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

Developments in Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 6, Nos. 1-2 January-June 1986

Ruling could lead to new programs for mentally disabled

Fourth Circuit discovers right to treatment

by Willis J. Spaulding

A mentally disabled client of a community mental health program has a constitutional right to appropriate services, even if that means creating new and costly programs for that client. This important ruling is now the law in the states within the jurisdiction of the Fourth Circuit Court of Appeals.

On January 9, 1986, the Fourth Circuit Court of Appeals affirmed the order of a federal District Court in North Carolina, requiring the state to transfer its former patient from an inappropriate commmunity placement to a "stable suitable supervised community residential placement such as (1) a non-institutional specialized adult foster care situation . . . or (2) a group home with adults of average intelligence," and provide him with an array of non-residential services such as counseling, adult education and vocational training.

Youngberg v. Romeo applied to community placement

In *Thomas S. v. Morrow,*[1] the Fourth Circuit relied on the 1982 Supreme Court ruling in *Youngberg v. Romeo*[2], a case involving a resident of Pennsylvania's Pennhurst State School. In *Youngberg* the Supreme Court discovered in the Fourteenth Amendment's Due Process Clause substantive rights to food, clothing, shelter, safety, freedom from undue restraint, and treatment that was sufficient to protect the resident's rights to safety and freedom from undue restraint. The resident in *Youngberg,* Nicholas Romeo, had been placed in mechanical restraints for long periods of time, and had been injured by his own actions and by other residents of Pennhurst on numerous occasions. The members of the Court agreed that the Constitution gave him a right to enough treatment to prevent the undue use of mechanical restraints and to prevent an unreasonable risk of injury.

In *Thomas S.* the Fourth Circuit said that the plaintiff, who neither had been placed in mechanical restraints nor had suffered any physical injury, possessed the same constitutional right to treatment. The fact that Thomas S. had been discharged from the state hospital during the pendency of the litigation and was living in the community did not diminish the importance of his liberty interest in freedom from undue restriction. The restrictions imposed on Thomas S. consisted neither of mechanical restraints, nor even involuntary hospitalization, but of the appointment of a guardian with the power to select the ward's domicile and in the nature of the treatment provided by the state. These were the state-imposed restrictions which gave Thomas S. a right to sufficient treatment from the state to reduce the restrictions to a reasonable level in light of the circumstances of his case.

Thomas S. became a ward of the state at birth in 1963. At age eighteen he was adjudicated incompetent and a guardian was appointed for him. By the time of the District Court decision he had lived in forty different

Continued on page 2

Also in this issue

Continued from page 1

placements, including foster homes, group homes, children's homes, state hospitals, and a detoxification facility. He was given diagnoses of mental retardation at one point, emotionally disturbance at another, and finally, "adjustment disorder with mixed emotional features." At the time he brought his lawsuit in 1982 against state and local mental health administrators and his guardian, he had been committed for a second time to a state hospital. When the District Court entered final judgment in favor of Thomas S. in December, 1984, he was residing in a detoxification center, not because he was an alcoholic, but, in the view of the Court of Appeals, because of "expediency and a desire to save money."

Lack of funds no defense

Lack of funds may be a defense to monetary damages under *Youngberg*, but it was not a defense to the prospective, injunctive relief sought by Thomas S. The Fourth Circuit's rejection of the defendants' claim that the state could not afford to provide Thomas S. with the kind of services he was demanding is susceptible to two slightly different readings.

Cost, Judge Butzner said at one point on behalf of the Court of Appeals, is a factor which qualified professionals may take into account in prescribing treatment, but only until fiscal considerations so distort treatment decisionmaking that it becomes a "substantial departure from accepted professional judgment." If this is so, perhaps the defendants' expert testimony was rejected not because it was concerned in part with costs, but because as a matter of law it otherwise fell below the professional judgement standard. Under this reading the Fourth Circuit did not rule out the successful reliance on a lack of funds defense in future right to treatment claims.

Another interpretation of the Fourth Circuit ruling is that the defendant may, but in this case did not, raise an affirmative defense that the professional judgment upon which the plaintiff relies fails altogether to take cost into consideration, or makes prohibitively costly recommendations. The Fourth Circuit noted that there was no reason to believe in this case that the various qualified professionals, including the state hospital staff, had made prohibitively costly treatment recommendations. This language suggests that under different circumstances a court might consider evidence on prohibitive costs, despite otherwise unimpeachable and unanimous professional judgment supporting the plaintiff's position.

Under either rationale, a defense which just maintains that the relief sought will cost the state something, or will entail reshuffling resources, should not survive the plaintiff's motion for summary judgment. And although the Court of Appeals seems to have left the door open for some kind of balancing between what is appropriate and what is practical in future cases, just how this balancing can be achieved in a manner consistent with the professional judgment rule remains to be seen.

The Fourth Circuit's equivocal response to the defense of budgetary constraints differed from that of the District Court. The District Court viewed professional judgment and budgetary considerations as independent, or even mutually exclusive, concepts, suggesting that:

> Lack of funding or of established alternatives is not a factor which may be considered in determining the scope of this constitutional right [to minimally adequate treatment].
>
> * * *
>
> To the extent that a professional's judgment is shown to have been modified to fit what is available, that judgment *likely* has become a "substantial departure from accepted professional judgment, practice, or standards."[3] [Emphasis supplied.]

Another recent decision, *Clark v. Cohen*[4], compelling community placement of a forty-four year old, mildly retarded resident of Pennsylvania's Laurelton mental retardation center, went even further to stress that a professional judgment, to be entitled to judicial deference (or, maybe, any weight at all), "has to be one based on medical or psychological criteria and not on exigency, administrative convenience, or other non-medical criteria."

The defense of lack of funds may have been less persuasive in the cases of *Thomas S.* and *Clark* because they were not class actions, in which the relief sought would require a major reallocation of state funds. Indeed, in both of these cases the costs of the appropriate community placement may turn out to be less than what hitherto has been provided to the plaintiffs. Still, either the Fourth Circuit's partial, or the District Court's simpler, wholesale elimination of fiscal considerations from the professional judgment standard, marks a dramatic development in the right to treatment both in practical and doctrinal terms. If adequacy of treatment is to be measured only by reference

Developments in Mental Health Law

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

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

Editor
Willis J. Spaulding

Managing Editor
Lynn A. Daidone

Assistant Editor
Jonathan A. M. Schnyer

Circulation Manager
Therese R. Wood

Guest Contributor
W. Lawrence Fitch

to the plaintiff's needs, the relief awarded may result in a proliferation of community programs where none existed before, and in that way a redefinition of treatment itself.

Lack of control rejected as a defense

The defendant had argued that Thomas S.'s "right to liberty of movement and freedom from undue restraint" had not been compromised because he "lives in the community and is not subject to the control of the state." The record showed that in the twelve months preceding the District Court's final order of December 7, 1984, Thomas S. had resided in a group home for developmentally disturbed adults and, at the time of the order, a detoxification facility.

By contrast, the plaintiff in *Youngberg* had been in mechanical restraints. Discharge from the institution to a community placement was not a consideration. It was in that factual context that the Supreme Court agreed that he was entitled to sufficient treatment to prevent an undue restraint of his freedom (and undue risk of injury). The members of the Court sharply disagreed on whether the Constitution assured a right to treatment, independent of that treatment needed to prevent undue bodily restraint, and might have been thought to have left open the question of whether there was a right to treatment once the patient's condition permitted freedom from mechanical restraint and discharge from an institution.

The Fourth Circuit implied that, compared to Nicholas Romeo, Thomas S. had an equally strong, and perhaps stronger, claim to treatment. The point of the Supreme Court's recognition of Romeo's right to freedom from undue restraint was that the right did not arise from but *survived* institutionalization, although diminished both by the nature of institutional life and by the reduced functioning that led to institutionalization. The constitutional right to freedom from undue restriction was, if anything, greater and more susceptible to compromise, in the case of a relatively highly functioning adult capable of life in a community placement.

The relief. . . may result in a proliferation of community programs. . . and in that way a redefinition of treatment itself.

It is not altogether surprising that the courts in *Thomas S.* found that restrictions short of mechanical restraints and involuntary hospitalization could give rise to a right to treatment. Two months after the *Youngberg* decision was handed down, the North Dakota District Court in *Association for Retarded Citizens of North Dakota v. Olson*[5] interpreted Justice Powell's opinion in *Youngberg* to affirm a "constitutional right to the least restrictive method of care or treatment" whenever "professional judgment determines that such alternatives would measurably enhance the resident's enjoyment of basic liberty interests."

In the North Dakota case the District Court left no doubt that its concern for this right continued well past the point where mechanical restraints were no longer a consideration. For example, enjoyment of this right would entail trips into the "outside communities," and "the opportunity to make small personal decisions concerning what to wear, what to eat, recreation, etc.," and, if prescribed by professional judgment, placement in a group home.

In determining whether there was sufficient state control to give rise to a right to treatment, the North Dakota court ignored the classification of patients as "voluntary" or "involuntary," because either the "voluntary" patients lacked the capacity to give informed consent, or if they had the capacity, their consent was not truly voluntary "in light of pressures from family and the high cost and unavailability of alternative care."

For the North Dakota court, and most courts which have had occasion to apply *Youngberg*, liberty, the undue restriction of which results in a right to treatment, has meant more that just freedom from the undue application of mechanical restraints within an institution. If, in the words of the North Dakota court, these liberty interests are violated whenever alternative treatment, irrespective of cost, would "measurably enhance the resident's enjoyment" of those interests, then perhaps just the provision of inappropriate "voluntary" or "involuntary" treatment in the public sector might be sufficient state control of the client to trigger a judicial review of treatment adequacy. And in cases where the state has chosen to withdraw both treatment and formal, legal restrictions from a former patient, a court might be willing to consider whether a constitutional right to treatment had been abridged, if, professional judgment, independent of fiscal considerations, indicates that continuing treatment would "measurably enhance the . . . enjoyment" of the patient's freedom of movement, or protect him from an unreasonable risk of harm.

The court viewed guardianship, together with the state's authority over the provision of treatment itself, as a sufficient showing of the kind of state control which gives rise to a right to treatment.

The Court of Appeals in *Thomas S.* did not have to go that far to find state control of the plaintiff. Thomas S. was subject to the authority of guardian who in North Carolina had the power to admit him to community facilities. The court viewed guardianship, together with the state's authority over the provision of treatment itself, as a sufficient showing of the kind of state control which gives rise to a right to treatment. Whether state or local treatment alone, unadjudicated incompetency alone, or treatment with less than truly voluntary, informed consent would satisfy the threshold requirement of some state control is an intriguing question left open by the Fourth Circuit.

Continued on page 16

In the Virginia General Assembly

Below are summaries and analyses of bills passed by the 1986 Virginia General Assembly and signed into law by the Governor which Developments in Mental Health Law *monitored during this year's legislative session.*

Two of the new laws, both concerning forensic evaluations, are analyzed in depth by Larry Fitch, beginning on page six.

Temporary detention order in civil commitment

Questions under Virginia civil commitment law have sometimes been raised about the fairness of the practice of detaining a person under the authority of either a "stale" temporary detention order (TDO), issued several days earlier, or a TDO based on a petition filed sometime in the past. A 1986 amendment specifies for the first time the time period during which a TDO may be executed (i.e., by taking the person proposed for commitment into custody), and the time period following the filing of a petition for commitment during which a judge or magistrate may issue a TDO on the basis of that petition.

Under the amendment, a petition for commitment, and any TDO issued on the basis of that petition, become void if the TDO is not executed within ninety-six hours after the petition is filed. The TDO also becomes void if not executed within twenty-four hours of being issued, or, if the judge or magistrate so indicates, a shorter period. Another TDO based on the same petition may be issued, provided it is both issued and executed within the ninety-six hour period following the filing of the petition.

Virginia law permits a judge and magistrate to issue a TDO either on the basis of a sworn petition or "on his own motion." A TDO, based on the judge's or magistrate's own motion, is common in some parts of the state when it is difficult to obtain a petition and file it in the clerk's office promptly. Since Virginia statutory law does not provide authority for law enforcement officers to detain persons in a psychiatric emergency without a TDO, the issuance of the TDO is sometimes expedited by contacting the judge or magistrate over the telephone. The judge or magistrate who then makes, verbally or in writing, a TDO, and does not have a sworn petition in front of him, acts solely on "his own motion."

The new amendment does not specifically bar a judge or magistrate, based on his own motion, from issuing or reissuing a TDO after a petition has been filed and has become void. But the unmistakeable intent of the new law is to require the judge or magistrate to take a fresh look at the facts alleged to support detention no later than ninety-six hours after the commitment process is initiated by petition or an informal request that the judge or magistrate act on his own motion.

SB 73; Chapter 478; amending § 37.1-67.1.

The CSB role in commitment

The role of the community services board (CSB) in civil commitment proceedings was expanded substantially by several laws enacted in 1986. Community services boards provide most local mental health, mental retardation and substance abuse services in Virginia. As a result of these new laws, CSBs will now have the following additional responsibilities:

- designating the public facility to which the committed patient will be sent, if he or she is not committed to a private hospital. Previously the state Commissioner of Mental Health and Mental Retardation made the designation.
- determining the appropriate outpatient placement when the court decides that there is a less restrictive alternative to inpatient placement. Previously the court was charged with making the designation.
- approving transfers of patients from state hospitals to private or Veterans' Administration hospitals.
- screening all persons proposed for committment. Prior law exempted from screening persons who had been examined at some point by a psychiatrist or clinical psychologist. The amendment will exempt from screening only persons in the custody of the Department of Corrections.
- preparing predischarge plans of patients in state hospitals in conjunction with the hospital. A new law will require both more comprehensive and more uniform planning. New elements of all plans include a specification of all income subsidies for which the patient will be eligible and all services which would be appropriate for the patient but which are currently unavailable.
- conducting an annual needs assessment, inventory of available services, and estimate of expected utilization of those services in part to insure that the CSB has the capability to perform these additional duties.

Because of the increased role of the CSB in all commitment proceedings, it will no longer be necessary for the court to notify the CSB of all commitments.

HB's 446, 447 and SB's 245, 246; Chapters 349, 176, 309, and 609; amending §§ 37.1-67.3, 37.1-98, and 37.1-198.

Licensure of psychologists

Until now, a psychologist practicing in the public sector in Virginia has not been required to be licensed, even when moonlighting in private practice. A new law will eliminate entirely his or her exemption from licensure in private practice, and in the public service, his or her practice must be supervised by a licensed psychologist or licensed clinical psychologist. School psychologists instead may be certified by the Department of Education or simply employed by a certified school for the handicapped.

HB 470; Chapter 581; amending § 54-944.

Pilot programs for the chronically mentally ill

An important joint resolution of the General Assembly was adopted in the 1986 Session calling for the creation of several pilot programs to improve the delivery of services to the

chronically mentally ill in the community. The resolution directs the state Secretary of Human Resources to develop the following programs, using personnel from different agencies and the $600,000 in funds earmarked for this purpose:

1. *Domiciliary care.* Implementation plans should be developed for a pilot project which, to the extent feasible, uses currently vacant state hospital buildings to provide a highly supervised domiciliary care center for chronically mentally ill clients who cannot function successfully in existing community services without intensive supervision. Consideration should be given to contracting for operation of the center, which would provide a range of program activities and community contacts, and to requiring the community services boards serving the affected catchment area to screen admissions.

2. *Local Service Management.* Implementation plans should be designed to test means of shifting responsibility for inpatient placements to community services boards. The boards should be given control over inpatient funds and authorized to determine appropriate placements from among state hospitals, local hospitals, and other community treatment alternatives. The design for this project should include efforts to develop criteria for use of public or private mental health hospitals and to provide necessary community service capacity, including case management, mobile crisis intervention, purchase of local inpatient services and short-term residential alternatives. Consideration should also be given to criteria for implementation and enforcement of existing outpatient statutes; to improved methods of distributing state funds to the boards; and to improved methods of monitoring a locally based system by the Department through on-site review, a sampling of case records, and other appropriate methods.

In addition, the Secretary of Human Resources shall plan and initiate, to the extent possible, implementation of the following two programs:

1. *Family Support.* A pilot project should be developed and implemented to serve low-income families with a mentally disabled member who is at risk of institutionalization because of depletion of family resources. Participating families should be provided with funds to purchase in-home support, respite care and other services needed to avoid unnecessary institutionalization.

2. *Management Information System.* A management information system sufficient to provide effective oversight and accountability should be planned and initiated, to the extent possible. The model system should incorporate data for existing and new board activities for the chronically mentally ill; data should address client characteristics, utilization rates, unit costs and tracking information. It should be useful for clearly formatted and meaningful management reports.

SJR 53.

Group homes

In reaction to the Virginia Supreme Court's decision in *Omega v. Malloy* [discussed 4 *Developments in Mental Health Law* 18 (July-December 1984)] the state legislature limited the ability of developers to bar group homes through the use of deed covenants restricting the use of the property to "residential" use or occupancy by single families. The new law will only apply to restrictive covenants executed after July 1, 1986.

To be immune from a single family or residential restrictive covenant, the group home must consist of no more than six handicapped persons and at least one resident counselor or other staff person. The kinds of handicapped persons protected by the new law include "physically handicapped, mentally ill, mentally retarded or developmentally disabled peresons." Efforts to specifically exclude substance abusers from the benefits of the law failed.

The new law emphasizes the continuing authority of local government to regulate the location of group homes through zoning ordinances. Another law enacted in 1986 gave county governments the authority to inspect and regulate group homes and similar facilities and to prevent the use of those facilities "when it is found that the safety of persons housed therein is adversely affected."

HB's 207 and 206; Chapters 574 and 159; amending §§ 36-91 and 15.1-510.8.

Adult protective services

Two new laws will improve the ability of the Virginia Department of Social Services to provide adult protective services to mentally disabled persons. One law expands the categories of persons required to report whenever they suspect that an adult is abused, neglected, or exploited, and for the first time specifies a penalty for failure to report adult abuse. The other new law addresses the need of the Department to obtain access to persons believed in need of services, when that access is denied, by providing a process for obtaining a court order compelling access.

The categories of persons who must report suspected adult abuse, neglect, or exploitation, will now include, in addition to health care providers, "any person employed by a public or private agency or facility and working with adults, [and] any person providing full-time or part-time care to adults for pay on a regularly scheduled basis."

The penalty for failure to make a mandatory report will now be not more than $500 for the first offense, and not less than $100 and not more than $1000 for any subsequent offense.

When the Department of Social Services is denied by a third party access to a person believed to be in need of protective services, or to his residence, they can now petition the circuit court for a court order. The court may enter this order on the basis of a sworn affidavit or testimony which establishes that a report that someone is in need of protective services has been received and that a third party has denied the Department access. The statute does not require notice of the court hearing

Continued on page 12

Virginia's New Forensic Evaluation Laws

Among the bills involving mental health law passed by the Virginia General Assembly in the 1986 session, the most notable for forensic examiners is HB 641. This bill, sponsored by Del. Samuel Glasscock (D-Suffolk), significantly alters procedures for the assignment of mental health experts in criminal cases.

The new law, which takes effect July 1, is designed to implement the United States Supreme Court's decision last year in *Ake v. Oklahoma*, ___ U.S. ___, 105 S.Ct. 1087 (1985). As discussed in more detail in a previous issue of *Developments in Mental Health Law* (Vol.5, Nos. 1-2), the *Ake* decision recognized the right of a criminal defendent to independent "psychiatric assistance" (1) when the defendent's "sanity" at the time of the offense is likely to be a significant factor at trial and (2) when the defendent's mental condition is relevant to sentencing in a capital case.

The primary objectives of the changes in Virginia law are (1) to establish a procedure for the provision of expert assistance at sentencing in capital cases, (2) to assure the defendent access to consultative as well as evaluative expert assistance, (3) to promote the independence of the expert assigned for the defense, (4) to recognize the qualification of psychologists to provide this assistance, and (5) to allow for reasonable compensation of court-appointed experts. The following is an unofficial section by section commentary. The amended law precedes each comment.

