or a clinical psychologist with a doctorate degree. Evaluators who perform the evaluation shall report their opinion to the Commonwealth and the defense~~ *appoint one or more qualified mental health experts to perform such an evaluation and shall order the defendant to submit to such an evaluation. The qualifications of the experts shall be governed by § 19.2-169.5(A). The location of the evaluation shall be governed by § 19.2-169.5(B). The attorney for the Commonwealth shall be responsible for providing the experts the information specified in § 19.2-169(C). After performing their evaluation, the experts shall report their findings and opinions to the court and to the attorneys for the Commonwealth and the defense.*

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

[8] 19.2-169.5 ~~Evaluation~~ *Appointment of mental health expert to assist defense on issue of defendant's* sanity *or mental condition* at the time of the offense; disclosure of ~~evaluation results~~ *the expert's findings.* — A. Raising issue of sanity *or mental condition* at the time of offense; appointment of *experts.* — If, at any time ~~after the attorney for the defendant has been retained or appointed and~~ before trial, the court finds, upon hearing evidence or representations of counsel *for the defendant,* that there is probable cause to believe that the defendant's ~~actions during the time of the alleged offense may have been affected by mental disease or defect~~ *sanity or mental condition is likely to be a significant factor in his defense and that the defendant is indigent and, therefore,*

unable to pay for expert assistance, the court shall ~~order that an evaluation of the defendant's sanity at the time of the offense be performed by at least one~~ *appoint a qualified mental health expert to evaluate the defendant's sanity or mental condition at the time of the offense and to assist in a defense based on the defendant's insanity or impaired mental condition. If, at any time after the attorney for the defendant has been retained or appointed and before trial, the court finds, sua sponte or upon hearing representations of the attorney for the Commonwealth, (i) that the defendant's behavior at the time of the offense may have been affected by mental disease or defect and (ii) that counsel for the defendant has made no provision for a psychiatric or psychological evaluation of the defendant's sanity or mental condition at the time of the offense, the court shall request counsel for the defendant to explain, in an ex parte proceeding before the court, why such an evaluation has not been sought. If counsel for the defendant represents (i) that he believes that the defendant's behavior at the time of the offense may have been affected by mental disease or defect, (ii) that the defendant refuses to submit to an evaluation of his mental condition at the time of the offense, and (iii) that he believes that the defendant may not be competent to make an informed decision whether to submit to an evaluation of his mental condition at the time of the offense, then the court shall conduct a hearing to determine whether the defendant is competent to make an informed decision whether to submit to such an evaluation. Before conducting the hearing, the court may order an evaluation of the defendant's competency to make such a decision pursuant to procedures specified in § 19.2-169.1. If the court finds, by a preponderance of the evidence, that the defendant, although competent to stand trial, is not competent to make an informed decision whether to submit to an evaluation of his mental condition at the time of the offense, then the court shall order such an evaluation to be performed by a qualified mental health expert. If the court finds that the defendant is competent to make an informed decison whether to submit to an evaluation, such an evaluation may be ordered only with the defendant's consent. The mental health expert appointed to evaluate the defendant's sanity or mental conditon at the time of the offense pursuant to this section (i) shall be* a psychiatrist or *a* psychologist with a doctorate degree in clinical *or counseling* psychology *and (ii) shall be* qualified by *specialized* training and experience to perform ~~such~~ *forensic* evaluations.

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

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

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

E. Disclosure of evaluation results. — ~~The summary of the evaluators' conclusions described in subsection D shall be sent to the attorney for the Commonwealth and the court.~~ The ~~full~~ report described in subsection D shall be sent solely to the attorney for the defendant and shall be deemed to be protected by the lawyer-client privilege; however, the Commonwealth shall be given the report, the results of any other evaluation of the defendant's ~~mental state~~ *sanity or mental condition* at the time of the offense, *and copies of psychiatric, psychological, medical, or social records obtained during the course of any such evaluation,* after the attorney for the

Continued on page 38

Continued from page 37

defendant gives notice of an intent to present psychiatric or psychological evidence pursuant to § 19.2-168 of the Code.

