A 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. 8, No. 1 January-June 1988

Four comments on *United States v. Charters*

On May 8, 1988, a three-judge panel of the Fourth Circuit Court of Appeals handed down its decision in *United States v. Charters* (No. 86-5568). The opinion, written by Judge Murnaghan, intensified a long-standing controversy over the right of a committed patient to refuse antipsychotic medication. The federal government is currently seeking review *en banc* of the decision. And the Virginia General Assembly, as this newsletter goes to press, is considering a broad legislative response to *Charters*.

The case began in 1983 when Michael Charters was charged by federal authorities in Virginia with threatening the President of the United States. In February of 1984, and on five subsequent occasions, the District Court for the Eastern District of Virginia found Charters incompetent to stand trial and committed him to Butner Federal Correctional Institution. In 1986 the district court entered an order authorizing the forced medication of Charters.

The Fourth Circuit overturned that decision and remanded the case to the district court with instructions to determine first whether Charters should be transferred to a state hospital. If Charters is to remain in federal custody, the district was instructed to determine whether he was "medically competent." The Fourth Circuit concluded:

> if the court determines that Charters is medically competent, he must be permitted to refuse antipsychotic medication. In making the determination of medical competence, the court should evaluate whether Charters has followed a rational process and can give rational reasons for his choice to refuse antipsychotic medication; (3) If the court determines that Charters is not medically competent, it should determine whether there is clear and convincing evidence of what Charters would do if he were competent; (4) If a substituted judgment cannot be made, the court should order forcible medication only upon finding that it is in Charter's best interests.

The four comments that follow explore the wide range of issues raised by this opinion:

- Is the case for recognizing a right to refuse medication stronger after a forensic commitment than after an ordinary civil commitment? While the Fourth Circuit in *Charters* distinguished in its footnote 15 an earlier decision of that court essentially permitting unrestricted medication of a civilly committed patient, from Larry Fitch's point of view, there are more reasons to force medication in a forensic setting. This issue is of immense practical importance since it determines the applicability of the decision to the far more numerous population of civilly committed patients.
- Is the decision based on an erroneous understanding of the effect of antipsychotic drugs? Paul Appelbaum and Richard Bonnie take issue with the court's "misconceptions" about antipsychotic medications. Leonard Rubenstein wonders how it is that the court decided that antipsychotic medications have a greater impact on patient autonomy than mechanical restraints. If the issue is just one of empirically researched data on side-effects the court may be wrong. If it is only a question of values impinged upon by both the intended and unintended effects of antipsychotic medication, then the question is not whether the court is wrong, but whether it is fair.
- Is there a middle ground? The parties seem to have presented the court with only two alternatives. The government urged the court to allow forced medication whenever it was the professional judgment of the physi-

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cian that the patient needed the medication. The patient's attorneys argued, successfully, that medication could be forced only after a formal, judicial determination of incompetency to make the medical decision, and then it had to attempt to replicate the decision that the patient would make if competent. Would the court have accepted an administrative determination of incompetence, or a streamlined judicial determination (e.g., one at the time of commitment not involving appointment of a guardian), if state or federal law provided that option?

Judging professional judgment

by Leonard S. Rubenstein

United States v. Charters may or may not become a watershed in litigation concerning the right to refuse medication, but certainly it will stimulate reinterpretation of the "professional judgment standard" established in *Youngberg v. Romeo* regarding the constitutional rights of institutionalized persons.

In *Romeo*, a profoundly retarded individual confined in a Pennsylvania institution was injured, by himself and by others, dozens of times. He sued officials at the institution for damages, asserting constitutional rights to protection from harm, freedom from undue restraint, and training. The United States Supreme Court held that individuals confined in institutions have the rights to protection from harm, freedom from undue restraint, and such training as is necessary to fulfill those rights. The Court held, however, that "in determining whether the State has met its obligations in these respects, decisions made by the appropriate professionals are entitled to a presumption of correctness." The decision has always been puzzling, because unlike decisions in other areas of the law, it appears to equate the exercise of professional judgment with the protection of constitutional rights.

While several courts had grappled with the question of how *Romeo* applies to the right of a person to refuse consent for psychiatric treatment, *Charters* went further, holding that the professional judgment standard does not apply where a physician wishes to medicate a competent patient against his will. Equally important, *Charters* reinterpreted *Romeo* to limit the scope of *Romeo's* professional judgment standard in cases where competence is irrelevant to the issue. Rather, it outlined the elements of an entirely different approach to the professional judgment standard. Generally speaking, rather than read *Romeo* as creating a blanket rule of deference, the court seemed to create a continuum of deference to professional judgment, and listed criteria to consider when deciding at what point deference is owed.

The Fourth Circuit Court of Appeals identified four factors which placed *Charters* in a different place than *Romeo* on this continuum:

> 1) the duration of harm—the court differentiated the possibly permanent effects of medication from what the court perceived as the temporary effects of restraints used on Nicholas Romeo;
>
> 2) the manner of restraint—the court differentiated between physical effects and the effects on a person's mind or "freedom of thought";
>
> 3) the imminence of harm to the resident or others—the court found that Charters displayed no violence in over three years without medication whereas Romeo frequently injured himself without restraints;
>
> 4) the special expertise of the professional—the court differentiated between judgments within the professional's knowledge and judgments not within the special expertise of the professional, including a decision whether the benefits of medication outweighed their risks.

Charters' application of these factors is, in some instances, questionable: for example, are physical restraints really less involved with the matters that "define individuality" than medication? Do such restraints have less permanent effects than medication? But that is less important than the fact that these factors were taken into consideration at all.

How will these or other continuum factors apply in cases of seclusion of psychiatric patients? Of routine restraints for mentally retarded people? Of the fact of institutionalization at all? *Charters* opens the door to an entirely new form of analysis—judging professional judgment.

A poorly charted decision

by W. Lawrence Fitch

In many ways, I like this opinion. It is irrepressibly logical and very clearly written. And it speaks for the dignity of the mentally disabled. But for the patient who requires treatment with medication in order to achieve competency to stand trial on a criminal charge, I think this opinion misses the mark.

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, Mental Retardation and Substance Abuse Services. The opinions expressed do not necessarily reflect the official position of either the Institute or the Department.