§ 19.2-169.5. Evaluation of sanity at the time of the offense; disclosure of evaluation results.—*A. Raising issue of sanity at the time of offense; appointment of evaluators.* - If, at any time 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 sanity will be a significant factor in his defense and that the defendant is financially unable to pay for expert assistance, the court shall appoint one or more qualified mental health experts to evaluate the defendant's sanity at the time of the offense and, where appropriate, to assist in the development of an insanity defense. Such mental health expert shall be a psychiatrist or a clinical psychologist with a doctorate degree and shall be qualified by training and experience to perform such evaluations. The defendant shall not be entitled to a mental health expert of his own choosing or to funds to employ such expert.

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 sanity 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 necessay to perform an adequate evaluation of the defendant's sanity at the time of the offense, but not to exceed thirty days from the date of admission to the hospital.

C. Provision of information to evaluators. - The court shall require the party making the motion for the evaluation, and such other parties as the court deems appropriate, to provide to the evaluators appointed under subsection A any information relevant to the evaluation, including, but not limited to (i) copy of the warrant or indictment; (ii) the names and addresses of the attorney for the Commonwealth, the attorney for the defendant and the judge 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; (v) any available psychiatric, psychological, medical or social records that are deemed relevant; and (vi) a copy of the defendant's criminal record, to the extent reasonably available.

D. The report. - The evaluators shall prepare a full report concerning the defendant's sanity 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 report 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 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 sanity at the time of the offense , and copies of psychiatric, psychological, medical, or other 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 pursuant to § 19.2-168 of the Code.

Originally enacted in 1982, this section prescribes the procedures that govern evaluations of a defendant's mental state at the time of an alleged offense. Until this year, the statute authorized court-ordered evaluations upon a finding of "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." In its amended form, the statute provides for the appointment of an expert upon a finding of "probable cause to believe that the defendent's sanity will be a significant factor in his defense. . . ."

This revised language is drawn directly from the Supreme Court's opinion in Ake, a case in which the insanity defense was an issue. Prior to this amendment, it had been possible to invoke § 19.2-169.5 to obtain an evaluation whenever the defendent's mental condition was relevant, whether or not the insanity defense was an issue. The Virginia Supreme Court's decision last year in *Stamper v. Commonwealth*, 228 Va. ___ (1985), however, apparently rejecting the diminished capacity defense (i.e., expert testimony on *mens rea*), significantly restricted the opportunity to present evidence of the defendent's mental state at the time of the offense in the absence of an insanity defense. But, it might be argued, that opportunity was not barred altogether. Certainly, for example, the defendant attempting to negate the *actus reas* element of the offense charged (i.e.,, the voluntary act requirement) would wish to present the testimony of an expert to show that, because of some mental or physical disability (e.g., epilepsy, dissociation, concussion), his or her behavior at the time of the offense was automatic (i.e., not within his or her conscious physical control) and therefore not culpable.

Assembly Amends Jail to Hospital Transfer Laws

In order to facilitate the psychiatric hospitalization of persons in jail awaiting trial and in need of emergency treatment, the Virginia General Assembly in 1982 enacted Virginia Code § 19.2-169.6. This law authorized the judge with jurisdiction over the jail inmate's criminal case to order the inmate hospitalized upon a finding that the inmate met certain admissions criteria in the opinion of a qualified mental health professional. Before the hospitalization could occur, the inmate's attorney had to be notified and given an opportunity to object to the findings of the mental health professional, but no hearing was required.

A task force appointed in 1984 to study the problems of the mentally ill in Virginia's jails found that, while the hospitalization procedure prescribed by § 19.2-169.6 in fact was quite useful in many cases, in others it could not be used at all, either because the criminal court judge was unavailable to order the commitment or because the inmate's criminal defense attorney could not be located and given an opportunity to object to the findings of the mental health professional. In these cases in most localities in the state, the task force found, civil commitment pursuant to § 37.1-67.1 *et seq.* was employed.

But, last fall Virginia's Attorney General issued an advisory opinion that the civil commitment procedure no longer should be used in these cases — that § 19.2-169.6 provides the exclusive legal basis for the hospitalization of persons detained in jail prior to trial. In a separate opinion, the Attorney General's Office advised that civil commitment also was inappropriate for jail inmates who had been convicted but were awaiting sentencing — that § 19.2-176 provides the sole legal basis for hospitalization in these cases. Inmates tried, convicted, and sentenced could be civilly committed, the AG's Office stated informally, because no other law exists for the hospitalization of this population.

In reaction to these rulings, several bills were introduced in the 1986 General Assembly session to provide alternatives to the procedures specified in §§ 19.2-169.6 and 19.2-176 for the hospitalization of jail inmates — alternatives that would make emergency hospitalization possible in the absence of the criminal court judge or the inmate's criminal defense attorney. The laws that ultimately were passed, which take effect July 1, represent a compromise of the various bills that were introduced. Although these laws do, indeed, enable emergency hospitalization under practically any circumstance, the procedures they prescribe potentially are confusing and raise problems of their own.

While leaving the existing hospitalization procedures essentially intact (i.e., while continuing to allow for hospitalization on order of the criminal court judge, with no requirement that a formal commitment hearing be held), the new laws provide as an alternative that the inmate may be hospitalized pursuant to a temporary detention order (TDO) issued in accordance with procedures specified in the civil commitment law, § 37.1-67.1. The inmate must be hospitalized in a facility designated by the Commissioner of Mental Health and Mental Retardation as appropriate for persons under criminal charge. No right to make application for voluntary admission is recognized. Subsequent commitment hearings must be held in the court with jurisdiction over the inmate's criminal case. For inmates hospitalized pursuant to a TDO, this hearing ordinarily must take place within 48 hours. For inmates hospitalized by the court with criminal jurisdiction, no hearing is necessary until the expiration of 30 days.

At least in those cases in which the hospitalization is initiated by a TDO, it is expected that the new laws will impose heavy demands on officials responsible for transporting inmates back and forth between the community in which the inmate was jailed (and where the court with criminal jurisdiction is located) and the community in which the designated hospital is located. In addition, heavy

Continued on page 12

Similarly, the defendant who intends to raise the defense of involuntary intoxication, or who raises voluntary intoxication as a defense to a charge of premeditated murder, would wish to consult with an expert prior to trial. Whether such assistance might be expected under this revised provision is unclear.

Although it is possible to read the *Ake* decision narrowly, to require the provision of expert assistance only in those cases in which the defense of insanity is raised, it is unlikely that the constitutional principles on which *Ake* was decided are so narrow. Rather these principles seem to require the provision of expert assistance whenever the defendant's mental condition is relevant to his or her culpability. Accordingly, it can be argued that the term "insanity" in § 19.2-169.5 should be interpreted broadly to refer to any abnormal mental condition regarded by the substantive law as relevant, whether or not presented in the form of an insanity defense.

In its original form, § 19.2-169.5 was ambiguous as to whether an evaluation of the defendant's mental state at the time of the offense could be requested by either the defense or the prosecution or only by the defense. In its revised form, it is clear that, at least initially (i.e., prior to the defendant's giving written notice that he or she intends to present evidence of insanity at the trial), only the defense attorney may request an evaluation. The statute also makes it clear that court-ordered evaluations are available only to defendants who are "financially unable to pay for expert assistance." (Defendants able to pay presumably may arrange for such evaluations privately.) Finally, the statute provides that "the defendant shall not be entitled to a mental health expert of his own choosing or to funds to employ such expert." Rather, the court may appoint any qualified expert who is available to provide independent assistance on the defendant's behalf.

Drawing directly from the holding in *Ake*, the amended version of §19.2-169.5 provides that the expert appointed for the defense is expected not only to evaluate the defendant but also, "where appropriate, to assist in the development of an insanity defense." In *Ake*, the United States Supreme Court spoke of the defendant's right to an expert to assist in the "evaluation, development, and presentation of the defense," including "determining whether the insanity defense is viable" and "preparing the cross examination of state's psychiatric witness." Presumably, this level of assistance is contemplated by the amendments to § 19.2-169.5

With regard to the kinds of experts who might be appointed in these cases, the new law provides that psychologists as well as psychiatrists may continue to serve as in the past. Much has been made of *Ake's* reference to the defendant's right to the assistance of a "competent psychiatrist." Very few, however, seriously have suggested that the Court intended by this to restrict the pool of potential experts to those trained in psychiatry. Indeed, even Joel Klein, counsel for the American Psychiatric Association and author of the APA's amicus brief in the *Ake* case (a brief to which, incidentally, the Court's opinion in *Ake* bears a striking resemblance), has acknowledged that the Court's use of the term "psychiatrist" was intended to refer generically to the kinds of mental health professionals otherwise qualified under the law to provide expert assistance in these cases. (Address by Joel Klein, J.D., at the Sixth Annual Conference of the National Association of State Mental Health Forensic Directors, San Francisco, CA, September 19, 1985.)

With regard to the qualifications required of psychologists, the law in Virginia has long been unclear. The 1982 amendments authorized evaluations of a defendant's mental state at the time of the offense by psychiatrists, psychologists "with a doctorate degree in clinical psychology," and "clinical psychologists with a doctorate degree." At the same time, "clinical psychologists with a masters degree" were authorized to assess competency to stand trial under § 19.2-169.1

Virginia Code § 54-275 provides that the title "clinical psychologist" may be employed only by psychologists licensed as such in Virginia. Pointing to this statute, some psychologists in Virginia have argued that only licensed clinical psychologists may qualify as "clinical psychologists with a doctorate degree." Others, however, believe that, because licensure as a clinical psychologist in

Spring forensic symposium

The Institute of Law, Psychiatry and Public Policy's Spring Forensic Symposium will be held Friday, June 27, at the Omni Hotel in Charlottesville, Va. The symposium, which is open at no cost to alumni of the Institute's Forensic Evaluation Training Program, will feature a presentation by Paul S. Appelbaum, M.D., A.F. Zeleznick Professor of Psychiatry and Director of the Program in Psychiatry and the Law at the University of Massachusetts Medical Center. Dr. Appelbaum will discuss the ethical boundaries of forensic psychiatry in light of the United States Supreme Court's opinion in *Ake v. Oklahoma*.

The program also will include an examination of recent developments in Virginia's forensic evaluation laws and workshops on the following topics: (1) the evaluation and treatment of mentally retarded offenders; 2) the assessment of legally relevant organic and metabolic disorder; (3) post-traumatic stress disorder in the Vietnam veteran; and (4) the role of psychological testing in the forensic evaluation. The program has been approved for CME and CEU credit. For more information, contact W. Lawrence Fitch, Director of the Forensic Evaluation Training and Research Center, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804/924-5435).

Virginia requires possession of a doctorate degree, the General Assembly's reference to masters-level clinical psychologists in the competency evaluation context, and its explicit requirement that clinical psychologists who assess mental state at the time of the offense possess a doctorate degree, demonstrates its intent not to require licensure of clinical psychologists for the purposes of forensic evaluation. This view has been confirmed by several members of the Department of Mental Health and Mental Retardation task force that developed the legislation that was enacted in 1982.

The issue of licensure for forensic psychologists arose in the legislative debate again this year. After hearing the testimony of several witnesses on the matter, a Senate Courts of Justice subcommittee that was assigned to explore this and related issues expressed its clear intent not to require by this statute that psychological experts in criminal cases be licensed as clinical psychologists. As recommended by this subcommittee, the new law provides that the expert assigned to provide assistance where the sanity issue is raised — or where the defendant's mental state is relevant to capital sentencing — "shall be a psychiatrist or a clinical psychologist with a doctorate degree and shall be qualified by training and experience to perform such evaluations." (Masters-level psychologists continue to be qualified to conduct evaluations of the defendant's competency to stand trial pursuant to §19.2-169.1.)

Since 1982, the law has specified certain information that must be provided to the court-appointed expert by the attorney requesting the expert's assistance. Added to the list this year is "a copy of the defendant's criminal record, to the extent reasonably available."

A major change in the law this year concerns the extent to which the findings of the expert assigned for the defense might be discovered by the attorney for the Commonwealth. Since 1982, the expert conducting an evaluation under §19.2-169.5 has been charged with preparing two reports: a full report for the defense and a summary of conclusions for the Commonwealth. Only after written notice that the defense intended to present evidence of insanity at the trial was the Commonwealth entitled to a copy of the full report. In order to implement *Ake's* expectation that assistance provided to the defense be independent — i.e., as if provided by a retained expert — the new law eliminates the requirement that a summary report be prepared for the Commonwealth. The Commonwealth, however, retains its right of access to the report for the defense after the defendant gives written notice of an intent to present evidence of insanity at the trial. In addition, under the new law, after this notice is given, the Commonwealth acquires a right of access to copies of "psychiatric, psychological, medical, or other records obtained during the course of [the] evaluation."

§ **19.2-168. Notice to Commonwealth of intention to present evidence of insanity; continuance if notice not given.**—In any case in which a person charged with a crime intends (i) to put in issue his sanity at the time of the crime charged and (ii) to present testimony of an expert to support his claim on this issue at his trial, he, or his counsel, shall give notice in writing to the attorney for the Commonwealth, at least twenty-one days prior to his trial, of his intention to present such evidence. In the event that such notice is not given, and the person proffers such evidence at his trial as a defense, then the court may in its discretion, either allow the Commonwealth a continuance or, under appropriate circumstances, bar the defendant from presenting such evidence. The period of any such continuance shall not be counted for speedy trial purposes under § 19.2-243.

This section prescribes the procedures that govern the provision of notice by the defendant who intends to put in issue his sanity at the time of the offense and present the testimony of an expert on this issue at the trial. The 1986 amendments extend the time by which such notice must be given from 10 days to 21 days prior to trial. In addition, the new law authorizes the judge "under appropriate circumstances" to bar the defendant from presenting the testimony of an expert if he or she fails to comply with the 21-day notice requirement. The alternative remedy of allowing the Commonwealth a continuance was the exclusive remedy before this year.

§ **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 sanity at the time of the offense, the court shall appoint one or more qualified mental health experts to perform such an evaluation. The court shall order the defendant to submit to such an evaluation and advise the defendant on the record in court that a refusal to cooperate with the Commonwealth's expert could result in exclusion of the defendant's expert evidence. The qualification 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 § 19.2-169.5 C. After performing their evaluation, the experts shall report their findings and opinions, and provide copies of psychiatric, psychological, medical or other records obtained during the course of the evaluation to the attorneys for the Commonwealth and the defense.

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

This section prescribes the procedures for evaluations on behalf of the Commonwealth after the defendant gives notice pursuant to §19.2-168 that he or she intends to present the testimony of an expert at the trial on the issue of the defendant's mental state at the time of the offense. New this year is the requirement that the judge "order the defendant to submit to such an evaluation and advise the defendant on the record in court that a refusal to cooperate with the Commonwealth's expert could result in exclusion of the defendant's expert evidence." In addition, the provision now requires the expert not only to report his or her findings but also to provide copies of "psychiatric, psychological, medical, or other records obtained during the course of the evaluation." Finally, the new law provides that, as an alternative to barring the defendant's expert testimony when the defendant refuses to cooperate with an evaluation for the Commonwealth — the only remedy available heretofore — the court in its discretion may admit evidence of the defendant's refusal to cooperate.

§ 19.2-264.3:1. Expert assistance when defendant's mental condition relevant to capital sentencing.—*A. Appointment of expert.*—Upon (i) motion of the attorney for a defendant charged with or convicted of capital murder and (ii) a finding by the court that the defendant is financially unable to pay for expert assistance, the court shall appoint one or more qualified mental health experts 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) the defendant or the defendant's mental condition at the time of the offense. The mental health expert appointed pursuant to this section shall be either a psychiatrist or clinical psychologist with a doctorate degree and shall be qualified by training and experience to perform such evaluations. The defendant shall not be entitled to a mental health expert of defendant's own choosing or to funds to employ such expert.

B. Location of evaluation; 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 § 19.2-169.5 B 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 shalll 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 contents of the report.—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 and 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 other records obtained during the course of 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 twenty-one 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 may, in its discretion, upon objection of the Commonwealth, either allow the Commonwealth a continuance or, under appropriate circumstances, bar the defendant from presenting such evidence.

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. The court shall order the defendant to submit to such an evaluation, and advise the defendant on the record in court that a refusal to cooperate with the Commonwealth's expert could result in exclusion of the defendant's expert evidence. The qualification of the experts shall be governed by § 19.2-264.3:1 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 § 19.2-169.5 C. After performing their evaluation, the experts shall report their findings and opinions and provide copies of psychiatric, psychological, medical or other records obtained during the course of the evaluation 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, that the defendant has refused to cooperate with an evaluation requested by the Commonwealth, the court may admit evidence of such refusal or, in the discretion of the court, bar the defendant from presenting his expert evidence.

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.

This section, new in 1986, prescribes procedures for the provision of expert assistance at sentencing in capital cases. These procedures closely track those applicable to the provision of expert assistance on the issue of the defendant's mental state at the time of the offense prescribed by §§ 19.2-169.5, 19.2-168, and 19.2-168.1.

Under the new law, any defendant charged with or convicted of a capital crime who is financially unable to pay for expert assistance is entitled to the assistance of a court-appointed expert upon motion of his or her attorney. Employing language that appears elsewhere in Virginia's capital sentencing laws, the statute provides that the expert appointed for the defense shall "evaluate the defendant and .... 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."

Provisions governing the location of the evaluation, qualifications of experts, provision of information to the experts, disclosure of evaluation results, notice of intent to present expert testimony at sentencing, and appointment of an expert to conduct an evaluation for the Commonwealth are virtually identical to those that apply where the defendant's mental state at the time of the offense is at issue.

Serious questions were raised during the legislative process about the constitutionality of provisions authorizing the court to bar the defendant from presenting his or her expert evidence upon a finding that the defendant either failed to give timely notice of his or her intent to present expert evidence at sentencing or refused to cooperate with an evaluation for the Commonwealth. The United States Supreme Court has stated very clearly that the capital defendant must be given every opportunity at sentencing to present whatever evidence is available that might be viewed as mitigating by the trier of fact. See, for example, *Lockett v. Ohio,* 438 U.S. 586 (1978), and *Eddings v. Oklahoma,* 455 U.S. 104 (1982). Ultimately, those favoring including this remedy prevailed. Even they, however, recognized that the remedy is one to be employed only in the most compelling of cases, for example, where the defendant's failure to give notice is calculated to prejudice the prosecution (e.g., by requiring a continuance between the time of trial and the time of sentencing, thus raising the possibility that a new jury will be required at sentencing), or where the defendant's refusal to cooperate with an evaluation for the Commonwealth was knowing, voluntary, and intelligent.

Since 1982, the law in Virginia has provided that statements made by a defendant during an evaluation of his or her competency to stand trial or mental state at the time of the offense, or during treatment prior to trial, could be used against the defendant at trial only on the issue of the defendant's mental state at the time of the offense after that issue was raised by the defendant, and could be not used affirmatively by the Commonwealth to prove that the defendant committed the crime charged. Extending this protection to apply in the capital sentencing context, the new law provides that no statement made by a defendant during a capital sentencing evaluation or any other forensic evaluation or during treatment prior to trial "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 (e.g., future dangerousness). Such statements or disclosures shall be admissible in rebuttal only when relevant to issues in mitigation raised by the defense." This provision is designed to enable the defendant to exercise the right to a meaningful mental health evaluation without having to give up the right not to incriminate himself or herself at sentencing.

§ 19.2-175. Compensation of experts.—Each psychiatrist, psychologist or other expert appointed by the court to render professional service pursuant to §§ 19.2-168.1, 19.2-169.1, 19.2-169.5, 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 such service. The fee shall be determined in each instance by the court that appointed

the expert, in accordance with guidelines established by the Supreme Court after consultation with the Department of Mental Health and Mental Retardation. Except in capital murder cases the fee shall not exceed $400, but in addition if any such expert is required to appear as a witness in any hearing held pursuant to such sections, he shall receive mileage and a fee of $100 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.