§19.2-175. ~~Expenses of physicians, etc.~~ *Compensation of experts.* — Each ~~expert or physician or clinical psychologist skilled in the diagnosis of insanity or mental retardation or other physician~~ *psychiatrist, psychologist, or other expert* appointed by the court to render professional service pursuant to §§ 19.2-166.1, 19.2-169.1, 19.2-169.5 ~~or~~, paragraphs (1) and (2) of § 19.2-181, *or 19.2-264.3:1*, who is not regularly employed by the Commonwealth of Virginia except by the University of Virginia School of Medicine and the Medical College of Virginia, shall receive a reasonable fee for ~~each such examination and report thereof to the court~~ *such service.* The fee shall be determined in each instance by the court ~~which made the appointment~~ *that appointed the expert* in accordance with ~~the relevant regulations promulgated by~~ *guidelines established by the Supreme Court after consultation with* the Department of Mental Health and Mental Retardation. ~~In no event shall a fee exceed $200, but in addition if any such expert be required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of $50 for each day during which he is required so to serve.~~ Itemized account of expense, duly sworn to, must be presented to the court, and when allowed shall be certified to the Supreme Court for payment out of the state treasury, and be charged against the appropriations made to pay criminal charges. Allowance for the fee ~~and for the per diem authorized~~ shall also be made by order of the court, duly certified to the Supreme Court for payment out of the appropriation to pay criminal charges.

§ 19.2-264.3:1. *Expert assistance where defendant's mental condition relevant to capital sentencing. — A. Appointment of expert. — Upon (i) motion of the attorney for a defendant charged with capital murder and (ii) a finding by the court that the defendant is indigent and, therefore unable to pay for expert assistance, the court shall appoint a qualified mental health expert to evaluate the defendant and to assist the defense in the preparation and presentation of information concerning the defendant's history, character, or mental condition, including (i) whether the defendant acted under extreme mental or emotional disturbance at the time of the offense; (ii) whether the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law was significantly impaired at the time of the offense; and (iii) whether there are any other factors in mitigation relating to the history or character of the defendant or the defendant's mental condition at the time of the offense. The mental health expert appointed pursuant to this section (i) shall be a psychiatrist or a psychologist with a doctorate degree in clinical or counseling psychology and (ii) shall be qualified by specialized training and experience to perform forensic evaluations.*

B. Location of evaluations; provision of information to experts. — Evaluations performed pursuant to subsection A may be combined with evaluations performed pursuant to § 19.2-169.5 and shall be governed by § 19.2-169.5B and C.

C. The report. — The expert appointed pursuant to subsection A shall submit to the attorney for the defendant a report concerning the history and character of the defendant and the defendant's mental condition at the time of the offense. The report shall include the expert's opinion as to (i) whether the defendant acted under extreme mental or emotional disturbance at the time of the offense, (ii) whether the capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law was significantly impaired, and (iii) whether there are any other factors in mitigation relating to the history or character of the defendant or the defendant's mental condition at the time of the offense.

D. Disclosure of evaluation results. — The report described in subsection C shall be sent solely to the attorney for the defendant and shall be protected by the attorney-client privilege; however the Commonwealth shall be given the report, the results of any other evaluation of the defendant's mental condition conducted relative to the sentencing proceeding, and copies of psychiatric, psychological, medical, or social records obtained during the course of any such evaluation, after the attorney for the defendant gives notice of an intent to present psychiatric or psychological evidence in mitigation pursuant to subsection E.

E. Notice to the Commonwealth of intention to present testimony by mental health expert. — In any case in which a defendant charged with capital murder intends, in the event of conviction, to present testimony of an expert witness to support a claim in mitigation relating to the defendant's history, character, or mental condition, he or his attorney shall give notice in writing to the attorney for the Commonwealth, at least 30 days before trial, of his intention to present such testimony. In the event that such notice is not given and the defendant tenders testimony by an expert witness at the sentencing phase of the trial, then the court shall require the defendant, or his counsel, to make disclosure of evaluation results pursuant to § 19.2-264.3:1[E] and may allow the Commonwealth a continuance. The fact that the defendant or his attorney gave and later withdrew notice under this secton shall not be admissible against the defendant at the guilt phase or the sentencing phase of the trial.

F. Expert assistance for the Commonwealth after notice.

1. If the attorney for the defendant gives notice pursuant to subsection E and the Commonwealth thereafter seeks an evaluation concerning the existence or absence of mitigating circumstances relating to the defendant's mental condition at the time of the offense, the court shall appoint one or more qualified experts to perform such an evaluation and shall order the defendant to submit to such an evaluation. The qualification of the experts shall be governed by §19.2-264.3: 1A. The location of the evaluation shall be governed by § 19.2-169.5B. The attorney for the Commonwealth shall be responsible for providing the experts the information specified in § 19.2-169.5C. After performing their evaluation, the experts shall report their findings and opinions to the court and to the attorneys for the Commonwealth and the defense.