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The court suggests that because treatment to restore trial competency is primarily for the benefit of the state—to enable the trial to proceed—and "reflects little concern for the well-being of the detainee," the patient's interests in avoiding unwanted treatment are enhanced. I believe, however, that the patient's interests, when weighed against those of the state, are diminished under these circumstances. Where it can be ascertained that a *civil* patient is able rationally to reject medication offered for his or her benefit, forcing medication, I would agree, offends human dignity. The same is true, I believe, for a civil patient who, during a competent moment in the past, has expressed a reasoned decision not to be medicated in the future. Only when the patient is unable to make a rational choice, and has made no such rational choice in the past, is forcing medication tolerable—and, then, only when it has been determined by an independent arbiter (e.g., a judge) that such treatment serves the patient's best interests. To allow "professional judgment" to govern under these circumstances, as many courts have, I find disquieting. The decision whether or not to impose medication on an unwilling patient is only partly medical; the substantial liberty interests that must be taken into account are clearly outside the expertise of the clinician. Moreover, to permit the decision to be made entirely within the confines of the medical institution is to invite the appearance of unfairness, at least in the eyes of the patient. Accordingly, if Michael Charters had been a civil patient, I would hail this opinion. However, because Charters was not a civil patient—because Charters was not in treatment solely or even primarily for his benefit—I believe the court should have taken a different approach.

The state *does* have a legitimate—and compelling—interest in resolving criminal cases, and to allow that interest to be frustrated by an incompetent defendant who can articulate a rational objection to treatment (e.g., "I don't want to get well, be tried, and go to prison") is highly undesirable, I believe. To deny the state its opportunity to try a defendant because the treatment necessary to render the defendant competent would not serve the defendant's best interests is equally inappropriate. Query: Is it in the best interests of the defendant to regain competency to stand trial on a charge of capital murder where the evidence of guilt is compelling?

Of course, the simple fact that a patient is facing criminal charges should not justify subjecting the patient to an undue risk of harm from which other patients would be protected. The patient unquestionably is entitled to some degree of protection under these circumstances. But the protection offered by the *Charters* court is misguided. It fails to recognize that the risk of the medication—the side effects that the court so vividly describes—is associated almost exclusively with long-term treatment. For the patient in treatment for his or her own benefit—and, thus, for whom treatment presumably will extend well into the future—these risks are very real (although not to be compared with psycho-surgery, as the court suggests). But for the criminal defendant for whom medication is prescribed to enable a rapid and brief stabilization, to last only so long as the trial requires, these risks are much less significant. Indeed, the risk of permanent injury as a result of short-term use of antipsychotic medication is exceedingly small. (See Solomon and Davis, "The Refusal of Antipsychotic Medication: A Clinical View," 3 *Developments in Mental Health Law* 1, 1983.)

Accordingly, a more palatable remedy, I believe, would be to permit the state to force medication to restore trial competency (whether or not the defendant is incompetent to make a treatment decision), but to limit the period of medication to the minimum ordinarily considered medically necessary to effect stabilization and, then, if the defendant has regained competency, to require that the trial proceed expeditiously. For the defendant who does not regain competency during the time period allowed, forced medication would be terminated and further treatment to restore competency would be conditioned on a finding of restorability without medication. Such a remedy would afford defendants real protection from harm and at the same time, in most cases, would allow the trial process to move along as usual. The remedy fashioned in *Charters*, on the other hand, I believe, offers criminal defendants practically nothing: the hypothetical defendant who is incompetent to stand trial but competent to refuse medication will remain hypothetical (i.e., judges will be quick to equate the two incompetencies); clear and convincing evidence of the reasoned treatment preference of the incompetent patient will remain elusive (who records a preference on these kinds of matters, anyway?); and antipsychotic medication will remain the treatment of choice for psychotic disorder (and with no guarantee that the period of medication will be kept brief).

"A more palatable remedy would be to permit the state to force medication to restore trial competency"

Romeo misunderstood

by Paul S. Appelbaum, M.D.

In the six years since the United States Supreme Court's decision in *Youngberg v. Romeo*, judicial approaches to the right of patients in psychiatric treatment facilities to refuse antipsychotic medication have fallen into two categories. The federal courts, following the apparent intent of the Court in *Romeo*, have uniformly held that patients' constitutional rights are limited to assuring that a professional judgment is made with regard to their treatment. Many state courts, on the other hand, looking to escape from *Romeo's* limits, have turned to state constitutional, statutory and common law to find a further

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The practice of psychiatry and suicide litigation

by Irwin N. Perr

Editor's note: The following article is based on a speech given by Irwin Perr at the Tenth Annual Symposium on Mental Health Law, held May 28-29, 1987, where a number of topics were presented related to professional liability.

I have pursued an interest in the subject of litigation related to suicide since 1960.[1] Since that time an immense literature on suicide has evolved, as has a great increase in litigation concerning suicide to the point where it probably now constitutes at least the second greatest number of lawsuits against psychiatrists. Over the years little has really changed in terms of suicidal behavior and responsibility from the clinical standpoint, but I have observed the American legal system, in an increasingly erratic manner, attempting to impose blame on professional persons when suicide occurs. Study of legal cases has been only of limited use if one is seeking principle, rationality, consistency, and application of accumulated knowledge for reasonable legal purposes.[2]

Judicial decisions have become increasingly bizarre as judges make diagnoses, order treatments, reject treatments, and discharge patients, as well as often manifest gross ignorance of the issues about which they make law, relying on lawyers and doctors who pose as experts—when in reality they are but persuaders, advocates, and propagandists with an economic or other agenda. The applicability of the jury system to evaluation of care also continues to be troublesome.

These are strong words but I feel that they are justified in discussing the current American trends in allowing lawsuits against psychiatrists and hospitals for the behavior of people with mental problems.

Legal fictions

Traditionally malpractice conveyed certain specific elements; it implied that a professional person failed to adhere to a professional standard with direct injury to a person who relied on that professional person. Medical malpractice most often occurred in a hospital environment and frequently involved a surgical, or other, intervention wherein somebody did something wrong to the patient who was injured, such as a surgeon conducting the wrong procedure on a patient. The wrongful behavior is clear: the surgeon is the actor and the injured party plays no role in being damaged, but is the passive recipient of someone else's behavior.

As time has gone on the legal profession has enriched itself by expanding the bases allowed for litigation. Thus patients may sue for something that was not done, from which an injury resulted. Now the claim is not based on an act, but on a nonact. A juror may be able to tell if an act has occurred, but not so easily a non-act. (Perhaps this is somewhat equivalent to asking a person to prove that he is not a communist.) Thus a patient (or the lawyer on behalf of the patient) will argue that the physician should have done various tests to make a certain diagnosis. Increasingly patients who develop cancer claim that the doctor failed to make a diagnosis, thus depriving the patient of a chance for life. Despite the fact that such diseases slowly evolve, and therefore, often are not easily diagnosable in early stages, jurors can identify with claimants as potential sufferers and support claims of malpractice. But even here where an act of omission is claimed, the patient plays no particular role in what occurs.