This section provides for the compensation of experts assigned to conduct evaluations or otherwise povide expert assistance pursuant to Va. Code §§19.2-169.1, 19.2-169.5, 19.2-168.1, paragraphs (1) and (2) of 19.2-181, or 19.2-264.3:1. The amendments this year increase the maximum fee for such service from $200 to $400 (except in capital cases, where no maximum is specified) and increase the expert witness fee from $50 to $100 per day. In addition, the new law provides that payment be made pursuant to guidelines established by the Virginia Supreme Court in cooperation with the Department of Mental and Mental Retardation.

— W. Lawrence Fitch

General Assembly

Continued from page 5

to be given to the party denying access.

SB's 204 & § 312; Chapters 213 & 487; amending §§ 63.1-55.4 & 63.1-55.3.

Child protective services

The authority of the Department of Social Services and the juvenile and domestic relations district courts to intervene in family matters on behalf of a child is significantly greater under a law enacted this year. The increase in authority was accomplished primarily by expanding the statutory definitions of "abused or neglected child" and "child in need of services."

Under the new law the definition of "abused or neglected child" will also include a child "[w]ho is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis." This new category of children who are considered abused or neglected under Virginia law will not only increase state authority to modify or terminate the parental rights of persons with mental disabilities, but will also result in greater reporting duties on the part of mental health and mental retardation professionals providing services to those persons.

The definition of "child in need of services" (CHINS) was amended to add a new ground for CHINS adjudication by a juvenile and domestic relations district court. Prior to the amendment, a CHINS adjudication could be based on a finding of truancy, disobeying parents, running away from home, or committing an offense, such as a curfew violation, which is an offense only for children. To these bases of a CHINS adjudication, the new law adds one premised on a prediction of dangerousness. A CHINS includes "[a] child whose behavior, conduct or condition presents or results in a serious threat to the well-being and physical safety of the child."

Persons required to report or investigate child abuse or neglect have the authority to talk to the child in question or any of his or her siblings without the consent of the parent. This authority was clarified by a provision which permits the interview to take place outside the presence of a parent.

SB 237; Chapter 308; amending §§ 16.1-228, 16.1-251, 16.1-252, 16.1-253, 63.1-248.2 and 63.1-248.10.

Transfer Laws

Continued from page 7

demands may be placed on the clinical staff of the designated hospital if these clinicians are to be expected to appear as witnesses at commitment hearings in these cases.

In addition to raising logistical concerns, the amendments to § 19.2-176 substantially alter that statute's central purpose. As originally conceived in 1982, § 19.2-176 was to function much like guilty-but-mentally ill laws in other states, giving the trial court judge the authority to send a convicted defendant to a hospital for treatment rather than sentencing him or her to a period of incarceration in a jail or prison. The provision allowed the judge to order hospitalization in lieu of sentencing for any defendant who was mentally ill and in need of treatment in a hospital rather than a jail. And it allowed the judge to keep the defendant in the hospital until such time as the defendant no longer required hospitalization. Finally, it provided that the period of hospitalization was to be deducted from any sentence subsequently ordered.

Under the new law, hospitalization must terminate within 30 days unless the court finds by clear and convincing evidence that the defendant meets the criteria for involuntary commitment that apply to the hospitalization of any other jail inmate. Subsequent periods of hospitalization, of course, may be ordered, but only upon a finding that the defendant remains committable under these criteria.

— W. Lawrence Fitch

Homes for adults

Current law in regulating board-and-care facilities (in Virginia, called "homes for adults") makes a distinction in licensure between those facilities which may accept nonambulatory residents and those which may not.

A 1986 amendment offers a complicated definition of the terms "ambulatory," and "nonambulatory ," which depend principally on the resident's ability to get out of the facility in an emergency without assistance.

A "nonambulatory" resident is one whose mental or physical disability would prevent him from leaving the building without assistance from another person.

"Ambulatory" residents include both "independently mobile" persons who can exit the home for adults in an emergency without assistance, and "semimobile persons." The explanation of who is "semimobile," and therefore who may be accepted by a home for adults licensed only for ambulatory residents, is the most important aspect of the new amendment.

"Semimobile" residents must be "able to exit the home with assistance of a wheelchair, walker, cane, prosthetic device or verbal command." Additionally, the facility must either meet the I-2 specification of the B.O.C.A. building code, or locate this category of residents on the first floor within three minutes and fifty feet of a ground level or ramped exit.

HB 654; Chapter 430; amending § 63.1-174.1.

Continuing care contracts

"Continuing care contracts" (e.g. life-care contracts), provide private board, lodging and nursing services for elderly persons, often for the rest of their lives. Since 1985 Virginia has regulated continuing care contracts primarily through the requirement that providers register and file disclosure statements with the State Corporaiton Commission. These statements are intended to inform the potential consumer of continuing care services of the financial soundness of the provider and the nature of the services offered and the grounds for the termination of services.

The 1985 act limited the grounds for termination of services to four broad categories including (i) "proof" that the resident is a danger to himself or others, (ii) non-payment of fees, (iii) interference with other residents' quiet enjoyment, and (iv) refusal to comply with "reasonable" rules.

The 1986 legislature expanded the permissible grounds for termination to also include (v) misrepresentations, e.g., about the resident's need for health services, which affect the cost of or eligibility for services, and (vi) breach by the resident of the continuing care contract.

While these changes do not directly benefit the consumer, other changes made in the 1986 General Assembly do. While the law does not require the provider to maintain reserve funds, continuing care facilities which begin construction after June 30, 1986, will not be able to use entrance fees to finance construction. The amended act will require that entrance fees, which can often be quite substantial, be held in escrow by a bank or trust company, invested in approved assets, and released to the provider only after the facility is occupied or ready for occupancy.

SB 65; Chapter 598; amending §§ 38.1-955, 38.1-957, 38.1-960 and adding 38.1-959.1.

Impaired health professionals

The chief administrative officers and chiefs of staff of hospitals and other health care institutions in the state will have a greater responsibility for reporting impaired health professionals because of a new law. The 1986 amendment makes some cosmetic changes in its description of the categories of information which must be reported to a licensing board, and then adds a new category which requires reporting:

[The] voluntary resignation from the staff of the health care institution or voluntary restriction or expiration of privileges at the institution of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution or a committee thereof for any reason related to possible medical incompetance, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.

Additionally, a new section was added to the Code which assures civil immunity to persons reporting impaired health professionals, provided there is not "bad faith" or "malicious intent" in reporting or otherwise providing information regarding the impaired professional.

SB's 181 and 188; Chapters 303 and 604; amending §§ 54-325.1 and 8.01-581.19:1

Forced human research

In 1979 Virginia adopted laws protecting human subjects of research, and directed its State Board of Mental Health and Mental Retardation to implement these laws through regulations. Regulations became effective September 1, 1983. One key element of the protection offered under these laws is the requirement that research be conducted in most cases only with the informed consent of the subject, regardless of his age or if he was competent to give consent. If the competent subject was a minor the consent of his parent was also required.

If the patient is not competent to give consent, consent could be obtained from a legally authorized representative, subject to two important conditions. First, the legally authorized representative could not consent to hazardous, nontherapeutic research. Second, notwithstanding the consent of a legally authorized representative (to therapeutic or non-hazardous research), the law provided that "no person shall be forced to participate in any human research."

This second restriction on consent was removed by the 1986 General Assembly. The amended law now only prohibits forcing research on competent persons. This prohibition is pointless since these persons ordinarily will have consented to the research. The meaning of this amendment is further obscured by specifically

providing that the experimental, therapeutic treatment of certain progressive organic brain diseases, to which the legally authorized representative had consented, "shall not constitute the use of force."

The bill was intended to clear up any ambiguity in the law concerning what constitutes force in administering experimental or therapeutic treatments to patients incompetent to give consent. Neurologists working with Alzheimer's disease patients specifically favored the legislation to clearly permit the use of experimental or therapeutic treatments on Alzheimer's patients who often cannot give consent for such treatments.

The net effect of the 1986 amendment is to make the appointment of a legally authorized representative more critical. Prior to amendment, the prohibition of forcing research on any person, even if he were incompetent, provided protection against an improperly appointed representative or a representative who did not share the values of the subject. Since an incompetent patient had a right to refuse participation in research, it was not as important to carefully define the meaning of competency, or the procedures adequate for appointing a "legally authorized representative" for the purposes of human subject research.

A 1974 law applicable to patients in facilities operated, funded or licensed by the Virginia Department of Mental Health and Mental Retardation prohibits research without the consent of the patient or his guardian or committee. See § 37.1-84.1. But in state regulations implementing that statute, the human subject research statutes and regulations are incorporated by reference, and, thus, require for research involving an incompetent patient the consent of a "legally authorized representative," rather than a guardian or committee. Just who, in addition to a guardian or committee, is "legally authorized" under state common law and regulations is unlikely to be clarified soon.

HB 632; Chapter 274; amending §§ 37.1-234, 37.1-235 and 37.1-236.

Health maintenance oganizations

The Virginia State Corporation Commission will prescribe minimum standards of mental health and substance abuse services which health maintenance organizations (HMO's) must provide. Most Virginia insurance statutes including those mandating minimal mental health and substance abuse services do not directly apply to an HMO. The new law will require HMO's to include in their packages of "basic health services" some mental health and substance abuse services, in accordance with State Corporation Commission standards.

These standards cannot require more mental health and substance abuse services than currently "mandated" for accident and sickness policies (including health benefit programs offered by preferred provider organizations) by §§ 38.1-348.7 and 38.1-348.8. These insurance statutes require both that certain coverage be provided, and that certain additional coverage be offered at an additional charge. These appear to leave to the SCC the tasks of deciding whether both these categories of coverage are "mandated," and how many of the services in the mandated coverage are required of HMO's.

All accident and sickness policies in the state must provide coverage of at least thirty days per year of treatment in a general hospital or mental hospital for mental disorders. This coverage must include inpatient substance abuse treatment in a general hospital or licensed alcoholic rehabilitation facility, although the insurer may impose certain additional limitations on this substance abuse coverage, such as a ninety-day lifetime limit on inpatient substance abuse coverage.

As optional coverage, policies must offer outpatient mental heath services roughly comparable to outpatient services provided for physical disorders. And, under § 38.1-348.8, the policies must offer coverage of forty-five days of inpatient substance abuse treatment and forty-five days of outpatient substance abuse treatment. The optional substance abuse coverage includes a broader range of facilities than the required thirty-day coverage of inpatient mental health treatment.

HB 604 and SB 169; Chapters 528 and 76; § 38.1-863.

Marital sexual assault

Amidst great controversy the General Assembly created two new categories of criminal sexual offenses and encouraged counseling rather than punishment of persons charged with those offenses.

Under the amended law, either a man or woman can be charged with committing the statutory offenses of rape, forcible sodomy, and inanimate object sexual penetration, even though the victim is a spouse. Where the victim is the accused's spouse, though, the state must prove, in addition to the usual elements of the offense, either that the spouses were living separate and apart at the time of the offense, or that the accused also caused serious physical injury to his or her spouse.

Where neither of these two special conditions can be proven, the accused might still be convicted of a new, lesser included offense of "marital sexual assault." This offense requires only proof that the rape, sodomy or inanimate object sexual penetration be accomplished "against the spouse's will by force or a present threat of force against the spouse or another person."

While in 1984 the Virginia Supreme Court interpreted the rape statute to permit prosecution in cases where the victim was the defendant's spouse, the Court required proof of a complete "de facto" end to the marriage, not just evidence that the spouses were living separate and apart at the time of the offense.

Both new offenses require for prosecution the victim to report the offenses, if he or she is able to, within ten days.

Additionally, both offenses are subject to provisions aimed at diverting cases out of the criminal justice systems

where that will serve to benefit the victim and maintain the family unit. The courts are encouraged to refer the accused to community mental health programs prior to trial for a determination of whether the accused can benefit from counseling.

Based on the evaluation, and with the consent of the accused and the victim, the accused may be ordered into counseling, and all proceeedings suspended until the completion of counseling. At the end of the period of counseling the accused is again evaluated. The charges can then be dropped if the court finds, based on the evaluation and any other information generated by the court services unit, that dismissal of the charges "will promote maintenance of the family unit and be in the best interest of the complaining witness."

The court may also refer the defendant into counseling after a finding of guilt but before judgment is entered, and upon successful completion of counseling, dismiss the charges, or the court may enter a judgment of guilt and then suspend imposition of a sentence upon completion of counseling.

HB 378; Chapter 516; amending §§ 18.2-61, 18.2-67.1, 18.21-67.2 and adding §§ 18.2-67.2:1, 19.2-218.1 and 19.2-218.2.

Housing for the disabled

In an effort to increase low income housing for the disabled, the Virginia General Assembly established a new Interagency Coordinating Council on Housing for the disabled and granted the Virginia Housing and Development Authority new power aimed at increasing resources for low income housing for the disabled.

The Interagency Coordinating Council is to be made up of representatives from various state agencies, appointed by the heads of the agencies that have an interest in the rights of the disabled. The council is directed by HB 198 to develop a statewide policy on housing for the disabled and to submit annual reports to the governor. The council is to be funded by a share from each of the agencies appointing representatives.

HB 197 directs the Virginia Housing and Development Authority to provide technical assistance at the state and local levels in the use of both public and private resources to increase low income housing resources for the disabled.

HB's 198 and 197; Chapters 244 and; adding §§ 2.1-703.1 and amending § 36-55.30.

ASAP

To improve the administration and effectiveness of local alcohol safety and rehabilitation (ASAP) programs, the Commission on Virginia Alcohol Safety Action Programs has been established by the General Assembly.

The commission will consist of eleven various government officials familiar in matters related to alcohol safety programs. Duties of the commission include overseeing local program plans, operations and performance and establishing a system for distributing funds to local programs with budget deficits.

In addition to establishing the commission itself, HB 393 requires the commission to appoint an advisory committee "to make recommendations regarding its duties and administrative functions."

HB 393; Chapter 580; amending § 18.227-1.2.

Freedom of Information Act

The Virginia Freedom of Information Act will now explicitly guarantee a noncustodial parent or guardian access to the scholastic or medical records of minors, including institutionalized minors, unless the parental rights have been terminated or a court has specifically denied access to the records.

HB 581; Chapter 469; amending § 2.1-342.

Medical malpractice review panels

Health maintenance organizations (HMO's) are now covered under provisions of the medical malpractice statute allowing review of malpractice cases by a Medical Malpractice Review Panel before the case goes to court.

The bill defined "health maintenance organizations" as any person licensed pursuant to Chapter 26 of Title 38.1 who provides or arranges for one or more health care plans. The bill was introduced in response to a U.S. District Court decision construing health maintenance organizations to not be health care providers as defined in the act.

Another bill amending the medical malpractice statute made a number of procedural changes in the section governing the Medical Malpractice Review Panel.

HB's 285 and 92; Chapters 511 and 227; amending §§ 8.01-581.1, 8.01-581.2, 8.01-581.3, 8.01-581.4, 8.01-581-6, and 8.01-581.7, and adding §§ 8.01-581.3:1, 8.01-581.4:1, 8.01-581.4:2 and 8.01-581.11:1.

Medical assistance services

Medicaid cost containment measures mandated by the 1984-86 Appropriations Act have been entered into statutory law by HB 168, which specifically authorized the initiation of cost containment or other measures as set forth in the appropriations act.

Some of the measures include the exploration of less expensive alternatives to institutional care, the use of outpatient surgical services when appropriate, and the requirement of second opinions for designated elective surgeries.

HB 168; Chapters 393 & 455; amending § 32.1-325.

Handicapped children

An effort will be made to develop a statewide strategy for meeting the educational needs of older handicapped children (those 15 and over) and easing the burden of transition of these handicapped children to adulthood, as a result of the passage of HB 798.

Three state agencies are added by the law to the list of nine which previously made up the Interagency Coordinating Committee on Delivery of Related Services to Handicapped Children. The three agencies are the Department of Housing and Community Development, the Virginia

Housing Development Authority and the Department for the Deaf and Hard-of-Hearing.

Added to the Coordinating Committee's responsibilities is the directive to develop "a strategy for meeting the anticipated educational and vocational needs of handicapped children aged fifteen or over, and for identifying existing barriers to a successful transition from special education to adult life."

HB 798; Chapter 284; amending § 2.1-700.

Child welfare

Child-caring institutions no longer have to petition the Juvenile and Domestic Relations Court for approval of a temporary entrustment agreement if the parents of that child voluntarily place the child under the agency's care.

SB 340; Chapter 88; amending § 63.1-204.

Biotinidase deficiency

Biotinidase deficiency, an in-born error of metabolism which can lead to mental retardation, has been added to a list of five other diseases for which newborn infants in Virginia must be tested, unless the parent objects for religious reasons.

HB 411; Chapter 172; amending §§ 32.1-65, 32.1-66 and 32.1-67.

Human rights commissions

Human Rights Commissions in certain localities have been granted the power to subpoena documents, a power specifically denied to these commissions by past legislation.

The bill affects only those localities employing the urban county executive form of government. Although counties under a county manager form of government are authorized to establish human rights commissions, they were not granted the subpoena power.

Besides the additional power to subpoena documents, the duties and powers of Human Rights Commissions will remain the same.

HB 19; Chapter 495; adding §§ 15.1-783.1 and 15.1-783.2 and repealing § 15.1-776.1.

Anatomical gifts

Doctors receiving anatomical gifts for themselves are now authorized to perform the transplant or removal operation, but cannot participate in determining the cause of death of the donor. And in the case of a gift of the brain, laboratory technicians trained by a licensed neuropathologist can recover the brain.

SB 212; Chapter 110; amending § 32.1-292.

Thomas S. v. Morrow

Continued from page 3

Other facts in *Thomas S.* which may have influenced the finding of state control include the use of a state employee as guardian, the guardian's continual shifting of the plaintiff from one placement to another, past (and a potential for future) commitments into the state hospital, and the state's foster care of Thomas S. from birth until the age of majority. These facts may have been important more to show how unreasonable the degree of state control was, and thus how inadequate treatment was, than to rebut the state's defense that there was no control of the plaintiff at all. While the question of state control *vel non* seems to have been made independently by the court on the basis of its reading of North Carolina statutes on guardianship and authority for the provision of mental health services, the question of whether this control amounted to an undue restriction was viewed as inseparable from the question of what was minimally adequate treatment, and these questions were answered by application of the professional judgment rule.

In the application of the professional judgment rule, an explicit balancing of minimal treatment efficacy against patient liberty is not required, as it is by the "least restrictive alternative" criterion of many civil commitment statutes. The use of the professional judgment rule implies that any treatment-related restriction is permitted if the treatment falls within the broad parameters of the rule. Conversely, treatment which does not satisfy the rule, will be viewed, as the *Thomas S.* decision illustrates, as too restrictive, without any real examination of the ways in which the plaintiff's activities were really restricted. It is entirely possible that in some respects the "appropriate" placement to which Thomas S. will be transferred will be more restrictive than some of the prior placements that led to the litigation.

Plaintiff's use of the professional judgment rule

The Supreme Court's formulation of the professional judgment rule in *Youngberg* reflected an endorsement of medical and institutional expertise that can be traced directly back to two 1979 decisions, *Parham v. J.R.*,[6] involving the commitment of children, and *Bell v. Wolfish*,[7] involving the administration of pre-trial detention facilities. This deference to medical and institutional expertise was based in part on the Court's conviction that treatment providers and institutional administrators can make complex decisions that judges and juries cannot, and so the federal courts should not be too quick to second-guess the professionals.