2. If the court finds, after hearing evidence presented by the parties, out of the presence of the jury and prior to the sentencing phase of the trial, that the defendant has refused to cooperate with an evaluation requested by the Commonwealth, the Commonwealth may introduce otherwise admissible evidence derived from the evaluation, and the court may advise the jury, in its instructions at sentencing, that the defendant refused to cooperate with the evaluation.

G. Disclosure by defendant during evaluation or treatment; use at capital sentencing proceedings. — No statement or disclosure by the defendant made during a competency evaluation performed pursuant to § 19.2-169.1, an evaluation performed pursuant to § 19.2-169.5 to determine sanity at the time of the offense, treatment provided pursuant to § 19.2-169.2 or § 19.2-169.6, or a capital sentencing evaluation performed pursuant to this section, and no evidence derived from any such statements or disclosures, may be introduced against the defendant at the sentencing phase of a capital murder trial for the purpose of proving the "aggravating circumstances" specified in § 19.2-264.4. Such statements or disclosures shall be admissible in rebuttal only when relevant to issues in mitigation raised by the defense.

— W. Lawrence Fitch

Congress Seeks to Overturn Smith v. Robinson

Following the Supreme Court's controversial reading of the Education For All Handicapped Children Act (P.L. 94-142), in *Smith v. Robinson,* 104 S.Ct. 3457 (1984), Congress recently moved to amend the EAHCA and overturn the Court's decision. In *Smith,* the Court held (with Justices Brennan, Marshall and Stevens dissenting) that where EAHCA is applicable to a complaint presented by a parent or guardian, EAHCA is the exclusive avenue through which the claim may be asserted. Because attorneys' fees are not available under the EAHCA the Court ruled that attorneys' fees were not available to parents or guardians who prevailed in their EAHCA claims.

Both the House of Representatives and the Senate have passed (November 12, 1985 and July 31, 1985, respectively), closely similar measures to reverse the Court's interpretation of EAHCA. Their separate bills provide, first, that the parents or legal guardians of handicapped children who prevail in actions or proceedings to secure rights under the EAHCA may, at a court's discretion, be reimbursed for attorneys' fees incurred during the dispute, second, § 6.5 of the EAHCA is amended to read that nothing in the Act shall be construed to restrict or limit the rights, procedures and remedies under Title V of the Rehabilitation Act or other federal statutes (such as 42 U.S.C. § 1983), with the qualification that parents or guardians seeking relief that is also available under the EAHCA must exhaust administrative remedies under that Act to the same extent as would be required had the action been brought under the EAHCA.

Although the original House Resolution H.R. 1523, differed significantly from its Senate counterpart, most notably in the former's ambitious attempt to ensure that § 504 of the Rehabilitation Act continues to be implemented in accordance with regulations in effect on July 4, 1984, the House's final measure largely conforms to the Senate's version. The House resolution was adopted by voice vote on November 12, 1985 and it is to be expected that remaining differences between the two bills (of which the most significant concerns the method of assessing legal fees for publicly-funded attorneys), will be quickly resolved in joint conference.

It is noteworthy that both versions of the bill originally permitted parents or legal representatives of handicapped children to recover legal expenses in administrative proceedings as well as in formal court disputes. However, a last minute amendment to the House resolution provides that the authority for courts to award attorneys' fees incurred at the administrative level will terminate after four years, during which time the General Accounting Office would study the law's effects. The Senate's measure does not contain any similar "sunset" provision.

Fourth Circuit Affirms Verdict Against Buschi Plaintiffs

On October 29, 1985, the Fourth Circuit Court of Appeals affirmed the district court judgment against seven former employees at Virginia's Western State Hospital. The employeess had complained *inter alia* of a conspiracy to deprive them of their rights under the first amendment to criticize patient care and to recite only their names and job classifications when asked about the specifics of their criticisms.