The management of psychiatric patients is different. Much mental illness involves socially disruptive behaviors by patients which result in injury to third parties. The law states that mental illness, while possibly excusing one from criminal responsibility, does not excuse one from civil liability for negligence and other tort actions. Unfortunately for claimants, many mentally ill people have little money or at least do not have the 'deep pockets' that so attract those who live off the tort system.

In recent years, stimulated by the infamous *Tarasoff* case, psychiatrists and hospitals have been held responsible or have been accused of being responsible for the behavior of mentally disturbed people, the litigators utilizing a variety of theories and principles whose unfairness has been so clear that it has resulted in a movement towards statutory limitation in a number of states. A key element (in the context of a legal system that provides confusing or even contradictory rules) has been attributing to professional people the capacity to predict and control the behavior of mentally ill people.

In litigation referring to suicide and suicide attempts, the victim or injured party is not a third party; the victim is in actuality the offender and the damage is self-inflicted. No court yet has allowed a person to sue himself or herself for self-injury. (The law has come close in some jurisdictions, however, in allowing children and spouses to sue the allegedly guilty spouse for automobile or other injuries where the spouse has insurance. In such cases it is ironic that the alleged offender has a direct interest in being found guilty because he or she will ultimately be financially rewarded by such a finding).

One case actually involved the family of a woman who committed suicide; they attempted to utilize the *Tarasoff* doctrine by claiming that the

psychiatrist was negligent for not warning the patient that she might commit suicide, a peculiar claim even a California court could recognize as preposterous. Obviously the person who committed suicide knew of the possibility. It would be silly to state that the psychiatrist had a duty to tell the patient about her own communication of suicide ideation.

A significant difference between criminal acts and suicide is this: one has an almost infinite capacity to rape, rob, commit sex crimes, assault, etc., whereas one can commit suicide successfully only once. I am aware of one study in which sex offenders in private admitted to an average of 75 sex crimes each. Thus a pattern of behavior in crime can be established and become somewhat of a predictor of later behavior. The same is not true of suicide. There can be no pattern of actual suicide.

Efforts involving a suicidal implication can include threats, gestures, attempts, and suicide itself. A gesture is an act without particular likelihood of suicidal death. The gesture may involve trivial or non-life-threatening behavior. It may be done in front of others or with a public warning—a cry for help, or it may be part of an effort at intimidation or manipulation directed at others. Some call this behavior parasuicidal. This contrasts with the use of the term failed suicide, in which the attempt is serious in intent and modality but merely did not work. Such a person would usually be considered more suicidal than one who is using a threat or gesture, although this is not necessarily valid. Not only does this involve matters of degree, but even where categorization is clear, the meaning is not. Obviously these concepts may not apply to those who are determined to end their lives. They do it and if they do it completely, they can effectuate their goal on the first effort. People who use guns, for example, only rarely do not succeed. Thus, the data contradicts those who say that an attempt predicts suicide. The highest risk group may be the group with no relevant history of suicidally oriented behavior.

Specific laws have compounded the problem. Some states, in formulating mandatory hospitalization statutes or rules, have attempted to restrict involuntary hospitalization to those who have made a suicide attempt—reflecting the prevalent view that this is a reasonable prognosticator. As will be seen that standard is not particularly efficacious. An elderly, single, sickly, socially isolated alcoholic white male who is depressed, feels worthless, and is preoccupied with death and suicide is a much greater risk than a 22-year-old hysteric white female who has made 15 suicidal gestures or attempts. With the former, the attempt when it occurs will not involve professional review because of the likelihood of success.

"The highest risk group [for suicide] may be the group with no relevant history of suicidally oriented behavior."

Another legal fiction regarding suicide is the use of the concept of dangerousness. In many states, dangerousness to self in the presence of mental illness is the key to legal authority to hospitalize. The professional participants literally play along with the requirements of the law and dutifully use the requisite words dealing with dangerousness in order to hospitalize the person who is mentally ill and needs hospitalization. Thus a person who shows limited self-threat builds a record of "dangerousness" after several hospitalizations. When a suicide ultimately occurs, the therapist is then accused of failing to recognize risk when he or she has already classified the person as "dangerous."

The law on suicide can be confusing. For instance, if a person's estate is deprived of life insurance when death from a suicidal act is called intentional, then one can obtain that coverage by asserting that it was not intentional or purposeful, but rather, the result of mental illness.

Of course, families are severely affected by suicide. Often the survivors wish to avoid blame for the acts of the deceased either for themselves or for the deceased person, and typically in our society one encounters the belief that someone is responsible for everything. If it is not the person who died by suicide who is responsible, then it is someone else. This projection of blame can have both emotional and monetary rewards.

Claims dealing with suicide are inherently based on two elements: prediction and control. If, in fact, professionals cannot predict, then they should not be held responsible on this basis. If they are to be held for failures in control, then that failure should be based on several elements: 1) they did in fact predict imminent suicide; 2) they instigated specific control mechanisms to deal with the imminent threat; and 3) they were negligent in the application of their own imposed control systems.

Studies of suicide prediction

One approach to the study of suicide is to study populations of completed suicide; one then may make conclusions as to the nature of those who die by suicide. The problem with such a method is that it may not discriminate from a normal population or from a broader psychopathologic population in which suicide may occur, but with a frequency that is small in proportion to the numbers in the group at risk.

While analysis of such factors gives a clue as to likelihood, particularly over a long period of time, such factors are of only minimal utility once their applicability and limitations have been recognized. I recall, for example, one case in which a judge noted that suicide is a characteristic of schizophrenia. Some studies do indicate that the lifetime risk of suicide in schizophrenia is 10 to 12% to as much as 20%.[3] Pokorny reported a five-year rate of 456/100,000 per year in persons hospitalized with schizophrenia.[4] That also means that 99.5% of schizophrenics will not commit suicide in a given year.

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Highlights of the Forensic Evaluation Research Report

by W. Lawrence Fitch and Janet I. Warren

The Forensic Evaluation Training and Research Center (FETRC) at the Institute of Law, Psychiatry and Public Policy continued this year to monitor and refine its Forensic Evaluation Information System (FEIS). The heart of the FEIS is a one-page "forensic information form" submitted by mental health professionals throughout Virginia for evaluations performed on court order. The form records a range of case information, including criminal charge, diagnoses, and psycho-legal opinion. One thousand fifty forensic information forms were submitted between July 1, 1985, and May 31, 1987.