In part, however, the professional judgment standard was a product of the Court's view of federalism and desire to conserve federal judicial

resources by discouraging civil rights challenges of state institutional practices. From this perspective the professional judgment rule could have been expected to be used chiefly as a shield by the state defendants in right to treatment cases, with the usually insurmountable burden on the plaintiffs to demonstrate that the defendant's "presumptively valid" action

> is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.[8]

Instead, in *Thomas S.* the professional judgment rule proved to be a formidable sword for the plaintiff. The professional judgment rule not only gave added weight to the plaintiff's evidence, but effectively excluded all of the defense's evidence offered in rebuttal, so that plaintiff prevailed in a summary judgment. The defendants had submitted affidavits supporting their contention that treatment had been minimally adequate. The District Court not only refused to accept these opinions as presumptively valid, but rejected them entirely as immaterial, "because the professional's stated judgment was modified to conform to the *available* treatment, rather than to the *appropriate* treatment, for the plaintiff's condition."[9] [Emphasis in original]

Other evidence included in the defense affidavits, consisting of the recommendations of the state hospital staff, was, by contrast, accepted by the District Court and the Court of Appeals as adequate grounds for awarding the summary relief sought by Thomas S. The courts made a show of deference to this expert evidence, maintaining that the *Youngberg* professional judgment rule left them no alternative but to enjoin the state to provide the community services prescribed by the state hospital staff.

This application of the professional judgment rule, far from insulating state institutional practices from constitutional attack, makes the state more vulnerable to summary judgment against it, at least in certain kinds of right to treatment cases. It is important to note that *Thomas S.* was an individual action for prospective relief. An action for damages would permit consideration of cost factors that make the professional judgment rule more useful to defendants. A class action even for prospective relief also would entail a diversity of professional opinions on each member of the class that would make summary judgment for the plaintiff class unlikely. The consensus of opinion, including that of the state hospital staff, supporting the placement Thomas S. sought, was critical to the outcome of the case. Where both the plaintiff and the defendant produce conflicting opinions, both of which qualify as professional judgment, the professional judgment rule would favor maintenance of the status quo through summary judgment for the defendant.

The courts made a show of deference to this expert evidence, maintaining that the Youngberg *professional judgment rule left them no alternative but to enjoin the state to provide the community services prescribed by the state hospital staff.*

In *Thomas S.* the professional judgment rule did have its intended effect of minimizing judicial second-guessing of treatment decisions, albeit decisions in this case relied on by the plaintiff. Ironically, this will also increase federal judicial involvement in allocating state resources needed to implement these decisions, a consequence not considered in *Youngberg*. At least in the Fourth Circuit, many, if not most, institutionalized persons, and a significant number of clients of community programs, may be in as good a position now as Thomas S. to produce the kind of evidence of unanimous professional judgment needed to compel the creation of less restrictive modalities of treatment, regardless of cost.

The impact of *Thomas S.*

Will state mental health and mental retardation professionals now hesitate to make comprehensive predischarge plans for state facility residents out of concern that, as in *Thomas S.*, those plans will serve as the basis for a federal injunction if they are not implemented? Probably not. *Thomas S.* demonstrates that some federal courts are quite willing to disregard expedient professional opinion. And poor planning will increase the risk that a court will someday find a violation of a right to treatment. But more importantly, treatment professionals may see in a potential injunction the best hope of improving state funding for mental health and mental retardation services and will therefore encourage right to treatment litigation.

Will *Thomas S.* discourage guardianship, particularly public guardianship? It may be that once a patient is discharged from a state facility, or converted to a voluntary status, the court will decline to find state control of the patient in the absence of guardianship. But in many cases the absence of guadianship services forecloses discharge from a hospital to community treatment requiring informed consent. In those cases guardianship may be required as an element of minimally adequate treatment. Not all states in the Fourth Circuit have provisions for public guardians such as the one appointed for Thomas S., and because of that those states may be more, not less, vulnerable to right to treatment claims when the unavailability of a guardian or some other kind of surrogate treatment decisionmaker impedes discharge and community placement of state hospital patients.

Where voluntary institutional or community treatment is provided to a client who, although not formally adjudicated incompetent, in fact cannot engage in informed treatment decisionmaking, the courts may find that the client is subject to control under a *de facto* guardianship equivalent to the formal guardianship in *Thomas S.*, or that the nonconsensual treatment itself, particularly if it is residential,

sufficiently restrictive to give rise to a right to treatment.

Neither a curtailment of treatment planning nor the avoidance of guardianship will insulate the state from a right to treatment claim, and both strategies may actually increase the likelihood of such a claim. The State of North Carolina is seeking review of *Thomas S. v. Morrow* before the United States Supreme Court. If the case is not accepted for review, or if it is affirmed, *Thomas S.* may lead to a reorientation of the community treatment planning process around the client's specific needs, rather than the availability of resources, and to a reconsideration of the role of guardianship in community treatment. If so, this decision will become a landmark in mental health litigation of more significance than the decision over a decade ago in *Wyatt v. Stickney.*[10]

As this article was going to press the Supreme Court announced its denial of certiorari in Kirk v. Thomas S., *No. 85-1590, 54 U.S.L.W. 3757 (May 19, 1986).*

Notes

1. Thomas S. v. Morrow, 781 F.2d 367 (4th Cir. 1986), *aff'd* 601 F.Supp. 1055 (W.D. N.C. 1984), *cert. denied sub. nom.* Kirk v. Thomas, 54 U.S.L.W. 3757 (U.S. May 19, 1986) (No. 85-1590).
2. 457 U.S. 307 (1982).
3. 601 F.Supp. at 1059-1060.
4. Clark v. Cohen, 613 F.Supp. 684, 704 (E.D. Pa. 1985).
5. 561 F.Supp. 473 (1982), aff'd in part & modified in part, 713 F.2d 1384 (8th Cir. 1983).
6. 442 U.S. 584, 607 (1979).
7. 441 U.S. 520, 544 (1979).
8. 457 U.S. at 323.
9. 601 F.Supp. at 1059.
10. 325 F.Supp. 781 (M.D. Ala 1971), on submission of proposed standards by defendants, 334 F.Supp. 1341, enforced, 344 F.Supp. 373, aff'd sub nom. Wyatt v. Alderholdt, 503 F.2d 1305 (5th Cir. 1974).

In the Virginia Supreme Court

On November 27, 1985, the Virginia Supreme Court had occasion to consider two cases of interest to the behavioral sciences. One, *Hopkins v. Commonwealth,* affirmed a conviction for abduction on the basis of a witness who, prior to his testimony, had been questioned under hypnosis. The other, *Lowe v. Commonwealth,* upheld the constitutionality of sobriety checkpoints.

Hypnosis

A court, subject to several guidelines, may admit the testimony of a witness who on a previous occasion had been hypnotized to induce memory recall, the Court ruled in *Hopkins v. Commonwealth,* 230 Va. ____, 2 VLR 652 (Nov. 27, 1985). Jerry Wayne Hopkins had appealed convictions in two different courts for murder and abduction. His conviction for abduction was based in part on the testimony of the murder victim's boyfriend, Tyrone Griffin. During the investigation Griffin had given a statement to the police. In an effort to recall more details, he was hypnotized and questioned by a local anesthesiologist. After Griffin again described the events leading up to his calling the police, he was awakened from the trance. Both Griffin and the physician maintained that the hypnosis had not enhanced his recall.

The defendant's attack on the admission of Griffin's testimony at trial had two prongs. First, the defendant argued that the testimony was tainted by the hypnosis and should have been excluded. The Supreme Court replied that the fact that Griffin had been hypnotized was not in itself reason for excluding the testimony. If the trial court found neither suggestiveness in the hypnotic technique nor alternation in the witnesses statements before and after hypnosis, the court could find the witness competent to testify. The Supreme Court cautioned that a full and accurate record of the hypnotic session might be critical to establishing the admissibility of the testimony.

While there was no record of the hypnosis in this case, there was a pretrial hearing in which the court ruled that the hypnotic technique was free of suggestiveness and that Griffin's statements prior to the hypnosis were no different than afterwards. This satisfied the Supreme Court that his testimony was admissible and made it unnecessary to rule whether testimony which was altered or induced by hypnosis was admissible.

The second prong of the defendant's argument was that, although the hypnosis had not changed the content of Griffin's testimony, it had the effect of making both Griffin and the jury more confident of its truth. The Supreme Court acknowledged the possibility that hypnosis could have this effect in some cases. But in this case, the trial court had adequately remedied the problem through two measures. The court had allowed the defense to put on expert testimony on the effects of hypnosis on witness recollection and confidence. And the court had given a jury instructions permitting the jury to consider the effect of hypnosis on the witness's confidence and manner of testifying.

The Virginia Supreme Court's approach to hypnosis in *Hopkins* falls somewhere between the extremes taken in other jurisdictions of excluding any testimony of a witness who had been hypnotized during the investigation, without inquiry into the actual effect of the hypnosis on recall, and admitting all testimony following hypnosis, and allowing the jury to decide whether it is credible. The Court took care to inventory all the "potentially dangerous effects of hypnosis on a witness's testimony," such as unconscious suggestion, confabulation, and increased confidence of the witness. The Court reiterated its rejection of testimony from a witness at the time he is under hypnosis, or admission of an earlier statement made under hypnosis in *Greenfield v. Commmonwealth,* 214 Va. 217, 204 S.E.2d 414 (1974). *Greenfield* was the Court's only previous decision concerning hypnotic testimony.

Sobriety checkpoints

Sobriety checkpoints do not violate the Fourth Amendment provided they limit an officer's discretion as to whom to stop by requiring all vehicles to do so, according to the Virginia Supreme Court in its decision in *Lowe v. Commonwealth*, 230 Va. ____, 2 VLR 738 (1985).

Joining the rapidly growing number of appellate courts asked to rule on the issue, the Virginia Court limited its review of the case to the initial stopping of the vehicle and whether such a brief detention was conducted "pursuant to a practice embodying neutral criteria." The Court based its first ruling on sobriety checkpoints on two U.S. Supreme Court decisions, *Delaware v. Prouse*, 440 U.S. 648 (1979) and *Brown v. Texas*, 443 U.S. 47 (1979).

In *Prouse*, the Supreme Court struck down a random police spotcheck of a motorist but limited its ruling in *dicta* to random checks and left open the possibility for states to develop constitutionally acceptable roadblock plans that restrict police discretion.

The Court in *Brown* delineated a balancing test for reviewing cases involving police spotchecks, although this case also held a random search of a vehicle on the Texas-Mexico border to be unconstitutional. In examining police spotchecks of motorists, the Court said that three concerns must be weighed: "...the gravity of the public concerns served by the seizure, the degree to which the seizure advances the public interest, and the severity of the interference with individual liberty." 443 U.S. at 51. Central to this balancing, the Court continued, must be a consideration of whether a seizure is "based on specific, objective facts indicating that society's legitimate interests require the seizure of the particular individual, or that the seizure must be carried out pursuant to a plan embodying explicit, neutral limitations on the conduct of individual officers."

The Virginia Court found it unnecessary to expound on the public interest aspect of the balancing test, declaring in a footnote that the public's interest in reducing drunk driving is "overwhelming" and in no need of recitation. Instead, the Court concentrated on the second part of the test, whether the city's roadblock plan employed neutral criteria limiting the conduct of individual officers.

As to the existence of a neutral plan, the Court pointed out that the citys plan was well researched with respect to the law, the safety of police and motorists and standards for establishing the most effective locations for checkpoints. The Court did not examine, however, the degree of discretion exercised by the police after the initial detention of stopping the vehicle.

After the defendant was initially stopped in Lowe, a police officer noticed that the driver's eyes were "very red" and that there was an odor of alcohol about the driver's person. On the basis of those facts and no evidence of impaired driving or other behavior, the defendant was obliged to pull off the road, get out of the car, and perform three dexterity tests. He failed the tests, and was arrested for driving under the influence of alcohol. He took a breath analysis at the scene of his arrest, which indicated a blood alcohol level of .17.

The Virginia Court apparently viewed the increases in the length of detention as justified by the facts gathered subsequent to the initial stopping of the vehicle. While there may have been limits on police discretion to prolong the detention and demand a dexterity test that were not stated in the record, the redness of the eyes of the driver and the smell of alcohol standing alone seem to be enough in the Court's view to justify a significant increase in the length and invasiveness of the detention of the driver.

The Court relied on the limits on police discretion as to which cars to stop and the brevity of the initial detention to justify the operation of the checkpoint. However, their analysis did not embrace the totality of the checkpoint operation which involved much more discretion and much more than a mere license check. Surely the Court would have invalidated a program in which the police stopped a vehicle on the intuition that the driver was intoxicated, or a program in which all drivers were forced to perform dexterity tests. Nevertheless, it appears that the Court will countenance a program where all drivers are stopped and some detained further on the basis of unstated criteria, including such nonbehehavioral observations as redness of the eyes and an odor of alcohol.

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

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

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

Developments in Mental Health Law

Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804) 924-5435 Vol. 6, Nos. 3-4 July-December 1986

Mental disability law crosses a new frontier: a review of recent developments

by Richard J. Bonnie

Disability law continues to be one of the most rapidly developing areas of public law. It often appears to be a seamless web, even to the experts. Three interwoven threads give this fabric of law its distinctive color and character:

- The concept of liberty: the right to be free of unwarranted coercion or state intervention.
- The concept of entitlement: the government's duty to provide needed services, a duty which may be rooted in the Constitution or in statutory law.
- The concept of equality of citizenship: the right to be free of unwarranted discrimination in the distribution of burdens and benefits.

Sometimes these fundamental concepts tug against one another. For example, benefits may be provided to the mentally disabled on terms less generous than those provided for persons who experience other problems or conditions. And restrictions on personal liberty may be justified in terms of the objecting person's need for adequate services—that is, the right to treatment may clash with the right to refuse treatment.

Notwithstanding these tensions and ambiguities, however, the concepts of liberty, entitlement and equality provide the basic premises from which the law continues to develop. Recent developments in each of these three areas reflect an important theme in the continuing evolution of disability law—a shift in the focus of legal attention from institutional to community settings.

The permissible scope of coercion in non-institutional settings

One of the most divisive and fiercely debated issues in mental health law has been the criteria for involuntary psychiatric hospitalization. The United States Supreme Court sketched the boundaries of the state's authority to confine a person against his or her will in *O'Connor v. Donaldson* in 1975, and the libertarians and paternalists continue to fight about the permissible scope of the *parens patriae* basis for involuntary hospitalization. The tightening of statutory commitment criteria has occurred simultaneously with the well-known trend toward deinstitutionalization. It is not surprising, then, that commitment to *outpatient* treatment is now receiving considerable attention. When viewed from a wider frame of reference, the question being addressed is the permissible scope of legally coerced treatment in noninstitutional settings.

A procedure authorizing commitment to outpatient treatment has been on the books in Virginia and most other states for many years. But it is not often used. Moreover, most states, but not Virginia, also have coercive devices after hospital discharge—conditional discharge to facilitate rehospitalization of patients who are deteriorating and who fail to comply with conditions of outpatient treatment.

Continued on page 22

Richard J. Bonnie is Director of the Institute of Law, Psychiatry and Public Policy and John S. Battle Professor of Law at the University of Virginia.

Also in this issue:

Continued from page 21

The threat of hospitalization for civilly committed patients provides leverage for inducing compliance with prescribed treatment plans, especially medication. It is in this sense related to the use of the threat of criminal sanctions to induce compliance with prescribed treatment plans by persons under criminal charge or conviction—a practice long used in the treatment of substance abusers.

Many difficult issues concerning commitment to outpatient treatment must be addressed, such as:

- From a libertarian standpoint, is outpatient commitment a *less* restrictive alternative or a *more* restrictive alternative? That is, is the procedure likely to be invoked mainly in cases in which patients would otherwise be hospitalized, thereby *reducing* the aggregate restrictiveness of coerced treatment? Or does it *expand* the net of coercive intervention to persons who would otherwise be left alone?

- From a clinical standpoint, is coerced outpatient treatment efficacious? Does outpatient treatment reduce the likelihood of hospitalization (or rehospitalization) as compared with non-intervention? To the extent that the procedure is used for persons who would otherwise have been hospitalized, does it offer equivalent clinical benefits?

- From a legal standpoint, how should these plans be implemented? What procedures should be used to report or respond to non-compliance with the conditions specified in the commitment order? Should the clinicians responsible for providing treatment have the authority to forcibly administer medication?

There is some evidence in North Carolina that the legal sorting process doesn't yield the patients for whom outpatient commitment is the most suitable clinical intervention. Instead, a plea bargaining process occurs in which the patient's attorney views the outpatient alternative as a victory—as the equivalent of a lesser sentence. But just because an outpatient commitment order placates the person's family or is perceived as a legal victory, doesn't mean it is clinically appropriate or is likely to do any good. Most likely over the next few years, the use of legal leverage in the community will receive more careful and systematic attention.

At best, commitment to outpatient treatment can be a preferable alternative to involuntary hospitalization for a specific population of patients—for example, those with psychotic illnesses whose condition responds well to antipsychotic medication and who have a demonstrated pattern of non-compliance with medication after discharge from inpatient treatment. By the same token, however, any outpatient commitment order must be predicated upon a specific treatment plan prepared by the program to which the patient would be committed. This is necessary not only to assure clarity of expectations and procedures but also to assure that the procedure is used only for those patients the program is willing to accept; a judge should *not* be able to commit someone to clinically inappropriate outpatient treatment simply because it is perceived as being "less restrictive" than hospitalization.

Discrimination and community placement

In 1986, the Virginia General Assembly barred the use of restrictive covenants to impede the location of otherwise suitable group homes in residential communities. The legislature thereby nullified a 1984 decision of the Virginia Supreme Court which had permitted such an exclusionary use of a restrictive covenant.

This is an important piece of legislation, not as much for its practical effect as for its declarative or educational effect. It reflects a legislative judgment that the law should not enforce private prejudice against mentally disabled persons. Notwithstanding its moral significance, this sentiment is not self-executing. The major impediments to group homes are not found in restrictive covenants but in the local zoning process, where prejudicial attitudes are often masked by ostensibly legitimate considerations.

One of the most important developments in mental health law during the past year occurred when a challenge to a decision by a local zoning board excluding a group home made its way to the United States Supreme Court. In July 1980 a building on Featherston Street in Cleburne, Texas, was purchased for use as a group home for the mentally retarded. It was anticipated that the home, to be leased by an organization then called Cleburne Living Center (CLC), would house thirteen retarded men and women who would be under the constant supervision of CLC staff members. It was also anticipated that the home would be operated as a private ICF-MR (Level I Intermediate Care Facility for the

Developments in Mental Health Law

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

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

Editor
Willis J. Spaulding

Managing Editor
Lynn A. Daidone

Assistant Editor
Anne Bromley

Circulation Manager
Therese R. Wood

Guest Contributors
Richard J. Bonnie
W. Lawrence Fitch
Jonathan A.M. Schnyer
Larry Williams

Mentally Retarded), and would be eligible for Medicaid reimbursement. The site of the proposed home was an area zoned R-3 (apartment house district). Under the applicable Cleburne city ordinance the following uses are permitted in an R-3 district:

1. Any use permitted in district R-2
2. Apartment houses or multiple dwellings
3. Boarding and lodging houses
4. Fraternity or sorority houses and dormitories
5. Apartment hotels
6. Hospitals, sanitariums, nursing homes or homes for convalescents or aged, other than for the insane or feeble-minded or alcoholics or drug addicts
7. Private clubs or fraternal orders except those whose chief activity is carried on as a business
8. Philanthropic or eleemosynary institutions, other than penal institutions
9. Accessory uses customarily incident to any of the above uses

Because the group home was not covered by the listed uses, Cleburne informed CLC that a special use permit would be required. The city had determined that the proposed group home should be classified as a "hospital for the feeble-minded." After holding a public hearing on CLC's application, the city council voted 3-1 to deny the special use permit.