Among the highlights of the Fourth Circuit's opinion in *Buschi v. Kirven*, No. 84-1280, ___ F.2d ___ (4th Cir. 1985), was its rejection of the plaintiffs' allegation that the chairwoman and counsel of the Local Human Rights Committee conspired to violate the civil rights of the plaintiffs. **Developments** editor, Willis Spaulding, served as counsel.) In affirming the district court's award of summary judgment the appeals court referred to the plaintiffs' refusal to answer the inquiries of this citizens review committee which was investigating the complaints of the state ACLU, as "an exhibition of studied contempt" and "as obvious an act of insubordination as could be imagined." Some of the plaintiffs were discharged for their refusal to comply with their supervisor's instruction to cooperate with the Local Human Rights Committee. The appeals court found no basis in the plaintiffs' account of the actions of the Committee's chairwoman or counsel, for a complaint of conspiracy.

The district court had also found that the Local Human Rights Committee defendants were entitled to quasi-judicial immunity. The appeals court found it unnecessary to reach that question because the plaintiffs had failed in the first place to state a cause of action against these defendants.

The Fourth Circuit affirmed summary judgment in favor of the state assistant attorney general who advised state officials in their termination of the plaintiffs' employment, ruling that there could be no liability under the civil rights laws for a state attorney who merely rendered advice without malice and in good faith. The Fourth Circuit also endorsed the state attorney's refusal to provide counsel to the plaintiffs at the time he was advising agency officials.

On one of the questions that went to trial, whether the plaintiffs' freedom of speech (and freedom to withhold speech) was abridged by their supervisors, the Fourth Circuit approved the district court's ruling that, although the speech involved a matter of public concern, the truth of the plaintiffs' speech was not an issue. Whether the plaintiffs' actions (or inactions) were protected by the first amendment turned instead on "the effect of such speech or activity on the efficiency, discipline and proper administration of the agency." In this holding the appeals court relied on its recent decision in *Jurgensen v. Fairfax County*, 745 F.2d 869, 880 (4th Cir. 1984) and the Supreme Court's decision in *Connick v. Meyers*, 461 U.S. 138, 150 (1983). That issue was among those submitted to the jury, which returned a verdict for the defendants.

The Court of Appeals also rejected the plaintiffs' claim that as self-styled "whistleblowers" (i.e., public employees who publicly accused their supervisors of wrongdoing) they constituted a class entitled to the benefits of 42 U.S.C. section 1985 (3).□

Virginia Supreme Court Cuts Back Coverage of Workers' Compensation

The Virginia Supreme Court recently overturned the award of workers' compensation where an injury had been sustained during the repetitive lifting of heavy weights over a period of several months. *Kraft Dairy Group, Inc. et. al. v. Bernardini*, ___ Va. ___, 329 S.E.2d 46 (1985). Describing such an injury a "cumulative trauma," the Court ruled that a worker injured in the course of "normal, repetitive work" in which the "physical exertions" that caused the injury were "inherent in the normal work" cannot claim benefit of the "injury by accident" provision of the Workers' Compensation Act (see Va. Code § 65.1-7). The Court held that because the claimant could point to "no identifiable incident or sudden precipitating event . . .to which [the] injury could be attributed" (Id. at 48) there was no accident within the meaning of the Act.

In a case decided on the same day as *Kraft Dairy*, the Virginia Supreme Court reversed an Industrial Commission award of medical expenses incurred during treatment of tenosynovitis. *Western Electric Company v. Gilliam*, ___ Va. ___, 329 S.E.2d 13. Although agreeing that this condition was a disease and that it was caused by repeated work-related trauma, the Court denied compensation on the ground that such a condition was an "ordinary disease of life," that is, a disease "to which the general public is exposed outside of the employment." The Court ruled that disability resulting from work-related aggravation of such a "disease of life" is not compensable under the Workers' Compensation Act.

While the Virginia Supreme Court has not given recent consideration to workers' compensation claims of mental impairment, these two decisions appear to rule out awards for psychiatric problems such as occupational stress, even where it is attributable to a cumulative physical trauma.□

Continued from page 26

War soldiers were noted to suffer from symptoms of anxiety, fatigue, palpitations, and weakness. This became known as "soldier's heart" and, so, much of the medical attention then centered on the cardiac symptoms of such a state.

In World War I symptoms that we would now identify as fitting the DSM-III PTSD criteria were referred to as "shell shock." The symptoms that followed combat were attributed to cerebral concussions and the rupture of small vessels in the brain, an idea probably carried over from the old "spinal concussion" concept. This theory did not, however, account for the soldier who developed a stress response following the sight of badly wounded comrades when he himself was physically unharmed.