From the complete Forensic Evaluation Research Report we have highlighted here information concerning the kinds of evaluations clinicians in Virginia are asked to perform, the diagnoses they make in these cases, and the conclusions they reach on the psycho-legal questions presented. Anyone interested in receiving a copy of the complete report should write to Lynn Daidone, Administrator.

Evaluation logistics: referral questions and use of clinic resources

Of the 1,050 evaluations for which forensic information forms were submitted during the 23-month period, 277 (26.5%) addressed solely the defendant's competency to stand trial (CST), 121 (11.6%) addressed solely the defendant's mental state at the time of the offense (MSO), 496 (47.6%) addressed both CST and MSO, and 109 (10.4%) addressed sentencing concerns. The "other" category was checked in only 38 cases (3.6%). It is the impression of the FETRC that many attorneys in Virginia use pretrial evaluations to elicit information relevant to plea-bargaining or for use at sentencing because procedures for initiating pre-sentence evaluations are not clear. Presently the Virginia Code provides explicitly for pre-sentence evaluations only in capital cases (§19.2-264.3:1) and sex offense cases (§19.2-300). Section 19.2-176, used by some judges to order pre-sentence evaluations, in fact is designed solely to enable the therapeutic hospitalization of defendants prior to sentencing.

Information was also received on the number of clinicians involved in each type of evaluation, the time spent by these clinicians conducting interviews, collecting information and writing reports, and the length of time that elapses from the time of referral to the time of the final report for each type of evaluation. As expected, one clinician generally performs CST evaluations, while usually more than one clinician is involved in MSO, CST/MSO, and presentencing evaluations. CST evaluations were found to require approximately four hours; MSO evaluations required approximately eight hours. For combined CST/MSO evaluations, the average time spent was about seven hours. Finally, presentencing reports required, on average, almost eight hours, about the same as for MSO evaluations.

Competency to stand trial: diagnosis and psycho-legal opinion

Evaluators' findings concerning competency to stand trial are similar to those reported last year and continue to be in line with national averages. One hundred thirty-four of 773 defendants evaluated for CST (17%) were viewed as incompetent to stand trial. Of these, 21 defendants (15.6%) were believed to be unrestorably incompetent. In 17 cases (12.6%) restorability was deemed uncertain. In 112 of the 134 cases in which an opinion of incompetency was reached, impairment was discerned on both prongs of the competency standard, i.e., the defendant's understanding of the legal proceedings and ability to assist in the defense. The evaluator in 17 cases indicated that the defendant was able to understand the proceedings but was unable to assist in the defense. In only five cases did the clinician conclude that the defendant could assist in the development of his defense but was unable to understand the proceedings.

The diagnostic categories most often associated with opinions of incompetency were schizophrenia, mental retardation, affective disorder, and organic brain disorder, in that order. In those cases in which restorability was deemed "uncertain," schizophrenia was the most frequent diagnostic category, followed by organic brain disorder and mental retardation. Where restorability was deemed "unlikely," the leading diagnostic categories were mental retardation and organic brain disorder.

Significant variation appeared in the frequency with which defendants with particular diagnoses were deemed incompetent by the evaluating clinician. Of 92 defendants diagnosed as schizophrenic, 45 were believed to be incompetent. Only 19 of 52 defendants diagnosed as having mild or moderate mental retardation were felt to be so significantly impaired, however, while 12 of 54 defendants suffering from affective disorder and 12 of 56 defendants suffering from organic disorder were similarly appraised. Finally, only

three of 56 defendants diagnosed as suffering from a personality disorder were deemed by the evaluating clinician to be incompetent.

Mental state at the time of the offense: diagnosis and psycho-legal opinion

Of those cases in which MSO was a referral question, 196 (31.7%) were believed to involve a "mental disease or defect." ("Mental disease or defect" is the language used to describe the mental disorder necessary, but not sufficient, for legal insanity.) The diagnoses associated by the evaluators with a finding of "mental disease or defect" generally conform to what trial courts in Virginia have recognized when considering the question of legal insanity (i.e., psychotic disorder, organic disorder, or substantial mental retardation). Of some concern are three schizophrenic diagnoses, two "other" psychotic conditions diagnoses, and 21 organic brain disorder diagnoses that were coded as not reflecting a "mental disease or defect." Of even greater concern are eight personality disorder diagnoses that were classified as "mental disease or defect." Presumably, the schizophrenics were in remission and, therefore, functionally not incapacitated to the extent contemplated by Virginia's insanity standards; similarly, the organic brain-disordered individuals may have been in sufficiently early stages not to show significant cognitive or volitional impairment. With regard to the personality disorders, if they were of the borderline variety, the possibility of brief psychotic periods might justify classification as "mental disease or defect."

In only 47 of the 196 cases believed to involve a "mental disease or defect" was a clinical opinion offered supporting legal insanity. Of these defendants, 20 were identified as "significantly impaired" on all three prongs of the insanity standard: 1) ability to understand the nature, character and consequences of the act; 2) ability to distinguish right from wrong; 3) ability to resist the impulse to commit the act. In 16 of these cases, the defendant was deemed significantly impaired on two of the three prongs; in 11 cases, significant impairment was discerned on only one prong.

"As with incompetency, schizophrenia is the most frequently cited diagnostic category associated with an opinion suggesting legal insanity."

As with incompetency, schizophrenia is the most frequently cited diagnostic category associated with an opinion suggesting legal insanity. Organic brain disorder represents the second most frequent category. Affective disorders and mental retardation also are cited.

An opinion supporting legal insanity was offered in 13 of 51 cases in which the defendant was diagnosed as schizophrenic, eight of 45 cases in which the diagnosis was that of an organic impairment, and seven of the 47 cases in which an affective disorder was diagnosed. Of the 65 defendants referred for an MSO evaluation who were diagnosed as suffering from a personality disorder, only one was believed to have been insane.