CLC then filed suit in federal district court against the city, alleging that the zoning ordinance was invalid on its face and as applied because it discriminated against mentally retarded persons in violation of the equal protection clause of the Fourteenth Amendment. The District Court found that if the potential residents of the home had not been mentally retarded, "but the home was the same in all other respects, its use would be permitted under the city's zoning ordinance" and that the city council's decision "was motivated primarily by the fact that the residents of the home would be persons who are mentally retarded." Nonetheless, the District Court upheld the city's decision on the grounds that it was rationally related to several legitimate interests, including "the safety and fears of residents in the adjoining neighborhood."

The Court of Appeals for the Fifth Circuit reversed, concluding that the District Court had applied an unduly lenient standard in light of the fact that the city's decision discriminated against mentally retarded persons. Applying a so-called "intermediate standard of scrutiny," the Court of Appeals held that the ordinance was invalid because it did not "substantially further any important governmental interest."

The city then appealed to the Supreme Court. The Justices unanimously held that the city's refusal to issue the special use permit was unconstitutional, although the Court did not rule on the constitutionality of the ordinance itself. Three opinions were written, and many commentators have characterized the decision as a defeat for mentally disabled persons because six Justices refused to apply the more demanding standard of review applied by the Fifth Circuit. Nevertheless, the Court's decision is an unequivocal victory for the idea of equal citizenship and will serve as a valuable precedent in other cases challenging governmental decisions that unfairly discriminate against mentally disabled persons. The fact that a majority of the Court refused to endorse the standard of review employed by the Fifth Circuit is not especially important; the majority actually employed a higher standard than it said it was applying, and the debate carried on in the Court's three opinions has more to do with the unsettled nature of equal protection jurisprudence than it does with the constitutional rights of mentally retarded persons.

The Court unanimously held the city's action unconstitutional, seeing the denial of the special use permit for the Featherston home for what it was—a reflection of the unfounded fears of the neighbors. "The short of it," said Justice White, "is that requiring the permit in this case appears to us to rest on an irrational prejudice against the mentally retarded, including those who would occupy the Featherston facility and who would live under the closely-supervised and highly-regulated conditions expressly provided for by state and federal law." Justice Stevens, who concurred in a separate opinion joined by the Chief Justice, noted that "the record convinces me that this permit was required because of the irrational fears of neighboring property owners, rather than for the protection of the mentally retarded persons who would reside in [the Featherston] home." Finally, Justice Marshall observed in an opinion joined by Justices Brennan and Blackmun, that "Cleburne's ordinance sweeps too broadly to dispel the suspicion that it rests on a bare desire to treat the retarded as outsiders, pariahs who do not belong in the community."

The Court unanimously held the city's action unconstitutional, seeing the denial of the special use permit for the Featherston home for what it was — a reflection of the unfounded fears of the neighbors.

Thus there was no controversy about the outcome in this case. Every member of the Court was willing to scrutinize and discount the arguments raised by the City of Cleburne. However, disability advocacy groups were disappointed because the majority insisted that governmental classifications based on mental retardation did not warrant heightened judicial scrutiny. (Three Justices insisted that the majority had actually applied a heightened standard and that it ought to say so.) As I mentioned earlier, however, the *Cleburne* opinions merely echo and restate the Justices' long-standing disagreement about the scope of judicial review under the Fourteenth Amendment.

To summarize the point of apparent dispute using the Court's jargon, laws which draw lines based on "suspect" classifications, such as race or national origin, trigger "strict judicial scrutiny," and laws which classify on the basis of several other classifications, such as gender and legitimacy of birth, are "quasi-suspect" or "suspicious" and are subject to "heightened," though

Continued on page 40

In the United States Supreme Court

In the October 1985 Term the United States Supreme Court considered a broad range of controversies involving psychiatry and law. In addition to those analyzed below, guest contributor Larry Fitch discusses on page 26 of this issue three other important decisions concerning competency to confess, competency to be executed and the effects of asserting the *Miranda* right to remain silent on the insanity defense.

Court avoids ruling on ex-patient's right to purchase firearms

The Supreme Court vacated a United States District Court ruling striking down certain provisions of a federal statute which prohibits those referred to by the Court as former mental patients from purchasing firearms regardless of their current health. The Supreme Court ruled that the case became moot after Congress changed the law.

U.S. Department of Treasury v. Galioto, ____ U.S. ____, 54 U.S.L.W. 4844 (June 27, 1986), concerned a challenge to the constitutionality of the 1968 Omnibus Crime Control and Safe Streets Act, as amended by the 1968 Gun Control Act. The law prevented convicted felons and persons who had been involuntarily committed to mental institutions from purchasing firearms, allowing the former but not the latter an appeal.

A New Jersey man, who had been hospitalized for several weeks in 1971, was unable to purchase a firearm in 1982 and denied an appeal by the Bureau of Alcohol, Tobacco, and Firearms (BATF). He brought suit, claiming the statute violated his rights to equal protection and due process.

In amending the 1968 Gun Control Act this year, Congress has permitted any person denied a firearm under the law an appeal to the BATF. The Supreme Court implied that the amendment, allowing former mental patients to pursue such an administrative appeal, brought the statute in conformity with the equal protection clause.

The District Court also concluded that the old statute had violated the due process clause on the statute's "irrebuttable presumption" that all ex-mental patients were too dangerous to own a firearm. Since the amendment permits such persons at least an appeal to secure the right to purchase a firearm, the statute no longer raised a wholly "irrebuttable presumption."

On remand the District Court will consider whether the statute, as amended, continues to violate either the equal protection clause or the due process clause because of the restrictions placed on the purchase of firearms by former mental patients, beyond those restrictions placed on persons who have not been hospitalized.

Medicaid spenddown regulations upheld

Massachusetts' six-month spenddown period for calculating income of the medically needy to determine eligibility for Medicaid benefits does not violate the Social Security Act's "same methodology" requirement, the United States Supreme Court decided in *Atkins v. Rivera*, ____ U.S. ____, 54 U.S.L.W. 4731 (June 23, 1986).

The spenddown provision was created by Congress in 1965 to eliminate inequity between persons earning just below the income limit for Medicaid eligibility and those earning just above that amount.

The Social Security Act, as amended in 1982, mandates that Medicaid eligibility of persons classified as medically needy, e.g. persons who meet nonfinancial eligibility requirements for cash assistance under Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI), and those classified as categorically needy, e.g. persons eligible for cash assistance under SSI or AFDC, be determined using the same methodology. The Secretary of Health and Human Services subsequently issued regulations permitting states to use a maximum spenddown period of six months to compute income of the medically needy.

Rivera argued that the use of the six-month period for calculating income of medically needy applicants violated the same methodology requirement of the Act because the eligibility of the categorically needy is based on income earned in one month. The Massachusetts Supreme Judicial Court agreed.

The United States Supreme Court, reversing the Massachusetts high court, explained that the history of the "same methodology" language demonstrated that its intent never was to control the length of spenddowns but simply to instruct states to treat the components of income similarly for both medically and categorically needy persons. The Medicaid Act, said the Court, is silent as to how many months' excess income a state may require an individual family to contribute to medical expenses before Medicaid coverage should begin. In addition, the HHS regulation permitting the states to employ a six-month spenddown period expressly authorized the Massachusetts scheme.

Civil rights attorney's fees may be waived

Waiver of plaintiff's attorney's fees is permissible in civil rights litigation, and is not contrary to the intent of the Civil Rights Attorney's Fees Awards Act of 1976, the Supreme Court held recently in *Evans v. Jeff D.*, ____ U.S. ____, 54 U.S.L.W. 4359, (April 21, 1986).

The decision followed a dispute over the settlement of a federal rights action. The plaintiffs had sought to improve the education and treatment of mentally handicapped children in Idaho. In August of 1980, plaintiffs filed suit in the United States District Court for the District of Idaho seeking injunctive relief and attorney's fees. The District Court appointed an attorney from the Idaho Legal Aid Society, Inc., Charles Johnson, to represent the plaintiffs.

Agreement was reached in October of 1981 on the aspect of the complaint relating to educational services. Within the settlement was a waiver by the plain-

Parents can now recover attorney's fees in special education disputes

Legislation reversing the Supreme Court's decision in *Smith v. Robinson*, 468 U.S. 2 (1984), was signed into law on August 5, 1986. The new law, the Handicapped Children's Protection Act of 1986 (P.L. 99-372), authorizes attorney's fees for the prevailing parties in both civil actions and administrative proceedings to secure rights guaranteed under the Education for All Handicapped Children's Act (EAHCA), more often referred to as P.L. 94-142.

In *Smith* the Court read EAHCA to preclude attorney's fees from being awarded to parents who prevail in their claims. The Court ruled that parents of handicapped children must seek redress exclusively through EAHCA, which does not allow for attorney's fees, and not the Rehabilitation Act of 1973, which does provide attorney's fees. The Court reasoned that since Congress was so specific in writing EAHCA, the intent must have been to make EAHCA the sole remedy for hearing special education claims. Parents could not circumvent EAHCA by filing a claim under the broader provisions of the Rehabilitation Act if the claim was especially addressed by EAHCA.

By passing the Handicapped Children's Protection Act of 1986, Congress purported only to clarify its original intent to establish a right enforceable by litigation and available to all parents of school-age, handicapped children. In addition to providing attorney's fees, the new law declares that EAHCA does not prevent parents from seeking judicial remedies available under the Constitution, the Rehabilitation Act of 1973 or other federal statutes, as long as parents exhaust administrative remedies delineated under EAHCA prior to pursuing civil actions. The final major provision in the bill makes the law retroactively applicable to cases brought after or pending on the date *Smith* was decided (July 4, 1984).

Many versions of the bill were considered by both houses of Congress before final passage of the Senate version in July, 1985, and the House version in November, 1985. Only two major differences were left to resolution by the Conference Committee. One was a provision in the Senate bill which would have permitted that attorneys employed by organizations receiving public funds only be compensated for their costs, rather than the prevailing market rate. The other major disagreement was over language in the House bill which would have limited the collecting of attorney's fees in administrative proceedings to the four years following enactment, at which time the General Accounting Office was to study the law's effects. Compromise was achieved in July by both provisions being dropped, although some general limits on fees were set for all attorneys (i.e. no bonuses or multipliers).

tiffs of their claim to statutory attorney's fees. The District Court approved the partial settlement.

Agreement could not be reached on the treatment claims, so both parties prepared to try the case in the spring of 1983. Just before trial the defendants offered to settle, again insisting on a waiver of attorney's fees. The plaintiffs' attorney, Johnson, signed the settlement, feeling it was in his clients' best interest.

Johnson then filed a motion asking that the settlement be accepted, except that portion of it concerning attorney's fees. Johnson argued that he should be allowed to submit a bill for his costs and fees. The District Court denied the motion and Johnson appealed to the Court of Appeals for the Ninth Circuit. The Court of Appeals invalidated the fee waiver, left intact the rest of the settlement and remanded to the District Court for a determination of fees. The state appealed the ruling of the Court of Appeals to the Supreme Court.

The Supreme Court reversed the Court of Appeals, and enforced the fee waiver. Johnson argued that settlements contingent on complete fee waivers raised an ethical dilemma for the plaintiff's attorney specifically because if the settlement is in his client's best interest, he is forced to choose between what is best for his client and collecting his attorney's fees. Johnson also contended that the Civil Rights Attorney's Fees Awards Act of 1976 prohibited "coerced fee waivers," since the purpose of the Act was to provide attorney's fees for prevailing civil rights litigants.

The Court rejected Johnson's arguments. Ruling 6-3 in favor of the state of Idaho, the Court held that the question was not one of ethics but Congressional intent. Did Congress intend to prohibit all settlements contingent on fee waivers?

Congress' ultimate purpose, wrote Justice Stevens for the majority, was to enforce the civil rights laws. Fee waivers may actually encourage the settlement of civil rights suits in favor of the plaintiffs, Justice Stevens reasoned, since defendants have an interest in reducing their potential liability. Thus, the Court found fee waivers not to be contrary to Congressional intent.

Additionally, the Court pointed out that the Act authorizes, but does not mandate, the awarding of attorney's fees to successful plaintiffs. The Act provides that "the Court, in its discretion, may allow the prevailing party . . . a reasonable attorney's fee" in enumerated civil rights actions.

Having determined Congress' intent, the Court then considered whether the District Court abused its discretion by approving a settlement containing a complete fee waiver. The Court saw only two reasons not to grant fee waivers: 1) the defendant has no realistic defense on the merits; or 2) the waiver is part of a "vindictive" effort on the part of the defendants. The Court in this case found no evidence that the state policy was to prevent the awarding of attorney's fees.

Continued on page 29

Competency to confess; competency to die

Throughout the criminal justice process, questions may arise concerning the mental competency of the accused to exercise his or her rights under the law. There may be doubts about the defendant's general competency to stand trial, or some other, more narrowly drawn competency may be at issue.

Competency to stand trial has been the subject of extensive judicial interpretation, and its requirements are familiar to most forensic mental health professionals. Some of the more specific competencies, however, have received scant attention in the law and, thus, are not at all well understood by many clinicians who serve as experts in criminal cases. Recently, the United States Supreme Court rendered opinions clarifying the requirements of two of these more neglected competency issues. Competency to confess is an issue that concerns the mental condition of the defendant at the earliest stage of the criminal process. Competency to be executed concerns the defendant's mental condition at the end. The descriptions given by the Court to these two competencies are quite dissimilar, illustrating the importance of context to the meaning of competency for legal decision-making.

Colorado v. Connelly

Competency to confess was the sole issue before the U.S. Supreme Court in *Colorado v. Connelly*, ___ U.S. ___, 55 U.S.L.W. 4043 (1986). The defendant in this case, Francis Barry Connelly, was taken into custody and charged with second degree murder after he approached a police officer on the streets of Denver and confessed to killing someone in that city nine months earlier. While in custody and after notification of his *Miranda* rights to remain silent and to consult with an attorney, Connelly repeated his confession. The following day, during an interview with the public defender's office, Connelly became "visibly disoriented" and stated that "voices" had directed him to confess to the killing.

Subsequently, Connelly was found to be incompetent to stand trial and was hospitalized for treatment to restore his competency. After approximately six months of hospitalization, Connelly was found to have regained his competency to stand trial. The prosecution resumed.

At a preliminary hearing, however, Connelly's attorney moved to suppress all of Connelly's statements to the police on the grounds that they were not voluntarily made and therefore could not be used as evidence against him. A psychiatrist called for the defense testified that at the time that Connelly made the statements he was suffering from chronic schizophrenia and was experiencing hallucinations in which God commanded him either to confess to the police or commit suicide. The psychiatrist stated that, in his opinion, while Connelly's illness did not significantly impair his "cognitive" ability to understand his *Miranda* rights, it did interfere with his "volitional" ability to make a free and rational choice whether to confess. On the basis of this testimony, the trial court excluded Connelly's confession on the rationale that it was involuntary and therefore not admissible under the due process clause of the fourteenth amendment to the United States Constitution. The Colorado Supreme Court affirmed this ruling, holding that, in order to be admissible, incriminating statements must be "the product of a rational intellect and a free will."

The government appealed this decision to the United States Supreme Court. In an opinion written by Chief Justice Rehnquist, the Court reversed the judgement of the Colorado Supreme Court, holding that coercive police activity is a necessary predicate to finding that a confession is not voluntary under the meaning of the due process clause. Rehnquist observed that in every confession case heard by the Supreme Court in the last fifty years, a "crucial element" has been police "overreaching." He concluded that the mental condition of the defendant may be relevant to the question of the voluntariness, but only insofar as the state "exploits the defendant's weakness with coercive tactics."

The opinion suggests, however, that if a defendant is unusually susceptible to the techniques used by the police to elicit a confession, those techniques might be regarded as coercive and the resulting confession might be excluded as involuntary. The Court also concedes that evidence of the defendant's mental condition at the time of the confession might be relevant to (and admissible on) the question of the confession's reliability. But, in the absence of such police behavior, it is clear in the Court's opinion that the defendant's motivation (to confess) alone is of no consequence for the due process inquiry.

The Court ruled that the Colorado Supreme Court was mistaken in its finding that Connelly's *Miranda* rights waiver was invalid. Focusing again on the question of voluntariness (i.e., whether the waiver was voluntary), the Court observed that "[t]here is obviously no reason to require more in the way of a 'voluntariness' inquiry in the *Miranda* waiver context than in the Fourteenth Amendment confession context." Finally, the Supreme Court rejected the Colorado Court's ruling that *Miranda* waivers must be proved by the State by "clear and convincing evidence," holding that such proof need only meet the preponderence standard.

In a dissenting opinion, in which he was joined by Justice Marshall, Justice Brennan objected to the majority view that police coercion is required for a confession to be considered involuntary. Quoting from an earlier Supreme Court decision, *Culombe v. Connecticut,* 367 U.S. 568, 602 (1961), Justice Brennan observed that:

> The ultimate test remains that which has been the only clearly established test in Anglo-American courts for two hundred years: the test of voluntariness. Is the confession the product of an essentially free and unconstrained choice by its maker?. . .
>
> The line of distinction is that at which governing self-direction is lost *and compulsion, of whatever nature or however infused,* pro-

pels or helps to propel the confession.

Moreover, Justice Brennan observed, the very case on which the majority relied for the proposition that police wrongdoing is essential in fact discounted the significance of such wrongdoing: "In *Blackburn v. Alabama,* 361 U.S. 199 (1960), we held irrelevant the absence of evidence of improper purpose on the part of the questioning officers. There the evidence indicated that the interrogating officers thought the defendant sane when he confessed, but we judged the confession inadmissible because the probability was that the defendant was in fact insane at the time." [Quoting from *Townsend v. Sain,* 372 U.S. 293, 609 (1963).]

With respect to Connelly's waiver of his *Miranda* rights, Justice Brennan noted that clearly established precedent requires that such a waiver be not only voluntary but also "knowing and intelligent." Citing the Court's 1986 opinion in *Moran v. Burbine,* 475 U.S.___(1986), Brennan observed that "the waiver must have been made with a full awareness both of the awareness of the right being abandoned and the consequences of the decision to abandon it." The two requirements are independent, he stated: "Only if the 'totality of the circumstances surrounding the interrogation' reveal *both* an uncoerced choice *and* the requisite level of comprehension may a court properly conclude that the *Miranda* rights have been waived." (Quoting from *Moran v. Burbine, supra,* empha-

Continued on page 28

Criminal insanity and the right to silence

In an opinion rendered on January 14, 1986, the United States Supreme Court ruled that the use by a prosecutor of a criminal defendant's post-arrest, post-*Miranda* warnings silence as evidence of the defendant's sanity at the time of the offense violates the due process clause of the fourteenth amendment to the United States Constitution. *Wainwright v. Greenfield,*___ U.S.___, 54 U.S.L.W. 4077 (January 14, 1986).

The defendant in the case, David Greenfield, was charged in Florida with sexual battery. At the time of his arrest, Greenfield was advised of his right to remain silent and to speak with a lawyer and to have the lawyer present during questioning. He replied that he wished to speak with a lawyer before making any statement.

At Greenfield's trial, two police officers who were present at the time of the arrest testified that Mr. Greenfield had, indeed, exercised his right to remain silent and had requested an opportunity to consult with an attorney before answering the officers' questions. During closing argument before the jury, the prosecutor pointed to this testimony as evidence of Greenfield's sanity:

> Does he say, 'What's going on? No. He says 'I understand my rights. I do not want to speak to you. I want to speak to an attorney.' Again an occasion of a person who knows what is going on around his surroundings, and knows the consequences of his acts.

The jury rejected Greenfield's insanity claim and found him guilty. Greenfield appealed, arguing that the prosecutor's remarks concerning statements he made in the exercise of his right to remain silent violated the rule established in *Doyle v. Ohio,* 426 U.S. 610 (1976), which prohibits the use of post-arrest, post-*Miranda* warnings silence to prove the commission of an offense.