Whether or not they had been physically injured, many World War I veterans manifested intense and prolonged symptoms, including nightmares of war which led Freud to revise his dream theory. Nightmares involving combat experiences could not be interpreted as wish fulfillments; instead, they fell "beyond the pleasure principle."[7]

The psychological casualities of World War II caused renewed interest in the issue of psychic trauma. In 1945 Grinker and Speigel,[8] discovered nineteen frequent symptoms displayed by soldiers who had seen action. These symptoms included: restlessness, irritability, fatigue, difficulty in falling asleep, anxiety, startle reactions, tension, depression, personality change, alterations in memory, tremors, poor concentration, alcoholism, preoccupation with combat, decreased appetite, nightmares, psychosomatic symptoms, irrational fears, and suspiciousness.

The emotional reaction of soldiers to the systematic destruction of their fellow man was now labelled "battle-fatigue" and regarded by the military authorities as a normal response to combat. The afflicted soldier would be removed from the immediate battle area but not sent to the rear. Treatment was administered close to the front lines and the patient returned to active duty as soon as possible. The military closely scrutinized reports of battle-fatigue, fearing an epidemic of the disorder. The military was also concerned that high incidence of battle-fatigue would be seen as evidence of low morale and ineffective leadership.

As with much else about that war, the question of battle-fatigue among American troops fighting in Vietnam continues to be controversial. In his examination of the psychiatric casualty rate in Vietnam veterans, *Stress Disorder Among Vietnam Veterans,*[9] Charles R. Feigley found that, although the incidence of battle-fatigue appears to be surprisingly low this may be due to the inadequacy of the diagnostic categories and clinical definitions employed. He pointed out that such phenomena as drug abuse, racial strife, and the "fragging" of officers by their own troops may explain why battle-fatigue did not show itself in hitherto characteristic ways. He tentatively concluded that the reported low frequency of psychiatric casualties (twelve per one thousand, compared with one hundred and one per thousand in World War II and thirty-seven per thousand in the Korean War), was achieved at the cost of epidemic character pathology. It was not so much that soldiers did not suffer from extreme stress caused by combat as that they coped with it in novel ways.

An alternative explanation ascribes the low psychiatric casualty rate to good military psychiatry, frequent rest and relaxation and the fact that troops were not in action for prolonged periods of time, implying that their stress levels rarely reached the point at which psychiatric trauma occurred.

Natural Disasters and Civilian Stress

Although the observation and analysis of psychic trauma in combat contributed much to constructing a theory of PTSD of general applicability, it remained to be shown how these clinical findings related to the civilian world. An obvious point of departure was to study civilian populations traumatized by such natural disasters as fire, flood, plane crash, and shipwreck. Mardi J. Horowitz in the book *Stress Response Syndromes*[10] proposed the unifying concept that emotional responses to diverse traumas were manifested by intrusive thoughts and dreams of the trauma and the victim's attempts to avoid such thoughts.

[F]ollowing a traumatic event, the patient experiences a repetition of the incident in the form of recurrent mental images, dreams, nightmares, or obsessive thinking.

He argued that regardless of the type of specific trauma, a careful analysis of previous studies showed that individuals' psychological responses were quite similar whether the trauma was combat, concentration camp incarceration, loss of a loved one, rape, nuclear bombing or other types of victimization. After the traumatic event, the individual would experience symptoms such as intrusive thoughts and dreams and would then make efforts to deny and avoid these thoughts and feelings.

Horowitz demonstrated that, despite the wide range of traumatic experiences, the resulting symptoms

Continued on page 42

Continued from page 41

coincided with Grinker's and Speigel's list of symptoms found in combat soldiers. He also found certain other common themes as well. These included the fear of repetition, shame over helplessness, feelings of emptiness, rage at the cause of these feelings, guilt or shame over aggressive impulses, fear of aggressivity, survivor guilt, fear of identification with victims, and sadness in relation to loss. These observations were borne out in field studies.

To test the hypothesis gleaned from previous case histories, Horowitz developed the "Impact of Event Scale" in order to measure the severity of symptoms relating to intrusion and avoidance following a traumatic event.[11] To validate the scale he took sixty-six people as experimental subjects, all of whom had experienced serious but different life stresses in the previous year (e.g., accidents that caused bodily damage, assaults, illnesses, surgery, and the death of a parent or spouse). The subjects answered a series of questions concerning their experience of intrusive thoughts and their avoidance of them during a seven day period prior to the inquiry. The results of this investigation revealed that regardless of the type of serious life stress encountered, the responses were remarkably similar.