Of the criminal charges associated with an opinion of legal insanity, only two of 56 defendants charged with homicide were deemed legally insane, whereas 22 of 216 defendants charged with property crimes and public order offenses were perceived to meet the insanity standard by the evaluating clinician. This finding may reflect discrimination in terms of the referral threshold applied to different crimes. Where the charge is minor, and the consequences of conviction are correspondingly less severe, there is less incentive on the attorney's part to seek a mental health disposition unless such a disposition is compelling. Attorneys no doubt are more inclined to order pre-trial evaluations in cases involving homicide and other particularly serious offenses despite a low level of observed psychopathology simply to "cover all bases" and to avoid subsequent appeals charging ineffective assistance of counsel. □

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National Organization of Forensic Social Work Conference

The National Organization of Forensic Social Work Conference will take place in the historic seaport town of Mystic, Connecticut, April 6-9, 1988, at the Mystic Hilton. The two major topics to be covered at this year's conference are "AIDS: The Ethical Issues" and "Evaluating Allegations of Child Molestation in Custody Disputes." The annual business meeting will be held on the final morning.

Keynote speakers will be Paul Appelbaum, M.D., Jay Katz, M.D., and Elissa Benedek, M.D. Other presenters include Alvin Novick, M.D., Howard Zonana, M.D., The Honorable Charles Gill, Attorney Arnold Markle, Attorney M. Hatcher Norris, and Attorney Steven Wizner.

Registration and fees: Those interested in attending, both members and nonmembers, are urged to register by March 16, 1988. For more information, contact Linda Collins, NOFSW, P.O. Box 2060, Ann Arbor, MI 48105, (313)429-2531, ext. 271.

In the United States Supreme Court

Expulsion of emotionally disturbed school children barred

***Honig v. Doe & Smith*, No. 86-728, ____U.S.____, 56 U.S.L.W. 4091 (January 20, 1988).**

In a decision written by Justice Brennan the Court prohibited California school authorities from expelling emotionally disturbed school children.

The case began in 1980 with two separate incidents in San Francisco public schools. One involved a 17-year-old male student who choked another student and kicked out a school window. The other involved a 13-year-old male student whose disruptive behavior included stealing, extorting money from other students, and making lewd remarks to female students.

After these incidents the school district first suspended then expelled the students. A district court ordered the school to readmit the students pending completion of the process for modifying an individual education program (IEP) under the Education for All Handicapped Children Act (EAHCA) of 1975 (P.L. 94-142). Both the Circuit Court of Appeals and the Supreme Court upheld the district court's order.

Both these students had been identified as handicapped students. Their individual educational programs, mandated for handicapped children by the EAHCA, focussed on the difficulty these children had in controlling aggressive behavior because of their handicaps, and called for placement of the first teenager, Doe, in a special school for children with disabilities and for placement of the second child, Smith, in a half-day program at a middle school.

At issue was Section 1415(e)(3) of EAHCA. This "stay-put" provision requires that a handicapped child "shall remain in [his or her] then current educational placement" pending a review of the educational placement, unless the parents and the educational authorities agree otherwise (and in this case they did not). Some federal courts had recognized a "dangerousness exception" to the stay-put provision, allowing the unilateral expulsion of a handicapped child who was a danger to other students, as the school authorities claimed Doe and Smith were.

Justice Brennan, reviewing the history of widespread exclusion of handicapped children—particularly those with mental handicaps—from public schools, which led to the enactment of EAHCA, refused to read into that law a dangerousness exception. His ruling, joined by a narrow majority of the Court, prohibited the schools from unilaterally suspending the handicapped children for more than ten days or expelling them for misconduct growing out of their disabilities.

The decision permits the school authorities to seek an exception to this requirement from a district court, based on a showing of relative harm to the parties.

The court of appeals had ruled that the district court could order the state to provide services directly to the child where the local educational authorities had failed to do so. The vote in the Supreme Court was 4-4 on this aspect of the lower court's ruling, and as a consequence it was affirmed.

The *Honig* decision may prove to be more important in the far more numerous cases where the stay-put provision is abridged for fiscal or administrative reasons unrelated to misconduct. In those cases there would not appear to be any basis for a district court giving the school authorities permission to change a placement prior to the completion of the lengthy review process. And there is now a basis for the district court's ordering the state to provide the services called for in the IEP that the local educational authorities no longer can or will provide.

In cases involving misconduct, controversies can still be expected where the child may be handicapped but has not yet been identified formally as handicapped, where misconduct is not related to the handicap, or where the misconduct results in a delinquency adjudication.□

Outcome of hearing on hypnosis

In its final report published in October, 1987, the Council on Health Regulatory Boards recommends no additional state regulation of hypnosis. The Council does recommend, however, that individual health regulatory boards, including the Boards of Dentistry, Medicine, Nursing, Professional Counselors, Psychology, and Social Work, examine the standards of care maintained by their licensees who provide hypnotherapy and exercise their already-existing powers of discovering, investigating, and adjudicating complaints.

Although there may be fraudulent or deceptive business practices offering hypnosis training or services, the public should be protected from harm by the Virginia Consumer Protection Act, §59.1-196 to 207 of the Code of Virginia. A few formal complaints of dissatisfaction with the advertising, cost, or efficacy of hypnosis services have been documented, but in the past five years, there have been no complaints of actual harm. Stage hypnosis is singled out in the report as potentially being harmful to the public without any countervailing benefits.

Based on the evidence gathered and submitted during the policy review, the Council found that "the greatest risk of harm to the public from the use of hypnosis may come from services offered by regulated providers with little advanced training in hypnosis and without comprehensive and specific advanced training in the identification and treatment of diverse side-effects and after-effects."

The Eleventh Annual Symposium on Mental Health and the Law

presented by

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

and

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

May 19-20, 1988

National Conference Center
The Williamsburg Hilton
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; there is no charge for participation in Thursday morning's workshops. Luncheon on Friday is included in the registration fee; early registration is suggested to ensure luncheon seating. Return registration form to: *Institute of Law, Psychiatry and Public Policy, Blue Ridge Hospital, Box 100, Charlottesville, VA 22901.* For further information, please call (804) 924-5435.

Lodging

A block of rooms is being held for conference participants at The Williamsburg Hilton. The room rate is $84.00 per night, single or double occupancy. Reservations can be made by phoning the Hilton at (804) 220-2500; please refer to the room block being held for the Institute of Law and Psychiatry Symposium. This room block is being held until April 20, 1988; reservations after that date will be made on a space available basis only.

Continuing Education

Mandatory CLE

This program has been approved by the Virginia Mandatory Continuing Legal Education Board for 9.5 hours of credit; attendance at any Thursday morning workshop carries additional hours of credit. Accrued credit hours in excess of 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 up to 13.5 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) _____

Agency/Firm _____

Address _____

_____

Workshop Registration

Please check workshop(s) you would like to attend:

- ☐ Substance abuse confidentiality regulations
- ☐ Civil commitment
- ☐ Forensic evaluation
- ☐ Social Security mental disability benefits

Check Appropriate Fee: ☐ $75—regular ☐ $85—with CEU credit ☐ $75—physicians

- ☐ Fee enclosed (Please make check payable to: **Institute of Law, Psychiatry and Public Policy**)
- ☐ Bill me
- ☐ I am not on the Institute mailing list for the newsletter *Developments in Mental Health Law* and would like to receive this free publication. (Fill out registration form and mail to Institute address.)