Before the United States Supreme Court, the government argued that *Doyle* should not prevent the prosecution from commenting on the defendant's post-*Miranda* silence where such silence is offered as evidence of sanity, not as evidence that the defendant committed the offense. Writing for the majority of the court, Justice Stevens rejected this argument, observing that:

> The point of the *Doyle* holding is that it is fundamentally unfair to promise an arrested person that his silence will not be used against him and thereafter to breach that promise by using the silence to impeach his trial testimony. It is equally unfair to breach that promise by using silence to overcome a defendant's plea of insanity. In both situations, the state gives warnings to protect constitutional rights and implicitly promises that any exercise of the rights will not be penalized. In both situations, the state then seeks to make use of the defendant's exercise of those rights in obtaining his conviction. The implicit promise, the breach, and the consequent penalty are identical in both situations.

In reply to the government's argument that the state should not be denied the opportunity to present evidence that the defendant was rational at the time of his arrest, the Court observed that in Greenfield's case no such denial occurred, as the state was free to pose "carefully framed questions that avoided any mention of the defendant's exercise of his constitutional rights to remain silent and to consult counsel."

In a concurring opinion, joined in by Chief Justice Burger, Justice Rehnquist indicated his preference for a narrower ruling, which would fault only the prosecutor's reference to Greenfield's silence, not his request for an attorney: "I do not read the [*Miranda* warning] as containing any promise, express or implied, that the words used in responding to notice of the right to a lawyer will not be used by the state to rebut a claim of insanity." In addition, Justice Rehnquist indicated that he would have been sympathetic to the argument, had it been made, that the prosecutor's error was harmless beyond a reasonable doubt and therefore did not require reversal of the conviction because the testimony of the officers on which the prosecutor's information was based already had been admitted without an objection and "was there for the jury to consider on its own regardless of whether the prosecutor ever mentioned it."

by W. Lawrence Fitch

Continued from page 27

sis added by Justice Brennan.) Brennan expressed his befuddlement over the Court's willingness to overturn the entire judgement in *Connelly* without addressing this independent requirement for the *Miranda* waiver.

Finally, observing that previous Supreme Court decisions had always set a high standard of proof for the waiver of constitutional rights, and presenting as an example the Court's requirement that the prosecution meet a clear and convincing standard in demonstrating that evidence is not tainted by the absence of counsel at police line-ups [see *United States v. Wade,* 388 U.S. 218, 240 (1967)], Brennan opposed the majority position that Connelly's *Miranda* waiver need be proved only by a preponderence of the evidence.

In a third opinion, Justice Stevens concurred in the majority view that the *initial* statement Connelly made to the police—the statement he made prior to being taken into custody—was admissible because it involved no state action whatsoever (and therefore its use "for whatever evidentiary value [it might have]" is not "fundamentally unfair"); but he dissented from the majority view that subsequent statements—those made after the custodial relationship was established—also were voluntary:

> The Court's position is not only incomprehensible to me; it is also foreclosed by the Court's recent pronouncement in *Moran v. Burbine,* 475 U.S.___,___(1986), that 'the relinquishment of the right must have been voluntary in the sense that it was the product of a free and deliberate choice. . .' Because respondent's waiver was not voluntary in that sense, his custodial interrogation was presumtively coercive. The Colorado Supreme Court was unquestionably correct in concluding that his post-custodial incriminating statements were inadmissible.

Ford v. Wainwright

In *Ford v. Wainwright,*___U.S.___, 54 U.S.L.W. 4799 (1986), the Supreme Court for the first time held that the Constitution protects against the infliction of the death penalty on an offender who is "insane" (or, perhaps more accurately, incompetent to be executed). The Court also addressed procedures to be followed in determining an offender's "sanity" for this purpose, ruling that the procedures employed in Ford's case provided a constitutionally inadequate assurance of accuracy in fact-finding.

The defendant in this case, Alvin Bernard Ford, was convicted of murder and sentenced to death in 1974. Beginning in 1982, Ford's thinking and behavior began to change. Over time, he developed the delusion that the Ku Klux Klan and the guards in his prison had conspired to force him to commit suicide. He believed that the guards were killing people and placing their bodies in the concrete enclosures used for the beds in the prison, that his female relatives were being tortured and sexually abused somewhere in the prison, and that, in all, 135 of his friends and relatives were being held hostage in the prison. Some time later, he "appeared to assume authority for ending the 'crisis,' claiming to have fired a number of prison officials . . . [and] appointed nine new justices to the Florida Supreme Court."

Two psychiatrists who examined Ford on behalf of the defense indicated that Ford was suffering from paranoid schizophrenia. One concluded further that Ford "had no understanding of why he was being executed, made no connection between the homicide of which he had been convicted and the death penalty, and indeed sincerely believed that he would not be executed because he owned the prison and could control the governor through mind waves."

Based on these findings and further deterioration in Ford's mental condition, Ford's attorney invoked the procedure in Florida law for determining Ford's competency to be executed. Pursuant to this procedure, the Governor of Florida appointed three psychiatrists who together interviewed Ford for a total of 30 minutes. Present during the interview were Ford's attorney, attorneys for the State, and officials of the Florida Department of Corrections. Two of the psychiatrists concluded that Ford was psychotic but competent under Florida law. The third suggested that Ford's disorder "seem[ed] contrived and recently learned".

Consistent with his policy of "excluding all advocacy on the part of the condemned from the process of determining whether a person under a sentence of death is insane" [quoting from *Goode v. Wainwright,* 448 So. 2d 999, 1001 (Fla. 1984)], the Governor ruled on the question of Ford's competency without hearing arguments from Ford or his counsel and without indicating whether he had reviewed reports submitted by the psychiatrists who had evaluated Ford for the defense. The Governor's decision, that the execution should proceed, was challenged unsuccessfully in the Florida Supreme Court, the United States District Court, and the United States Court of Appeals. Finally, the United States Supreme Court accepted the case for review.

In his opinion for the Supreme Court, Justice Marshall traced the common law history of the bar against executions of the insane, noted that no state in the Union permits such executions, and concluded that, in the face of such universal objection, "this court is compelled to conclude that the 8th Amendment prohibits a state from carrying out a sentence of death on a prisoner who is insane."

With regard to the criteria to be applied in determining an offender's competency to be executed, the Court was unclear. The factors that the Court suggested should be considered include (1) whether the defendant is able to assist counsel in seeking a stay of execution, (2) whether the defendant understands the nature of the death penalty and why it was imposed, and (3) whether the defendant is able to make his peace with God. The Court suggested as possible rationales for the rule (1) that executing the insane is barbaric and offends human dignity, (2) that executing the insane can be no example to others and therefore serves no deterrence function, and (3) that executing the insane fails to exact adequate retribution since its "moral quality" does not equal that of the crime for which the punishment is to be inflicted.

With regard to the procedures that must be followed in determining an offender's competency to be executed, the Court again was imprecise, leaving to the states the task of devising

Continued on page 37

Continued from page 25

Ruling permits reapplication for Social Security mental disability benefits

Bowen v. City of New York, ___ U.S. ___, 54 U.S.L.W. 4536 (June 2, 1986).

At the federal district court level, the City of New York successfully challenged a secret policy of the Social Security Administration that had resulted in the denial or termination of disability benefits to thousands of mentally ill persons.

The covert policy of the Social Security Administration condemned in this case directed the state disability determination service to use the listings to screen out mentally ill applicants who, if their cases received the fuller consideration they were entitled by law, would be shown to lack the residual functional capacity to engage in substantial gainful activity. The listings ("Listing of Impairments") are administrative definitions of extreme disability designed to quickly screen in qualified applicants for benefits whose impairments meet those definitions.

On appeal, the Secretary of Health and Human Services did not contest the district court determination that the policy was illegal. Instead, the Secretary argued that many of the members of the plaintiff class on whose behalf the City of New York was suing were barred from reapplying for benefits. The Secretary argued that in some cases the 60-day period for appealing a denial or termination of benefits had expired; in other cases the disappointed claimant had failed to exhaust his administrative remedies (such as seeking reconsideration by the disability determination service, a hearing before an administrative law judge, or review by the Appeals Council) before filing suit in the federal district court.

It was this narrow issue that came before the Supreme Court. Speaking for a unanimous Court, Justice Powell turned aside all of the Secretary's arguments. The 60-day limit on seeking appeals of unfavorable disability determinations was ruled by the Court to be a statute of limitations which had been tolled until such time as the members of the plaintiff class learned of the illegal, clandestine policy which was responsible for the unfavorable determination. The failure of many members of the plaintiff class to exhaust their administrative remedies was excused by the Court on several different grounds, including the possibility that forcing the claimants to go back through the administrative appeals process might inflict further psychological injury on them.

The Social Security Disability Benefits Reform Act of 1984 brought a halt to the practice of using the listing to screen out claims based on mental impairments, and, within limits, now authorizes reapplication for benefits under the new law. The decision in *Bowen v. City of New York,* however, might be employed by any applicant affected by the former policy to seek a redetermination of eligibility for disability benefits under Titles II or XVI of the Social Security Act.

Death sentence upheld despite improper psychiatric testimony

The United States Supreme Court in *Smith v. Murray,* ___ U.S. ___, 54 U.S.L.W. 4833 (June 26, 1986), refused to consider constitutional questions concerning the admission of improper psychiatric testimony, allowing a death sentence to stand.

Smith was convicted of the May, 1977, murder of a woman and sentenced to death following a jury trial. Psychiatric evidence, obtained in a pretrial evaluation, was presented during the sentencing hearing. Defense counsel objected that the defendant had not been informed that the evidence might be used against him.

But on appeal to the Virginia Supreme Court, defense counsel failed to assign error to the use of the psychiatric testimony. Although various objections to the Commonwealth's use of the psychiatric testimony were raised in an *amicus curiae* brief, the Virginia Supreme Court affirmed the lower court conviction and sentence in all respects. Based on a rule of the court, only those arguments advanced by *amicus* that dealt with errors specifically assigned by the defendant himself may be considered on appeal.

The United States Supreme Court concluded that counsel's failure to press for the exclusion of damaging psychiatric testimony was not procedural default according to Virginia's rules, nor was it such a great error as to be constitutionally deficient under the test of *Strickland v. Washington,* 466 U.S. 668 (1984). The Court determined that Smith's claim was not so novel as to excuse noncompliance with Virginia's rules of procedures since various forms of the claim had been percolating in the lower courts for a number of years. The Court also noted that the psychiatrist's admitted testimony neither resulted in the preclusion of the development of true facts nor in the admission of false ones.

Justice Stevens, in a lengthy dissent, explained that federal habeas corpus was appropriate here, as the state's interest was not adequate to obstruct it. He concluded that constitutional violations that implicate "fundamental fairness" are not solely those that go to the accused's guilt or innocence.

Justice Powell also believed that because "the most severe of all sentences" was at stake, appropriate weight and attention should be given to defendant's claims. He determined that the introduction of the psychiatrist's comments violated the defendant's Fifth Amendment rights because he was not informed that information he gave to the psychiatrist might later be used against him. The violation of this right, argued Powell, "made a significant difference" in the jury's evaluation of the defendant's future dangerousness. Finally, Justice Powell concluded the use of the testimony violated the defendant's right under the Eighth Amendment to a fair sentencing proceeding.

Continued on page 30

Continued from page 29

Impermissible malice instruction may be harmless error

*Rose v. Clark,*____ U.S.____, 54 U.S.L.W. 5023 (July 2, 1986).

At trial in a Tennessee state court, Stanley Clark admitted to firing four shots at point blank range at his former girlfriend, Joy Faulk, and her boyfriend, Charles Browning, and killing them. Among Clark's defenses were his claims, supported by the testimony of two psychiatrists, that he was either insane or incapable of former criminal intent. Both lay and expert evidence was adduced of Clark's amnesia for the events, and his depression and heavy drinking at the time of the killings.

At the conclusion of the trial the court instructed the jury:

> All homicides are presumed to be malicious in the absence of evidence which would rebut the implied presumption. Thus, if the State has proven beyond a reasonable . . . doubt that a killing has occurred, then it is presumed that the killing was done maliciously. But this presumption may be rebutted by either direct or circumstantial evidence, or by both, regardless of whether the same be offered by the Defendant, or exists in the evidence of the State.

Clark was convicted of the first degree murder of Faulk and the second degree murder of Browning. These two crimes, requiring proof by the prosecution of different levels of intent, (premeditation and malice, respectively), were premised on the same behavior by Clark.

After an unsuccessful appeal to the Tennessee Court of Appeals, Clark successfully challenged the constitutionality of his conviction in federal district court. The district court, and later, the Sixth Circuit Court of Appeals, concluded 1) that the jury instruction was unconstitutional, and 2) such an error could never be harmless where a *mens rea* defense had been raised. Since the error was not harmless, the federal court directed that Clark be retried.

The Supreme Court, however, agreed with the state that such an instruction, although it is unconstitutional, could nonetheless be a harmless error. The Court remanded Clark's conviction to the Sixth Circuit Court of Appeals with the unmistakable expectation that the error would be found harmless. Justices Blackmun, Brennan and Marshall dissented.

All the Justices agreed that the malice instruction was unconstitutional. That question had been answered in *Sandstrom v. Montana,* 442 U.S. 510 (1979), a case decided shortly before Clark's trial began. *Sandstrom* forbade shifting to the defendant the prosecutorial burden of proving intent beyond a reasonable doubt, through an instruction which requires the jury to presume, (contrasted with those that allow the jury to infer), intent from a criminal act. Clark's conviction had been preceded by just such an impermissible, *Sandstrom* instruction.

But the Court majority in *Clark* was emphatic in classifying *Sandstrom* instruction with those other mistakes in a criminal trial which on review may be overlooked as "harmless." In *dictum* that was disputed in a concurrence by Justice Stevens, the majority went so far as to say that

> . . . if the defendant had counsel and was tried by an impartial adjudicator, there is a strong presumption that any errors that may have occurred are subject to harmless error analysis.

It is not difficult to detect in the majority's opinion, (and especially in former Chief Justice Burger's concurrence), a belief that not only are *Sandstrom* errors subject to "harmless error" analysis, but that the reviewing court should not hesitate to conclude that such errors are harmless.

Prisoners denied damages under fourteenth amendment

Negligent acts by state officials do not amount to a denial of due process under the fourteenth amendment, according to the United States Supreme Court's decisions in *Daniels v. Williams,* ____U.S.____, 54 U.S.L.W. 4090 (January 21, 1986) and *Davidson v. Cannon,* ____U.S.____, 54 U.S.L.W. 4095 (January 21, 1986).

In both cases, prisoners who sustained injuries while residing in state prisons sued for damages under 42 U.S. § 1983, claiming that the negligence of state officials resulted in a deprivation of property prohibited by the fourteenth amendment. In *Daniels,* the prisoner was injured after tripping over a pillow allegedly left by a guard on a prison staircase. In *Davidson,* the prisoner claimed guards should have prevented an assault, about which prison officials had been warned.

Justice Rehnquist, writing for the majority in both cases, distinguished an earlier Supreme Court decision in *Parratt v. Taylor,* 451 U.S. 527 (1981), which implied that § 1983 claims did not require proof of intentional misconduct. Rehnquist argued that while § 1983 did not require proof of intent, the plaintiff still had to show a violation of the "underlying constitutional right." And depending on the right, negligence might not be enough to sustain a claim.

What the effect of the two decisions will be is not altogether clear. Certainly fewer claims will be filed by prisoners under § 1983 and the fourteenth amendment. Instead, prisoners seeking damages probably will rely on an eighth amendment claim of cruel and unusual punishment. The Court held in *Estelle v. Gamble,* 429 U.S. 252 (1977), that the eighth amendment provides a remedy in cases where serious injuries are caused by "deliberate indifference" on the part of prison officials. Tripping over a pillow would not constitute deliberate indifference. Refusing to protect a prisoner from an assault might.

Since the eighth amendment does not apply to patients in state mental health and mental retardation facilities, however, the *Daniels* and *Davidson* decisions may have a greater impact on them than on state prisoners.

Continued on page 35

The Tenth Annual Symposium on Mental Health and the Law:

Professional Liability Issues in the Mental Health, Mental Retardation, and Substance Abuse Professions

presented by

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

The Virginia Department of Mental Health and Mental Retardation

May 28—29, 1987

Conference Center

Williamsburg Lodge

Colonial Williamsburg, Virginia

Registration

Registration can be assured by completing the attached registration form and returning it with the appropriate fee. No partial registrations are available. Luncheon on Friday is included in the registration fee; early registration is suggested to ensure luncheon seating. Please make checks payable to the Institute of Law, Psychiatry and Public Policy. Return registration to:

Institute of Law, Psychiatry and Public Policy
Box 100, Blue Ridge Hospital
Charlottesville, VA 22901

For further information, please call (804) 924-5435.

Lodging

A block of rooms is being held for conference participants at each of the following locations. To make reservations at the Williamsburg Inn, Lodge or Cascades, phone (804) 229-2070 and refer to room block ILP7; to make reservations at the Holiday Inn - 1776, phone (804) 220-1776 and refer to Mental Health and the Law Symposium room block.

Williamsburg Inn	$134 single or double occupancy
Williamsburg Lodge - Main	$100 single or double occupancy
Cascades Wings	$86 single or double occupancy
*Holiday Inn - 1776	$58 single or double occupancy

*Shuttle service from Holiday Inn to the Conference Center will be available.

Mandatory CLE

This program has been approved by the Virginia Mandatory Continuing Legal Education Board for ten (10) hours of credit. Accrued credit hours in excess of eight (8) may be carried forward from one year to meet the requirement for the next year.

CME

The University of Virginia School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The University of Virginia School of Medicine designates this continuing medical education activity for ten (10) credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association.

CEU

The University of Virginia Division of Continuing Education has approved this program for 1.0 Continuing Education Unit. There is a $10 fee for credit.

Registration

Name _____ Telephone (office) _____

Title _____ (home) _____

Address _____

_____

_____

Fee enclosed (check one): _____ $75; _____ $85 (with CEU credit)

Advance payment required unless special arrangements are made.

Program

Thursday, May 28

12:30 p.m. Registration at the Conference Center

1:00 p.m. Introduction: The Relation of Litigation to Quality Control
Richard J. Bonnie, LL.B.

1:30 p.m. Commissioner's Address: Malpractice Claims in a State Mental Health and Mental Retardation System
Howard M. Cullum

2:00 p.m. Update on Tardive Dyskinesia Claims
C. Cooper Geraty, LL.M., Moderator

Recent Cases and Legal Trends
Joel I. Klein, J.D.

The Clinician's Responsibility in the Management of Tardive Dyskinesia
Michael A. Solomon, M.D.

3:30 p.m. Coffee

3:45 p.m. Liability for Acts of the Dangerous Patient
Frank W. Pedrotty, J.D., Moderator

Prospective Assessment of Patient Dangerousness
Lisa S. Hovermale, M.D.

Evaluating the Merits of a Claim
Park Elliott Dietz, M.D., M.P.H., Ph.D.

Special Considerations for the Forensic Patient
Russell C. Petrella, Ph.D.

Recent Reformulations of the Standard of Care
W. Lawrence Fitch, J.D.

5:30 p.m. Recess

5:45 p.m. Reception (Cash Bar) on the Lodge Terrace

Friday, May 29

9:00 a.m. Legal Advocacy in Malpractice Claims Against Mental Health, Mental Retardation and Substance Abuse Professionals
C. Robert Showalter, M.D., Moderator

Counselling the Plaintiff and Cross-Examining the Defendant: The Perspective of the Plaintiff's Attorney
Guy E. Daugherty, J.D.

Pre-Trial Procedures in the Attorney General's Office from Investigation to Settlement
Jane E. Hickey, J.D.

10:45 a.m. Coffee

11:00 a.m. Interrelationship of the Virginia Tort Claims Act and the Medical Malpractice Act in Mental Health Malpractice Cases
Karen A. Gould, J.D.