Moving beyond these findings, Horowitz asked the question whether the "Stress Response Syndrome" also applied to experiences not generally regarded as distressing, harmful, or negative in polarity. He designed an experiment in which seventy-five health science students were shown four silent films of between six and nine minutes duration which involved either bodily injury, eroticism, cross-country running, or parent-child separation. It was found that the subjects developed intrusive and repetitive thoughts about all of the films, with the exception of that concerning cross-country running.

Horowitz suggested that normal individuals will tend to develop intrusive and repetitive thoughts after exposure to a variety of stressful events which are neither life threatening nor even particularly distressing. This study is frequently cited in discussions of how normal people cope with stressful experiences. In particular it raised the possibility that intrusive and repetitive thoughts represent an individual's attempt to gain mastery over the stressful event.[12]

DSM-III demands for a PTSD diagnosis the presence of a "recognizable stressor" that "would evoke significant symptoms of stress in almost anyone."

DSM-III

PTSD was officially recognized as a diagnostic category with the publication of DSM-III in 1980.[13] It is categorized as an anxiety disorder. The diagnostic criteria require that the symptoms are preceded by a recognizable stressor that "would evoke significant symptoms of stress in almost anyone." The diagnostic criteria also reflect the belief that the afflicted individual is reexperiencing the trauma through intrusive and recurrent thoughts, dreams, and feelings. The criteria include the numbing of responsiveness which correlated with the previously described idea of an attempt by the individual to master the traumatic event by denial. This denial may manifest itself in diminished interest, feelings of detachment, or constricted affect. The diagnostic criteria require at least two symptoms (of the six described) that were not present before the trauma.

DSM-III permits the diagnosis of a delayed or a chronic variant of PTSD. "Chronic" is defined as a duration of symptoms of six months or more. "Delayed" is defined as the onset of symptoms at least six months after the traumatic event.

Although the establishment of PTSD as a recognized type of anxiety disorder was a major breakthrough, the diagnostic criteria for the disorder present several problems, particularly in the context of litigation. DSM-III demands for a PTSD diagnosis the presence of a "recognizable stressor" that "would evoke significant symptoms of stress in almost anyone." This means that there will be some, perhaps many, individuals with all the symptoms of the disorder but to whom the diagnosis cannot be applied because the stressor preceding the symptoms is not of sufficient magnitude, as measured by the "objective" standard of the DSM-III, i.e., so severe that it would evoke symptoms in "almost anyone."

The DSM-III gives inadequate guidance as to the type of "recognizable stressor" required. This shortcoming is clinically troubling in the cases of major mental impairment following relatively minor physical injury seen, for example, in some automobile accident victims. DSM-III's restrictive diagnostic criteria do not permit the clinician to consider fully the victim's authentic, if possibly idiosyncratic, perception of a threat to personal safety and physical integrity.

For that reason clinicians often fail to agree on whether a person who witnessed the accidental death of a close relative, or, even more problematically, that of a stranger, and who manifests certain symptoms of PTSD, can be said to suffer from the disorder if "almost anyone" would not respond that way. To the usual difficulties of diagnosis, DSM-III adds the impossibility of generalizing about the response of "almost anyone" to what is almost by definition an extraordinary experience. In a courtroom setting, the lack of a consensus among clinicians about the use of this diagnosis would make almost anyone wary of accepting expert

opinions on the existence and severity of the psychic trauma.

The Proposed Revision of DSM-III

Soon the American Psychiatric Association will vote on whether to accept the August 1985 proposed revision of the PTSD criteria of DSM-III.[14] In the proposed revision, PTSD is again placed under the general heading of anxiety disorders.

The first part of the revised diagnostic criteria clarifies the term "recognizable stressor" by defining it as "an event that is outside the range of usual human experience and that is potentially psychologically traumatic — e.g., serious threat to one's life or personal physical integrity, destruction of one's home or community, or seeing another person who is mutilated, dying or dead, or the victim of physical violence."