Program

Thursday, May 19

Updates for Virginia Practitioners Workshops

7:30-8:00 a.m.	Registration for 8:00 a.m. Workshop
8:00-10:00 a.m.	Substance abuse confidentiality regulations *Willis J. Spaulding, J.D.* *Julie A. Stanley, J.D.*
9:30-10:00 a.m.	Registration for 10:00 a.m. Workshops
10:00-11:30 a.m.	Civil commitment *Willis J. Spaulding, J.D.* *Jane D. Hickey, J.D.*
10:00-11:30 a.m.	Forensic evaluation *W. Lawrence Fitch, J.D.*
10:00-12:00 noon	Social Security mental disability benefits *M. Kathryn Falls, M.S.W.* *C. Cooper Geraty, J.D., LL.M.*

1:00 p.m.	Registration for Symposium
2:00 p.m.	Public health law and mental health law: Intersections and analogies *Richard J. Bonnie, LL.B.*
2:30 p.m.	Human services and the law: Issues, programs and directions in Virginia *Howard M. Cullum, M.P.A.*
3:00 p.m.	Avoiding negligent release: Explicit standards versus legal fiction *Norman G. Poythress, Jr., Ph.D.*
3:30 p.m.	Risk assessment: Recent advances in the prediction of violent behavior *John Monahan, Ph.D.*
4:00 p.m.	Panel discussion *Willis J. Spaulding, J.D., Moderator* *John Monahan, Ph.D.* *Frank W. Pedrotty, J.D.* *Norman G. Poythress, Jr., Ph.D.*
4:45 p.m.	Recess
5:00 p.m.	Reception *(Cash Bar)*

Friday, May 20

9:00 a.m.	Use and misuse of mental health laws to control the spread of AIDS *Lawrence O. Gostin, J.D.*
9:50 a.m.	AIDS liability issues for mental health, mental retardation and substance abuse professionals *Donald H.J. Hermann, J.D., LL.M., Ph.D.*
10:40 a.m.	Coffee
11:00 a.m.	Panel discussion *R. Claire Guthrie, J.D., Moderator* *Richard J. Bonnie, LL.B.* *Lawrence O. Gostin, J.D.* *Donald H.J. Hermann, J.D., LL.M., Ph.D.* *Lisa S. Hovermale, M.D.* *Richard P. Keeling, M.D.*
12:00 noon	Luncheon
1:00 p.m.	Luncheon address: Civil commitment and the right to aftercare *Robert M. Hayes, J.D.*
2:00 p.m.	Homelessness and the mentally ill: Myths and reality of the Joyce Brown case *Robert Levy, J.D.*
2:30 p.m.	The Billie Boggs/Joyce Brown case: What really matters *John P. Petrila, J.D., LL.M.*
3:00 p.m.	Questions and Answers
3:30 p.m.	Competency to refuse treatment: Round table discussion of *U.S. v. Charters* *W. Lawrence Fitch, J.D., Moderator*
	Practical problems in complying with *U.S. v. Charters* *Russell C. Petrella, Ph.D.*
	Clinical evaluation of competency to refuse treatment *C. Robert Showalter, M.D.*
	Due process models and competency determinations *Jane D. Hickey, J.D.*
5:00 p.m.	Adjourn

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A Survey of Case Law on Mandatory Outpatient Treatment

by Frank Bartholf

In light of statutory restrictions on inpatient commitment, and the addition of specific outpatient commitment provisions to the laws of many states, it is surprising that so few reported opinions have dealt with the variety of legal issues raised by the practice of mandatory outpatient treatment.

For example, one major issue not yet confronted on an appellate court level is whether outpatient commitment may be predicated upon substantive criteria less demanding than those constitutionally required for inpatient commitment. In *O'Connor v. Donaldson*[1] the United States Supreme Court held that a person may not be involuntarily institutionalized unless he is proven to be dangerous to himself or others, or to be able to survive safely in freedom. Most state statutes require similar findings.

In contrast, a few states have recently enacted statutory criteria for outpatient commitment that are less demanding than the criteria required for inpatient commitment.[2] North Carolina's outpatient commitment law clearly no longer meets the *Donaldson* standard, focusing instead on preventing deterioration of the mental health of individuals with a history of psychiatric problems.[3] The constitutionality of such a "clinical" standard remains untested. Similarly, such issues as the procedures and standards of proof required by statutes for the initial imposition of mandatory outpatient treatment have not been addressed.

However, the courts have begun to answer other questions raised by the outpatient commitment practice. Case law in the last 15 years has covered a number of issues about changing the status of a committed outpatient.

Procedural requirements for institutionalizing the committed outpatient

Only a few courts have considered the procedures that must be followed before hospitalizing a person who is not on conditional release, but who has been ordered instead directly to mandatory outpatient treatment. In these cases the courts have uniformly assumed that the full procedure of an initial inpatient commitment hearing under the state's statutes is required.[4] However, one court was willing to slightly lighten the requirements even in this context. In *Matter of Mills*[5] the District of Columbia Court of Appeals held that in a hearing to permanently transfer a committed outpatient to inpatient status, "clear and convincing proof" was not required. *Mills* thereby distinguished the constitutional rights of the committed outpatient being hospitalized from the rights of someone under no form of commitment who may be committed only upon clear and convincing proof. The *Mills* court based this decision on a consideration of the committed outpatient's already reduced freedom from restraint and stigma, balanced against the state's interest in hospitalization.