12:00 Noon Luncheon in the Virginia Room

Luncheon Address: The Virginia Response to the Liability Insurance "Crisis"
H. Lane Kneedler, LL.B.

2:00 p.m. Suicide Litigation
Irwin N. Perr, M.D., J.D.

3:00 p.m. Discussion of Dr. Perr's Presentation
Park Elliott Dietz, M.D., M.P.H., Ph.D., Moderator

Discussants:
Guy E. Daugherty, J.D.
Karen A. Gould, J.D.
C. Robert Showalter, M.D.

4:00 p.m. Adjourn

Program Faculty

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

Howard M. Cullum
Commissioner
University Department of Mental Health and Mental Retardation

Guy E. Daugherty, J.D.
Howell, Daugherty, Brown and Lawrence
Norfolk, Virginia

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

W. Lawrence Fitch, J.D.
Director, Forensic Evaluation Training and Research Center
University of Virginia

C. Cooper Geraty, LL.M.
Mental Health Consultant
Protection and Advocacy for the Developmentally Disabled, Inc.
Anchorage, Alaska

Karen A. Gould, J.D.
Crews and Hancock
Richmond, Virginia

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

Lisa S. Hovermale, M.D.
Forensic Psychiatry Fellow
Institute of Law, Psychiatry and Public Policy
University of Virginia

Joel I. Klein, J.D.
Onek, Klein and Farr
Washington, DC

H. Lane Kneedler, LL.B.
Chief Deputy Attorney General
Commonwealth of Virginia
Associate Dean and Professor of Law
University of Virginia School of Law

Frank W. Pedrotty, J.D.
Assistant Attorney General
Commonwealth of Virginia

Irwin N. Perr, M.D., J.D.
Professor of Psychiatry and Professor of Environmental and Community Medicine,
Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey
Adjunct Professor of Law, Rutgers University Law School

Russell C. Petrella, Ph.D.
Director of Forensic Services
Virginia Department of Mental Health and Mental Retardation
Research Associate Professor of Psychology
University of Virginia

C. Robert Showalter, M.D.
Clinical Associate Professor of Behavioral Medicine and Psychiatry
Associate Medical Director, Institute of Law, Psychiatry and Public Policy
University of Virginia

Michael A. Solomon, M.D.
Director, Forensic Unit, Western State Hospital
Assistant Professor, Department of Behavioral Medicine and Psychiatry,
University of Virginia

Symposium Director
Willis J. Spaulding, J.D.

Wyatt case settled

The case which began as *Wyatt v. Stickney* on October 23, 1970, in a federal district court in Alabama has been settled. In an order entered September 22, 1987, the district court approved a settlement which dissolved the receivership into which the Alabama Mental Health and Mental Retardation system had been placed. The order also abolished the Office of the Court Monitor, which had been created to monitor compliance with judicially created standards of care. Pending motion by the state to vacate those standards, and motions by the plaintiff for judicially ordered funding and creation of an independent receivership were also denied by the court's order.

The order requires the establishment of a patient advocacy program and a quality assurance program. While both these programs may be internally operated by the Alabama Department of Mental Health and Mental Retardation, the court enjoined the state as well to create a committee of independent experts to assure that progress is made toward accrediting its facility and in placing members of the plaintiff class in community facilities. The settlement order places greater emphasis than prior orders in this litigation on accreditation from the Joint Commission on Hospitals and on community placement.

In January, 1987, the state appointed the committee of independent consultants called for by the settlement order. The committee includes:

Dr. James Foshee, Ph.D.
Robert L. Okin, M.D.
Kathy E. Sawyer
Clarence J. Sundrum, J.D.
Thomas B. Stage, M.D.

Dr. Stage is presently a psychiatric consultant for the Hospital Accreditation and Administration for the Commonwealth of Virginia, Department of Mental Health and Mental Retardation, Psychiatric Consultant for Medical Affairs for the Fairfax-Falls Church Community Services Board, Vienna, Virginia, and Consultant/Surveyor for the Joint Commission on Accreditation of Hospitals. Dr. Stage received his M.D. from Ohio State University and is certified in psychiatry and neurology. Additionally, Dr. Stage is certified by the American Psychological Association as a Mental Hospital Administrator. Dr. Stage has been actively involved in numerous professional associations including the American Psychiatric Association. □

Continued from page 30

Baby Doe Rules struck down

***Bowen v. American Hospital Association*, ___U.S.___, 54 U.S.L.W. 4579 (June 9, 1986).**

The administration's "Baby Doe" rules are not authorized by § 504 of the federal Rehabilitation Act, the Court ruled in a 5-3 decision. The decision, announced in a plurality opinion by Justice Stevens, joined by Justices Marshall, Blackmun and Powell, and concurred with by Chief Justice Burger, grew out of an April 9, 1982, incident involving "Baby Doe."

Baby Doe was a Bloomington, Indiana, newborn infant with Down's syndrome. In addition, the infant suffered from an esophageal obstruction. Surgery was required to permit feeding. The parents refused to consent to the surgery, and a local court, petitioned by the hospital to override the parents' decision, sided with the parents. The child died from starvation six days after birth.

On May 18, 1982, the Department of Health and Human Services began a four-year regulatory effort to prevent the withholding of health care to severely handicapped newborns under the authority of § 504 of the federal Rehabilitation Act of 1973. § 504 mandates that

> No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The HHS rules were challenged in court almost immediately by organizations such as the American Academy of Pediatrics and the American Hospital Association. The Final Rules, with some modifications, went into effect February 13, 1984, and became the focus of the litigation, which now included a suit filed against the government by the American Medical Association.

There were four parts of the regulations in controversy. First, federally assisted health care providers were required to post notices declaring that § 504 prohibited withholding care from severely handicapped newborns. Second, state agencies providing child protective services were charged with preventing medical neglect of severely handicapped newborns, and requiring reports of possible incidents of medical neglect. Third, HHS was given immediate access to patient records. Fourth, HHS was given an expedited compliance procedure. Two parts of the regulations calling for the voluntary establishment of "Infant Care Review Committees" to assist in treatment decisions were unchallenged.

The Supreme Court found that all four contested parts of the Final Rules were invalid exercises of rule-making authority. The Court's decision turned on the inadequacy of the evidentiary basis for the Rules. The Secretary simply could not point to cases in which, from the Court's perspective, it was a health care provider, rather than a parent, who withheld treatment from a severely handicapped newborn. The complex manner in which the Court reached its decision, however, has led many, including the dissenters, to interpret it as a broader condemnation

Continued on page 36

Continued from page 35

of federal regulation of health care decisions involving children under § 504.

The key to the Court's decision was found in the preamble to the Final Rules themselves. There the government, reversing its earlier position, stated that when

> a non-treatment decision, no matter how discriminatory, is made by parents, rather than by the hospital, section 504 does not mandate that the hospital unilaterally overrule the parental decision and provide treatment notwithstanding the lack of consent.

This line of reasoning, drawing on state common law and the constitutional right to privacy, proved to be fatal to the regulations. The Court, in analyzing the Baby Doe case and all other incidents on which the regulations were targeted, concluded that each was a case of the parent's refusing to consent to treatment, and not the hospital's refusing to provide it.

While the newborns were "handicapped persons" within the meaning of § 504, and the hospitals were recipients of federal assistance, the Court reasoned that it was because of the parent's refusal to consent—and not the infant's handicap—that the infant was denied treatment. And, the infant was not "otherwise qualified" for treatment, because of the parent's refusal to authorize treatment. The regulations were declared invalid because the administration could not produce evidence of the withholding of treatment, to which parents had consented.

While conceding that parents had the authority to withhold consent to treatment and that they were not subject to regulation under § 504, Justice White in his dissent argued that the "parental consent decision does not occur in a vacuum." Doctors can influence that decision by encouraging or failing to encourage the parents to consent to treatment.

Studies relied upon by HHS in rulemaking showed that many pediatric surgeons and pediatricians would either acquiesce in or actively encourage the refusal of parents to consent to surgery on newborns with Down's syndrome.

The regulations were declared invalid because the administration [HHS] could not produce evidence of the withholding of treatment, to which parents had consented.

By contrast, very few physicians would acquiesce in a parental refusal of consent where the infant had intestinal atresia but no other disorder.

The evidence that decisions to withhold treatment from handicapped infants were being made and that the conduct of the health-care providers could influence those decisions would have persuaded Justice White that the regulations were sufficiently rational.

Conviction-prone juries in capital cases approved

This unusual ruling by the United States Supreme Court came in the case, *Lockhart v. McCree,* ____ U.S. ____, 54 U.S.L.W. 4449 (May 5, 1986), the outcome of which many thought would be determined by social scientific research on juries. A state may use a single jury in capital cases to determine both guilt and sentence, even if, in removing from the jury persons unwilling to impose a capital sentence, the jury is also rendered more prone to find guilt.

McCree, in support of whom the American Psychological Association filed an *amicus* brief, relied on extensive social science research into the behavior of jurors in capital murder cases. This research demonstrated that "death-qualified" jurors were conviction-prone.

Lawyers for the state of Arkansas defended its practice of using a single jury in bifurcated capital cases by attacking the validity of the research. The Court's majority, however, sidestepped what had been expected to be the dispositive issue in the case, by conceding that the research was correct, but ruling that it did not matter.

Eighteen years ago the Court vacated the death sentence, but not the conviction, in a case where venirepersons who opposed to any extent the death sentence had been removed. The Court in this decision, *Witherspoon v. Illinois,* 391 U.S. 510 (1968), said that only persons who "made unmistakably clear . . . that they would *automatically* vote against the imposition of capital punishment" could be excluded from the jury. These venirepersons subsequently became known as "*Witherspoon*-excludables," and a jury from which they had been excluded, "death-qualified."

The defendant in *Witherspoon* had argued that the exclusion of jurors who were opposed in principle to the death penalty unfairly biased the jury in favor of the imposition of the death penalty. The Court agreed. The defendant also had contended that "death-qualified juries were more prone to convict" and offered the Court in support of his contention three empirical studies and a preliminary summary of a fourth.

The *Witherspoon* Court was not convinced of the evidence before it that death-qualified juries were more prone to find guilt, and refused to reverse the conviction in that case. The Court appeared to leave open the question of whether, if a defendant showed that his death-qualified jury was "less than neutral with respect to *guilt*," the state could be required to use two juries, the first for the determination of guilt, and the second (which alone would be death-qualified) for the determination of sentence.

After *Witherspoon* several social scientific studies were published suggesting that, in contrast to excluded venirepersons, "death-qualified jurors are, for example, more likely to believe that a defendant's failure to testify is indicative of his guilt, more hostile to the insanity defense, more mistrustful of defense attorneys, and less concerned about the danger of erroneous convictions." (54 U.S.L.W. at 4456) Even the process of death-qualification seems to increase the tendency of the jurors selected to convict.

In *Lockhart v. McCree,* an Arkansas defendant was convicted of capital murder by a death-qualified jury. This same jury imposed a sentence of life imprisonment without parole. In his federal habeas corpus petition, McCree claimed that the death-qualification of his jury (i.e., the removal of all *Withers-*

Continued from page 28

"appropriate ways to enforce the constitutional restriction upon its execution of sentences." The Court's objection to the Florida procedure, however, offers guidance for those who would fashion acceptable procedures. To begin with, the Court found that, in denying Ford an opportunity to be heard by the factfinder, Florida law failed adequately to involve Ford in the truth-seeking process. Quoting from *Solesbee v. Balkom,* 339 U.S. 9, 23 (1950), the Court observed that "the minimum assurance that the life and death guess will be a truly informed guess requires respect for the basic ingredient of Due Process, namely, an opportunity to be allowed to substantiate a claim before it is rejected."

A second defect in the Florida law identified by the Court was its failure to provide the defendant with an opportunity to challenge or impeach the opinions of the state-appointed psychiatrists. "Cross-examination of the psychiatrists, or perhaps a less formal equivalent, would contribute markedly to the process of seeking truth in sanity disputes by bringing to light the basis for each expert's beliefs, the precise factors underlying those beliefs, any history of error or caprice of the examiner, any personal bias with respect to the issue of capital punishment, the expert's degree of certainty about his or her conclusions, and the precise meaning of ambiguous words used in the report. Without some questioning of the experts concerning their technical conclusions, a fact-finder simply cannot be expected to evaluate the various opinions, particularly when they are themselves inconsistent."

Finally, the Court held that, in placing decision-making authority wholly within the executive branch of government, Florida law failed to guarantee neutrality in the factfinding process. "Under this procedure, the person who appoints the expert and ultimately decides whether the State will be able to carry out the sentence that it has long sought is the Governor, whose subordinates have been responsible for initiating every stage of the prosecution of the condemned from arrest through sentencing."

In a separate opinion, Justice Powell concurred in the judgement of the Court but stated his preference for a narrower standard for incompetency to be executed: "I would hold the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it." With regard to the question of what procedure must be followed in determining the competency issue, Justice Powell wrote that, while the procedures followed in Florida did not comport with basic fairness, a constitutionally acceptable procedure may be "far less formal" than the "kind of full scale 'insanity trial' Justice Marshall appears to find necessary."

In yet another opinion, Justice O'Connor, with whom Justice White joined, objected to the Court's ruling that the eighth amendment created a substantive right not to be executed while insane. Nevertheless, she concurred in the judgement of the Court, observing that due process was denied by Florida's failure to provide Ford with an opportunity to be heard on the matter of his *state statutory right* not to be executed while insane.

Finally, Justice Rehnquist, with whom then Chief Justice Burger joined, wrote a dissenting opinion in which he both rejected the view that the Constitution protects against the execution of the insane and approved the procedures followed in Florida to determine Ford's competency to be executed under Florida law. □

by W. Lawrence Fitch

---

poon-excludables from the jury), deprived him of his Sixth Amendment right to have the issue of guilt determined by 1) an impartial jury which was 2) selected from a representative cross-section of the community.

After reviewing fifteen social science studies, both the District Court and the Eighth Circuit Court of Appeals agreed with McCree, although the Eighth Circuit did not reach the impartiality claim. The Supreme Court, in a 6-3 decision, reversed the Court of Appeals.

The decision, written by Justice Rehnquist, addressed both the issue of whether the jury was sufficiently impartial, and whether it was drawn from a sufficiently representative cross-section of the community. For the purposes of the Court's ruling, the social science studies were accepted as valid, although Justice Rehnquist examined at some length the flaws in the studies, and was obviously unconvinced by them.

The Court ruled that the trial jury, unlike grand juries, did not have to be drawn from a representative cross-section of the community. And if it did, "*Witherspoon*-excludables" did not amount to a distinctive group such as blacks, women, or Mexican-Americans, of which the jury must be representative, either on a Sixth Amendment fair cross-section theory or equal protection theory.

On the question of impartiality, Justice Rehnquist noted that McCree had conceded that the jurors individually had been sufficiently impartial, and was complaining only that the jury collectively had been slanted toward conviction by the death-qualification process.

Justice Rehnquist's rejection of this complaint about the jury's impartiality reflected a number of loosely related concerns. Balancing the attitudes of individual jurors was impractical, he said. How could the defendant complain about jury bias that could also occur by chance? As long as the jurors are individually willing to apply the law, their collective predisposition toward conviction is of no constitutional significance. The standards for impartiality in the guilt phase of a capital trial are lower than in the sentencing phase. The state has an important interest in using a single jury in capital cases. It allows the state to put on much of the evidence only once instead of twice. And it allows a jury which had "residual doubts" about the conviction to impose a lesser sentence.

Continued on page 38

State adopts regulations specifying supervision of unlicensed psychologists

The Virginia Board of Psychology has adopted new regulations requiring supervision of unlicensed psychologists in the public sector. Prior to July 1, 1986, § 54-944 (d) of the Virginia Code exempted psychologists employed by state or local government from the requirement of licensure. An amendment by the 1986 General Assembly narrowed this exemption. The new law prohibits exempted psychologists from moonlighting in private practice. The law also requires that a licensed psychologist supervise the activities of the exempted psychologist in his public sector employment.

The Board of Psychology regulations (VRR 565-0102) explain the kind of supervision that is necessary for compliance with the statute. For example, the supervising licensed psychologist must now review and countersign all "assessment protocols, intervention plans and psychological reports" by the exempted psychologist within thirty days.

No later than October 29, 1986, the supervising psychologist must submit to the board a "supervisory protocol" for each unlicensed psychologist currently supervised, signed by the supervisor, supervisee, and representative of the public agency employing the supervisee. Thereafter, the supervisor must notify the Board within ten days of any change in a supervisory relationship, and send a new supervisory protocol to the Board within thirty days of the notice. □

Continued from page 37

This final rationale, that somehow the defendant in a capital case would benefit from a single jury, was characterized by Justice Marshall in his dissent as "offensive," "disingenous" and "cruel." The dissent was directed toward the standards by which the Court assessed the jury's impartiality. The concern for neutrality in the determination of guilt was no less, Justice Marshall maintained, than it was in the sentencing struck down in *Witherspoon*. And, the Court was viewing the requirement of neutrality too narrowly.

Justice Marshall's dissent urged the adoption of the perspective used by the Court in *Ballew v. Georgia*, 435 U.S. 223 (1978) which held that criminal convictions by a five-person jury violated the Sixth and Fourteenth Amendments. The *Ballew* Court, also confronted by social science studies, had been persuaded that larger groups, for example, were more likely to counterbalance individual bias. As a consequence the Court concluded that the reduction in the size of the jury had impermissibly "inhibit[ed] the functioning of the jury as an institution to a significant degree."

The social scientific research before the Court convinced Justice Marshall that death-qualification similarly had inhibited the functioning of the jury as an institution. This would be constitutionally permissible only if the state had a sufficiently strong interest in single juries in bifurcated capital murder trials. He proceeded then to examine the justifications for a single jury set forth in the majority's opinion.

[The Court's] final rationale, that somehow the defendant in a capital case would benefit from a single jury, was characterized by Justice Marshall in his dissent as "offensive," "disingenuous" and "cruel."

In cases where the first of two juries found innocence, he noted that it would be unnecessary to go through the time-consuming process of death-qualification altogether. While the state would have a right to exclude so-called "nullifiers" (persons who would vote for innocence because of their opposition to capital punishment) from the first jury, this would be simpler than removing the *Witherspoon*-excludables. In light of the low frequency of capital murder trials and the availability of cost-cutting measures, Justice Marshall concluded that "it cannot fairly be said that the costs of accommodating a defendant's constitutional rights under these circumstances are prohibitive, or even significant."

The majority's other justification for a single jury, that in a bifurcated capital murder case, the jury, having found guilt, would nonetheless be able to reduce the severity of the punishment if they harbored "residual doubts" about guilt, angered Justice Marshall. He pointed to the fact that 1) the defendant cannot waive this purported protection in exchange for better odds against conviction, 2) where a death sentence but not a conviction is set aside, states, including Arkansas, typically empanel juries whose only duty is the determination of sentence, and 3) the Supreme Court had consistently denied certiorari in cases holding that the defense cannot appeal to "residual doubts" in the capital sentencing proceeding.

On the merits of the social science studies before the Court, Justices Rehnquist and Marshall also parted company. Justice Rehnquist criticized the studies for depending on individual non-juror responses to a public survey, and failing to differentiate between "nullifiers," who should be removed from the jury determining guilt or innocence, and *Witherspoon*-excludables, who should not.

Justice Marshall was impressed by the unanimity of the studies. The fact that individual non-jurors had been studied instead of real juries was in his view acceptable in light of other studies showing that individual non-juror preferences are a "fair predictor" of how a person will act in a jury, and in light of long-standing opposition by the courts to research involving actual juries. The research also showed that similar

Federal Protection and Advocacy funding now available

After compromising their different versions of the bill, both Senate and House approved the Protection and Advocacy for Mentally Ill Individuals Act, P.L. 99-319, in May 1986; the president signed it into law the same month. With authorized funds of over $30 million for three years, the bill provides assistance to states in developing and continuing protection and advocacy services for mentally ill individuals. The purpose of these services is "to investigate reported abuse and neglect, and to pursue administrative, legal and other remedies."