Further, the revision acknowledges that reactivity to intense psychological stress may develop following exposure to subsequent events that "symbolize or resemble an aspect of the traumatic event" (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator). The diagnostic criteria would allow the delayed onset of PTSD to be found, but it abandons the concept of chronic PTSD.

The revised diagnostic criteria could have several important consequences. By describing the required "recognizable stressor" as "an event outside the range of usual human experience" rather than as one so severe "as to evoke significant symptoms of distress in almost everyone" and by giving concrete examples of stressors that would now qualify, many new violent occurrences will qualify without controversy as stressors causing PTSD. This revised formulation makes better use of knowledge gained from historical, military, civilian and experimental psychiatric experience, which emphasizes the importance of the victim's own perception of the threat to safety, physical integrity, and permanence. Most importantly, the determination that a stressor is outside the range of ordinary human experience is perhaps less speculative, and no less specific, than the determination that the stressor is one that would cause symptoms in "almost anyone."

Litigation may be affected if the revised diagnosis of PTSD is adopted. Tort claims of mental impairment caused by a psychic trauma could meet with greater certainty the proposed diagnostic criteria, than those in the current DSM-III. To the extent that the DSM-III's "objective" restrictions on stressors have deterred the prosecution of psychic trauma claims or their acceptance by the courts, there will be a rise in the number of litigants seeking a tort remedy for this disorder. But since the revision offers a more clinically valid, and legally relevant, set of criteria, time-consuming and costly disagreement among mental health professionals in and out of the courtroom may be reduced, and settlements facilitated.

While the number of fraudulent claims may increase as well, the technique of discovering malingered or pretended PTSD would not change with the adoption of the DSM-III revisions. The detection of these claims would continue to rest upon a careful forensic evaluation of the individual's response to the traumatic event.

Regardless of how the APA votes on the proposal to change the formulation of the PTSD diagnosis, it will remain critical for the forensic evaluator to establish causation by ensuring that the claimant's symptoms are genuinely experienced by the claimant were not present to the same degree before the alleged psychic trauma. Multiple and separate assessments, properly recorded, made by detached observers, both before and after the alleged traumatic event must provide a basis for the accurate appraisal of PTSD claims.□

Notes

1. Very recently, for example, Nebraska joined the growing minority of jurisdictions (16 to date) that allow, with certain limitations, bystander recovery for the negligent infliction of psychic trauma. *James v. Lieb* ___ Neb. ___, 375 N.W.2d 109 (1985). The Nebraska Supreme Court abandoned the zone-of-danger rule, whereby a plaintiff-bystander could only recover if he personally had been in danger of physical injury. The Court in *dictum* went on to say that it will no longer require plaintiffs claiming psychic trauma to plead and prove the presence of physical symptoms.
2. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Proposed Revisions* 4 (1985).
3. Quoted in Trimble, *Post-Traumatic Neurosis from Railway Spine to Whiplash* 5 (1981).
4. *Id.* at 9.
5. *Id.* at 18-20.
6. Breuer & Freud, "On the Theory of Hysterical Attacks," 5 *Collected Papers of Sigmund Freud* 27 (Strachey ed. 1957).
7. Freud, "Beyond the Pleasure Principle," 18 *Standard Edition of the Complete Psychological Works of Sigmund Freud* (Strachey ed. 1953-1966).
8. Griker & Speigel, *Men Under Stress* (1945).
9. Feigley, *Stress Disorders Among Vietnam Veterans* (1978).
10. Horowitz, *Stress Response Syndromes* (1976).
11. Horowitz *et al.*, "Signs and Symptoms of Post-Traumatic Stress Disorder" 37 *Archives of General Psychiatry* 85-92 (1980).
12. Horowitz & Wilner, "Stress Films, Emotion and Cognitive Response" 33 *Archives of General Psychiatry* 1339-1344 (1976).
13. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 238 (3d ed. 1980).
14. *Supra* note 2.

Youth Advocacy Program

The Youth Advocacy Clinic of the T.C. Williams School of Law, University of Richmond, is offering a continuing legal education seminar entitled "An Advocate's Guide to Meeting the Needs of the Handicapped Child Through Special Education." The event will be held on Friday, February 28, 1986 at the Law School. For further details contact Martha A. Schick, Administrative Assistant, Youth Advocacy Clinic, T.C. Williams School of Law, University of Richmond, Richmond, Virginia, 23173.

Developments in Mental Health Law
Box 100
Blue Ridge Hospital
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