Substantive criteria necessary for institutionalizing the committed outpatient

The courts are divided concerning whether the *Donaldson* criteria of dangerousness or grave disability must be met before the state may revoke the conditional release of a committed outpatient. (Statutory law is similarly divided.[6]) In *Birl v. Wallis*[7] a federal district court ruled that, in the case of an outpatient conditionally released from the hospital upon a finding that he or she no longer met the commitment criteria, the court must conduct a full commitment hearing, including a finding of dangerousness, before that outpatient can be involuntarily returned from a trial visit. (There is no mention of what this means for a patient released on a trial visit who still meets the criteria.) The *Birl* ruling was based on the court's critical supposition that a patient on trial release stands on constitutionally equivalent footing with a patient who has been fully discharged. The Idaho Supreme Court expressed a similar view in *Application of True:* "... [a] decision to revoke a mental health patient's conditional release status and to rehospitalize the patient must be accompanied by the determination that the conditions warranting hospitalization in the first instant are present again."[8]

At odds with these opinions is a California decision upholding the validity of a revocation for noncompliance under California law without a finding of dangerousness. *In re McPherson*, 176 Cal. App. 3d 332, 339-40, 222 Cal. Rptr. 416, 420 (1985). Similarly, the Supreme Court of North Dakota ruled in *In Interest of Cuypers*,[9] that a "least restrictive alternative" inquiry within a revocation hearing did not require a dangerousness finding as a predicate for rehospitalization.

Only two cases have considered whether the inpatient commitment criteria must be met in order to hospitalize a person initially committed to outpatient treatment. In both the Dis-

Continued on next page

Outpatient treatment,

Continued from previous page

trict of Columbia[10] and Florida[11] intermediate appeals courts ruled that committed outpatients could be hospitalized only if they met the same dangerousness standard required for the hospitalization of a person who had not previously been committed to outpatient status. Neither court couched its ruling in constitutional reasoning, but both were interpreting statutes that gave no specific direction regarding the findings required for such a change of status. The Florida court stated that:

> [f]or a court to order involuntary hospitalization, it is not sufficient that the patient merely failed to follow a plan for outpatient treatment. There must be clear and convincing proof that an individual is dangerous to herself or others before the state may deprive her of her freedom on the basis of mental illness alone.

Legal requirements for extending an order of mandatory outpatient treatment

In the case of *In re J. M. R.*[12] the Vermont Supreme Courtruled that extending mandatory outpatient treatment requires a finding of the same clinical criteria required to extend an inpatient commitment. (Vermont law tests the limits of the *Donaldson* criteria by allowing continued inpatient commitment based upon a finding of a substantial probability that discontinuing the treatment will lead to patient dangerousness.[13]) Six months later in the case of *In re G. K.*,[14] the Vermont Supreme Court also ruled that mandatory outpatients were entitled to have their commitments reviewed periodically according to procedures similar to those enjoyed by individuals committed to inpatient care. The court declared unconstitutional the statutory scheme providing for periodic review of outpatient treatment orders only by patient-initiated applications, holding that a "formal, automatic review procedure" was necessary to protect the "fundamental privacy and liberty interests" at stake.

A more flexible approach has been taken by the Minnesota Court of Appeals in *In the Matter of Alleged Mental Illness of Cordie.*[15] The Minnesota statute provides that a commitment may be continued only if:

> the court finds by clear and convincing evidence that (1) the person continues to be mentally ill... (2) involuntary commitment is necessary for the protection of the patient or others; and (3) there is no alternative to involuntary commitment.

In *Cordie* the court held that this statute was not violated by a trial court order extending outpatient commitment upon a finding that "Appellants remained mentally ill and commitment was necessary to insure continued outpatient treatment, without which Appellants could again pose a threat of harm to themselves..." This ruling seems to conflict with earlier Minnesota Court of Appeals decisions requiring strict adherence to the statutory criteria in cases involving the extension of inpatient commitments.[16]

Short-term involuntary inpatient evaluation periods

With *In re Richardson*[17] the District of Columbia Court of Appeals became the first court to specifically consider the permissibility of involuntary inpatient evaluations for patients subject to mandatory outpatient treatment orders. The court in *Richardson* stated that:

> When committing individuals to a course of outpatient therapy, exposing them to the pressures of life in the community, the court may reasonably anticipate that, in some instances, a patient's condition will deteriorate or that he will not comply with the terms of his release. In such a case, it is fully consistent with the interests of the individual and public, and compatible with the least restrictive alternative requirement, for the court to authorize the Hospital to return the individual to a brief period of inpatient observation where reevaluation or treatment appears to be clinically warranted.

The court, in a familiar line of reasoning, referred to these periods of short-term hospitalization as a part of the process of rehabilitation, and also mentioned the need for clinicians to have legal flexibility in making these medical decisions. Specifically, the *Richardson* court held that, as long as the hospital notifies the court and the patient's lawyer within 24 hours of the reasons for summary hospitalization within that time, no adversary hearing is constitutionally necessary if the patient is detained for five days or less. The Supreme Court of Minnesota followed *Richardson* in allowing the summary hospitalization of a conditionally-released patient for periods of up to 48 hours in *Matter of Peterson.*[18]

The permissibility of inpatient evaluation periods for mandatory outpatients in other jurisdictions may depend on the otherwise applicable procedures for detention and evaluation of persons alleged to be mentally ill. The procedural requirements for short-term evaluations vary widely from state to state. At one extreme are jurisdictions that allow physicians to initiate short-term evaluative detentions without any judicial involvement, such as Colorado (72 hours)[19] and New Jersey (seven days).[20]

However, after constitutional assessments, other states' supreme courts have imposed procedural requirements on evaluative detention. When deciding *In re W. H.*[21] the Vermont Supreme Court held that a trial court must make a "least restrictive alternative" determination before authorizing the forcible detention of a patient for a 72-hour evaluation period. Facing a similar question in the case of *In re Harris*,[22] the Supreme Court of Washington invalidated the state's statutory procedure allowing mental health professionals to issue a summons for a 72-hour evaluation period. The *Harris* court found that even 72 hours constitutes a massive curtailment of liberty, and, therefore, in a nonemergency situation, such a summons could be issued only after a magistrate finds probable cause and determines that hospitalization is the least restrictive means of intervention. Whether a court would apply such restrictions to this practice as used with mandatory outpatients may

depend on the court's assessment of how much the patient's liberty interests have already been curtailed by the outpatient treatment order.

Unfortunately, while a strong libertarian approach may protect the rights of the mentally ill, it may also ensure that there is little practical utility in the use of mandatory outpatient treatment. The retention of the dangerousness standard for each step in the mandatory outpatient treatment process may restrict the affected population to those who actually are in need of hospitalization[23] and away from those who can best prosper under such court orders. The solution, of course, is a sensible balance between the effective treatment of patients and their liberty interests. □

1. 422 U.S. 563 (1975).

2. Keilitz & Hall, *State statutes governing involuntary outpatient civil commitment*, 9 Mental and Physical Disability L. Rep. 378 (1985).