The Act defines abuse and neglect broadly:

> (1) The term "abuse" means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury to a mentally ill individual, and includes acts such as—
>
> (A) the rape or sexual assault of a mentally ill individual;
>
> (B) the striking of a mentally ill individual;
>
> (C) the use of excessive force when placing a mentally ill individual in bodily restraints; and
>
> (D) the use of bodily or chemical restraints on a mentally ill individual which is not in compliance with Federal and State laws and regulations.
>
> (4) The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury to a mentally ill individual or which placed a mentally ill individual at risk of injury, and includes an act or omisssion such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a mentally ill individual, the failure to provide adequate nutrition, clothing, or health care to a mentally ill individual, or the failure to provide a safe environment for a mentally ill individual.

In Virginia, . . . the new funding will be received by the state Department for the Rights of the Disabled.

Only an eligible system may receive funding under the Act, although the system is free to contract with any state agency or nonprofit agency that does not also provide treatment to mentally ill individuals and that has the capacity to provide advocacy services. The eligible system is defined by the Act to mean the system presently funded under part C of the federal Developmental Disabilities Assistance and Bill of Rights Act. In Virginia, that would mean that the new funding will be received by the state Department for the Rights of the Disabled.

The eligible system funded under this legislation must be allowed access to records with the client's or guardian's consent, or without it if the client is unable to grant it when there is probable cause to believe the person has been subject to neglect or abuse.

The compromises reached by both houses included:

- dropping the Senate's proposed cap on attorney fees, leaving that up to courts to decide;
- requiring that existing administrative remedies be pursued before legal action is taken, unless the former would cause "unreasonable delays";
- deleting the term "optimum therapeutic setting" in the house amendment, which could be more restrictive, rather than its intended meaning of "least restrictive";
- leaving the designation "residential facility" unspecified rather than defined; and
- specifying that half of the members of the advisory board be consumers of mental health services or family members of consumers. □

results were obtained when nullifiers were excluded.

Finally, Justice Marshall stressed that in the case before the Court, the social science studies had been presented to the District Court in the form of expert testimony. This provided the Supreme Court with a better understanding of the methodologies used in the studies than would have been possible had the studies simply been alluded to in argument to the Court.

During the October 1986 Term the Court will address the question in Buchanan v. Kentucky, *No. 85-5348, of whether the use of a death-qualified jury in a joint trial for murder violated the rights of the defendant against whom the death penalty is not sought.* □

Mental health law fellowship

The Institute of Law, Psychiatry and Public Policy, an interdisciplinary program affiliated with the University of Virginia Schools of Law and of Medicine, is offering a fellowship leading to an LL.M. degree in Mental Health Law. The 13-month program integrates clinical, academic, and research experience and may be designed to meet the student's individual interests. Stipend for the program beginning August, 1987, will be about $10,000, depending on available levels of support. For more information, please contact Lynn Daidone, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, Virginia 22901. (804) 924-5435.

Continued from page 23

not "strict," scrutiny. If the classification is not "suspect" or "suspicious," the Court will not second-guess the legislative decision and will confine its review only to whether the classification rests on a rational foundation—which is usually to say that it will be upheld.

The doctrinal issue raised in *Cleburne* was whether classifications based on mental retardation such as that drawn in the Cleburne ordinance would be characterized as "suspect" or "suspicious" and therefore subject to heightened judicial scrutiny. In essence, the majority said, when classifications based on mental retardation are involved, as compared with classifications based on ethnicity or gender, there is less reason for judicial suspicion and correspondingly greater reason to defer to legislative and political judgments.

Justice Marshall questioned this conclusion, finding persuasive reasons for judicial suspicion in this context. He summarized the sorry history of prejudice against, and ostracism of, mentally retarded persons (or "the feebleminded"). Indeed, Justice Marshall emphasized, the Cleburne ordinance itself was enacted around the turn of the 20th century when discrimination against, and fear of, mentally retarded persons was especially prevalent.

What is most interesting is that the majority's opinion never once explicitly mentions this history of discrimination. Instead, Justice White took note of more recent legislation, especially at the federal level, designed to *protect* the interests of mentally retarded persons. Justice Marshall was unpersuaded that recent federal legislation protecting their rights demonstrated that discriminatory attitudes had been erased. Whether or not constitutional interpretation *should* turn on judgments about recent social history, it is clear that this was the articulated basis for the disagreement in the *Cleburne* case. Moreover, the community's fear of mentally retarded persons was in fact the basis of the Cleburne ordinance and of its application to the Featherston home and the Court knew it. Notwithstanding recent legislative willingness to promote equal citizenship, residual prejudice undoubtedly remains.

. . . the Supreme Court is suspicious of classifications burdening mentally retarded persons, and will scrutinize them with greater care than ordinary legislative classifications.

The message of *City of Cleburne v. Cleburne Living Center* is that the Supreme Court *is* suspicious of classifications burdening mentally retarded persons, and will scrutinize them with greater care than ordinary legislative classifications. *City of Cleburne v. Cleburne Living Center* was clearly a victory for the ideal of equal citizenship for mentally retarded persons.

Entitlement to adequate community services

It goes almost without saying that the public mental health and mental retardation services system does not have the resources necessary to provide adequate care and support for its clientele. The annual appropriations process continues, unfortunately, to be almost a zero-sum game, as the effort is made to shift dollars from institutional budgets to community care without unduly compromising the adequacy of institutional care. Census-reduction is, of course, the critical variable in this process and yet, as all will acknowledge, the major failing of deinstitutionalization has been the failure to provide adequate funding for facilities and support services in the community.

For the most part, inadequacy of services is a political issue, not a legal one. In the class-action right-to-treatment suits of the 1970's, an activist federal judiciary measured the adequacy of institutional conditions against judicially articulated standards and, in effect, ordered the state legislatures to put up the money.

Some courts were more aggressive than others, but the underlying supposition was that the state's obligation was derived from libertarian premises, not from a free-standing obligation to provide needed services.

It was against the backdrop of this litigation that the Supreme Court decided *Youngberg v. Romeo* in 1982. Although the Court took a very narrow view of the scope of the state's obligation, it did adopt the basic thrust of the jurisprudence that had emerged in the lower courts. The Court began with the observation that, "as a general matter, a state is under no constitutional duty to provide substantive services for those within its borders." However, it was pointed out that the state of Pennsylvania had conceded "that a duty to provide certain services and care does exist" when "a person is institutionalized—and wholly dependent on the State." The Court then went on to hold that the state's duty to Romeo encompassed sufficient training to prevent unnecessarily restrictive conditions of confinement.

Romeo says nothing about the state's duty to a person who is, practically speaking, dependent on the state, but who is *not* institutionalized (or who *is* institutionalized but does not need to be). In short, does the state violate a person's constitutional rights when it discharges him without providing clinically adequate community services? Does the state violate a person's constitutional rights when it it keeps him in an institution because less restrictive services are not available elsewhere?

The U.S. Court of Appeals for the Fourth Circuit answered "yes" to these questions with a truly remarkable decision in *Thomas S. v. Morrow,* 781 F.2d 367 (Jan. 6, 1986). [see *Developments in Mental Health Law,* Vol. 6, Nos. 1-2, (January-June, 1986)] Thomas S. was placed for adoption by his mother at birth, and became a ward of the social services department of Gaston County, North Carolina. Thomas was never adopted and never placed in a home which could meet his special needs; he was moved in and out of forty foster homes and institutions. When community placements were unsuccessful, he was returned to the state hospital, but each time the staff insisted that hospitalization was not an appropriate placement.

In 1981, at the age of 17, he was placed at Gerald's Lazy Acres Rest Home for the elderly. When Thomas

turned 18, while living at Gerald's, he was declared incompetent. According to the social and psychological evaluations conducted in connection with the guardianship proceedings, Thomas' mental functioning was on the border between normal and mildly retarded, but his social functioning was at a much lower level, in the moderately retarded range. In light of his chaotic placement pattern and the absence of "consistent significant persons in his life," the evaluation team concluded that Thomas "needs a stable, very structured environment for three to six years" that would give him "consistency in social contacts" so that he could "develop trust in interpersonal relationships." In summary, the team concluded, Thomas' "psychosocial maladjustment is the critical issue that must be addressed."

After Thomas was declared incompetent, his guardian—a regional adult mental health specialist with the North Carolina Department of Human Resources—concluded, unsurprisingly, that the Lazy Acres Rest Home was not an appropriate placement and had him transferred to the mental retardation unit at the state hospital while efforts were undertaken to find an appropriate placement and to identify the necessary support services. This was in April, 1982. (Thomas was now 19.)

The hospital staff prepared a treatment plan and, six weeks after his admission, advised the community mental health agency of Thomas' needs upon his anticipated discharge on June 17, including community-based living either in a group home or adult foster care home. The Gaston County agency advised the hospital and Thomas' guardian that no residential placement was available. Thomas was not discharged as planned.

Finally, in 1982, suit was filed on Thomas' behalf against the North Carolina Department of Human Resources, against his guardian and against the Gaston County mental health and social services agencies. [Although the Court's opinion does not say so, I assume that the suit was inspired by the state hospital staff.] The plaintiff sought an order directing the defendants to place Thomas in an appropriate group home and to provide the other services recommended by the professionals who had evaluated and worked with him. (During the months after the suit was filed, several additional evaluations were conducted by the state hospital staff, elaborating on his needs.) About a year after the suit was filed, the district court entered a consent order permitting the Gaston County mental health and social service agencies to contract with an independent nonprofit organization for foster care and treatment for the next year.

Can a state avoid any constitutional obligations to its mentally ill and mentally retarded citizens simply by abandoning them?

Pursuant to this consent decree Thomas was released from the state hospital on March 3, 1983. He was placed with a foster family in Cleveland County. Although the arrangement was a positive one in many respects, Thomas decided to leave after nine months. He was recommitted to the state hospital and, after two weeks, he was placed in a home for developmentally disabled adults. After he ran away, he was placed in a rest home for elderly and emotionally ill adults. After three months, in August, 1984, he was moved to the Gaston County detoxification and night care facitlity.

On December 7, 1984, the district court entered summary judgment in Thomas' favor, directing the Secretary of Human Resources and the guardian to develop a treatment plan and appoint a case manager for him. It directed them to furnish Thomas with the treatment recommended by the qualified professionals who had evaluated his needs. In accordance with the recommendations, the order specified that Thomas should be placed in a "stable suitable supervised community residential placement such as: (1) a non-institutional specialized adult foster care situation . . . or (2) a group home with adults of average intelligence." Adhering to the recommendations, the court also directed that Thomas should be provided non-residential services such as mental health counseling, adult basic education and vocational training, and "opportunities for community interaction." The Secretary and the guardian appealed.

The Fourth Circuit affirmed the district court's order, ruling that Thomas was constitutionally entitled "to treatment and training based on the recommendations" of the professionals on the state hospital evaluation team. This included placement in an appropriate community residential setting. The Court was unimpressed with the state's arguments that state law made local governments, not the state government, responsible for community services, and that the order imposed an obligation on the state to establish new services.

The Fourth Circuit's decision in *Thomas S. v. Morrow* is virtually unprecedented. It could be read to impose an affirmative constitutional duty on the state to assure that adequate community resources are provided to implement treatment or habilitation plans for mentally ill or mentally retarded persons where a failure to do so would constitute a "substantial departure from accepted professional judgment, practice or standards." In other words, the case seems to establish and apply a "right to appropriate community services."

This is a long step from *Youngberg v. Romeo,* as the Fourth Circuit surely must have recognized. What is the constitutional predicate for the affirmative duty imposed on North Carolina in *Thomas S.*? Apparently, the Court thought it was constitutionally significant that Thomas "remains a legally incompetent adult who is a ward of a guardian appointed by the state." This would imply that the right to appropriate services recognized in *Thomas S.* applies to any person who is a ward of the state, but does not apply to a person who has not been adjudicated incompetent, and who therefore remains legally free to make his own choices about where or how to live his life. Does this imply that Thomas would not have been constitutionally entitled to appropriate services if the state had not

Continued on page 42

Virginia Supreme Court considers testamentary competency

Pace v. Richmond, 231 Va.____, 2 VLR 1777 (April 25, 1986).

In this decision the Virginia Supreme Court reiterated its well-established rules governing will contests based on claims of testamentary incompetency and undue influence. The case involved the two wills of Robert Lee Pace, who died at age 81 in 1981. Three years earlier he had executed his second will, in which he provided: "I make no bequest whatsoever to my nephews, Hamilton W. Pace and Montie R. Pace, who are able to look after themselves and who have paid little or no attention to me during the last ten years." The second will left an estate valued at $190,000 to three tenants on his property, including Mrs. Ingalls and her husband, who shared a duplex with the decedent.

The nephews challenged the will on the grounds that the decedent lacked testamentary competency. The nephews also contested the will on the grounds of undue influence by Mrs. Ingalls. The trial court struck the evidence of the nephews, refused to submit the questions of incompetency and undue influence to the jury, and admitted the second will to probate. The Virginia Supreme Court affirmed.

The case is instructive in several respects. Characteristic of such will contest, there was no expert evidence adduced by either side. The proponents of the will, who appear to have been assigned the burden of proving that the testator was competent, met that burden easily through the testimony of the lawyer who drafted the second will, his associate, and his secretary. The testator, who had recently lost the vision of one eye, also visited his ophthalmologist the day he executed his second will. Their testimony that the testator was "oriented, clear, concerned" (the doctor), that "he knew what his kin folk were" (the lawyer), that there was nothing unusual in his manner (the lawyer's associate) and that he was " alert and the way he always was" (the secretary), in the view of the Court "fully satisfies" the applicable standard of testamentary competency. That test, drawn from an earlier decision upholding the will of a woman on furlough from a mental institution provides that:

> Neither sickness nor impaired intellect is sufficient, standing alone, to render a will invalid. If at the time of its execution the testatrix was capable of recollecting her property, the natural objects of her bounty and their claims upon her, knew the business about which she was engaged and how she wished to dispose of her property, that is sufficient.

Because that test requires that competency be determined at the time of execution, the testimony of Pace's lawyer and the other witnesses called by the proponents of the will, concerning the testator's condition on the particular day that he made the second will, was determined by the Court to carry "great weight." So substantial was the weight given to this evidence that the testimony of the nephews' many witnesses to the effect that over the period from 1978 until his death the testator was becoming delusional, disoriented and distrustful of former acquaintances, was insufficient even to raise a jury issue on the question of incompetency.

The contestants argued on appeal

Continued from page 41

sought guardianship when Thomas had turned 18? Can a state avoid any constitutional obligations to its mentally ill and mentally retarded citizens simply by abandoning them?

The Fourth Circuit also tried to link the duty imposed in Thomas' case to the liberty interests mentioned in Romeo's case. The Court emphasized that the treatment plan was designed to deal with Thomas' suicidal and aggressive behavior and therefore implicated his liberty interest in personal safety. Moreover, the Court said, Thomas' interest in "freedom from undue restraint" was implicated by any placement which was more restrictive than warranted by his needs.

It seems clear, however, that this rationale is much broader than the analysis undertaken in *Romeo,* where the Supreme Court was dealing with the conditions *inside* the institution. (The Court reasoned that the state was obligated to provide training to reduce Romeo's self-destructive and aggressive behavior in order to reduce the need to resort to seclusion and restraint.)

In conclusion

Many of the most important innovations in mental disability law during the 1970's were animated by a common ambition—to shift the locus of care to te communities and to the least restrictive modalities of service. Legal mechanisms were utilized to make it harder to place people in institutions and to keep them there, and to improve the capacity of institutions to provide services enabling patients and clients to return to, and live successfully in, the community.

As these ambitions have been realized, the law has crossed new frontiers. Now that the locus of care has been shifted, new and puzzling problems are being presented, because the ideals of liberty, equality and entitlement overlap and require redefinition. The goals of mental health law also come more clearly in conflict with competing social values. The path that the law will follow cannot be confidently predicted. What is clear, however, is that those who wish to shape the changing legal landscape will confront exciting challenges in the years ahead. □

that their evidence at least created a jury issue on the question of undue influence. Their claim of undue influence appears to have consisted of fragmentary evidence that the Ingalls, particularly Mrs. Ingalls, who might have been the testator's mistress, took advantage of his deteriorating mental condition to alienate him from his relatives. The trial court also refused to submit this question to the jury, and was upheld in this decision by the Supreme Court.

On the question of undue influence the Court made it clear that the burden of proof was on the nephews, and that the standard of proof was "clear, cogent, and convincing" evidence. To show the Ingalls had exerted undue influence, it was necessary for the nephews to prove by this higher standard of proof that Pace "had no free will" with respect to testation. The Court found no evidence that the Ingalls had been anything more than good friends to the decedent. The Court's dim view of will challenges based on undue influence can be explained in part by the need to preserve one of the traditional functions of testation, that of encouraging considerate behavior toward elderly testators, in the hope of receiving property upon their death. The Court, citing a 1925 decision, said: "Influence is not undue which rests upon natural affection and desire to give property to those who are most considerate, attentive and useful to us." □

Law and psychiatry fellowship

The Fellowship in Forensic Psychiatry at the University of Virginia, located administratively in the Institute of Law, Psychiatry and Public Policy, is a one-year post-residency training program for psychiatrists.

One component of the fellowship is experience in the medicolegal evaluation of cases. The Forensic Psychiatry Clinic at the Institute has two divisions: Adult Criminal and Juvenile/Family. Each division accepts cases on the basis of their teaching value, correspondence with ongoing research, and public policy importance. To provide the Fellow with additional experience in an inpatient setting and a higher stipend than would otherwise be possible, he or she also spends one day a week at the Forensic Evaluation and Treatment Unit at Western State Hospital in Staunton, Virginia, directed by Michael Solomon, M.D., a 1983 graduate of the fellowship.

A second component of the fellowship is the opportunity to take courses anywhere in the University. Recent Fellows have elected to take courses in the School of Law, including Law and Psychiatry, Law and Medicine, Psychiatry and Criminal Law, Criminal Law, Crimes of Violence, and Torts. Other pertinent courses include Evidence, Psychology and Juvenile/Family Law, and Social Science in Law.

Ample time is available for research and writing, and the Fellow is strongly encouraged to develop an area of special expertise. The Fellow participates in Law School teaching, Institute training programs, forensic symposia, and hospital staff training to develop skills in teaching forensic psychiatry to varied audiences.

The stipend for PGY-V's is somewhat over $30,000 from July 1st through June 30th. No application forms are used. To apply, send a current curriculum vitae, three letters of recommendation, a one-page statement of your interests and reasons for pursuing a fellowship, and a sample of a case history you have prepared (it need not be a medicolegal case). Copies of any articles you may have written would also be valuable additions to your application.

Applications should be directed to:

Park Elliott Dietz, M.D., M.P.H., Ph.D.
Professor of Law
Professor of Behavioral Medicine and Psychiatry
School of Law
University of Virginia
Charlottesville, Virginia 22901

Coming in the next issue:

United States Supreme Court affirms handicapped rights

New Virginia laws affect professional liability and commitment

Virginia court permits spanking of mentally retarded residents

Spring forensic symposium

The Institute of Law, Psychiatry and Public Policy's Spring Forensic Symposium will be held Friday, April 17, at the Omni Hotel in Charlottesville, VA. The symposium, which is open at no cost to alumni of the Institute's Forensic Evaluation Training Program, will feature a panel on the role of mental health experts in child abuse cases.

The program has been approved for CME, CEU, and CLE credit. For more information, contact W. Lawrence Fitch, Director of the Forensic Evaluation Training and Research Center, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804/924-5435).

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

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