3. N.C. Stat. §122C-263(d) (1) (1986).

4. See In re Jones, 507 A.2d 155, 158 (D.C. App. 1986); C. N. v. State, 433 So.2d 661, 663 (Fla. App. 3 Dist. 1983).

5. 467 A.2d 971 (D.C. App. 1983).

6. Compare, e.g., Wash. Rev. Code Ann. §71.05.340(3) (1987) (allowing revocation for noncompliance of terms of conditional release) with R.I. Gen. Laws §40.1-5-11(3) (1984) (requiring dangerousness for recertification).

7. 633 F. Supp. 707 (M.D. Ala. 1986).

8. 103 Idaho 151, 162, 645 P.2d 891, 902 (1982).

9. 389 N.W.2d 812, 814 (N.D. 1986).

10. In re Jones, 507 A.2d 155 (D.C. App. 1986).

11. C. N. v. State, 433 So.2d 661 (Fla. App. 3 Dist. 1983).

12. 146 Vt. 409, 505 A.2d 662 (1985).

13. See Vt. Stat. Ann. tit. 18, §§7621, 7101(16), 7101(17) (1986).

14. 147 Vt. 174, 514 A.2d 1031 (1986).

15. 372 N.W.2d 24 (Minn. App. 1985).

16. See, e.g., Matter of Stewart, 352 N.W.2d 811 (Minn. App. 1984); State v. Casanova, 359 N.W.2d 696 (Minn. App. 1984).

17. 481 A.2d 473 (D.C. App. 1984).

18. 360 N.W.2d 333, 335 (Minn. 1984).

19. See Curnow v. Yarbrough, 676 P.2d 1177, 1181-82 (Colo. 1984).

20. See Matter of Z. O., 484 A.2d 1287, 1289 (N.J. Super. A.D. 1984).

21. 144 Vt. 595, 481 A.2d 22 (1984).

22. 98 Wash. 2d 276, 654 P.2d 109 (1982).

23. See Miller & Fiddleman, *Outpatient commitment: treatment in the least restrictive environment?* 355 (2) Hosp. and Community Psychiatry 149 (1984).

Frank Bartholf is a second-year student at the University of Virginia School of Law.

Social Security Notes

The Employment Opportunities for Disabled Americans Act, Public Law 99-643, establishes a major work incentive program for disabled or blind persons who receive Supplemental Security Income (SSI). Under the new law, effective July 1, 1987, cash benefits and/or Medicaid coverage are provided to certain SSI recipients who return to work despite severe impairments.

The provisions of the SSI law that provide a trial work period and extended period of eligibility are repealed with the enactment of Public Law 99-643. However, the major provisions of §1619 of the Social Security Act are improved and made permanent. The work incentive provisions of §1619 were initially enacted in 1980 as a three-year demonstration project and extended through June, 1987.

Section 1619 (a) allows for the continuation of SSI cash payments and Medicaid coverage to disabled individuals working and receiving income that is at or above the substantial gainful activity (SGA) level of $300 per month. Under this provision, an SSI recipient can earn as much as $300 a month in gross wages and continue to receive the full Federal benefit payment ($340 per month). The amount of the individual's SSI check is reduced as the earned income increases up to $765 per month. Section 1619 (a) applies only to disabled SSI recipients and not blind SSI recipients.

Section 1619 (b) allows disabled or blind persons to continue receiving Medicaid coverage after SSI cash payments stop. Thus, a disabled individual working and earning in excess of $765 per month will not receive an SSI cash payment, but can continue to receive Medicaid coverage if the coverage is necessary for that person to be able to continue working. The Medicaid coverage will continue until an individual's income can replace the Medicaid "threshold" of $1049 per month minus impairment-related work expenses or other exceptions.

To qualify for the work incentive program, an individual must have been found eligible for SSI benefits for the month preceding employment. Once employment is secured, the individual must notify the Social Security Administration (SSA) of the amount of monthly earned income to trigger enrollment on the work incentive program. Continuing quarterly reports of the individual's earnings must be provided to the SSA so the SSI benefit rate can be adjusted accordingly. The SSA will allow the individual to continue receiving the regular benefit amount for the first two months of employment before the SSI check is reduced according to an increased amount of earned income. However, if the individual discontinues work, it will be two months, in most cases, before the SSA increases the individual's benefit rate due to the grace period allowed at the beginning of employment.

SSI recipients are allowed to move on and off the employment rolls, and thus work incentive program, without submitting a new application for SSI benefits. However, when an individual has been employed continuously for a twelve-month period, a continuing disability review (CDR) will be scheduled to determine whether or not the person needs to continue SSI disability status.

Under the Social Security Act, SSI benefits are not available to most disabled individuals while hospitalized in a public institution. The Employment Opportunities for Disabled Americans Act allows individuals enrolled on the work incentive program to receive the full benefit rate for the first two months of hospitalization in any Medicaid facility or public medical/psychiatric institution. This provision is effective, however, only if the institutions involved agree not to require that the individuals use these SSI payments to offset the cost of hospital care.

Over a six-year period, the utilization of §1619 (a) and (b) demonstrated that many disabled or blind individuals desire employment and greater independence from income maintenance programs. The enactment of Public Law 99-643, which improves and makes permanent §1619 (a) and (b), sets forth a major advancement in efforts to encourage and support disabled or blind individuals who attempt to work despite severe impairments.

by Kathryn Falls

Charters, Continued from page 3

right of competent patients to refuse even professionally prescribed care.

The significance of the opinion in *Charters* lies in the willingness of the Fourth Circuit to challenge the applicability of *Romeo* to treatment with antipsychotic medication. Three lines of reasoning are employed to distinguish the fact situations in the two cases; not only is each problematic in its own right, but none of the three addresses the essence of the Court's rationale in *Romeo*.

First, the Fourth Circuit notes that the patient in *Romeo* was a profoundly retarded man who "was completely unable to participate in decisions concerning his medical treatment," and that mentally ill patients "can be competent to make decisions concerning their medical care." There is no indication, however, that the Supreme Court viewed competence as an important distinction when it decided *Romeo* (after all, some retarded persons can participate in making medical decisions), or when it remanded a right to refuse treatment case, *Rennie v. Klein*, for reconsideration in light of *Romeo*. The Court had a further opportunity to embrace this approach in *Mills v. Rogers*, but remanded the case for reconsideration in light of a competence-oriented approach that had been adopted as a matter of Massachusetts state law. In so doing, the Court suggested that rights under the relevant state law might exceed those embodied in the Constitution. Competence appears to be irrelevant to the Supreme Court's constitutional reasoning.

"The notion that antipsychotic medications unalterably change the mind in a manner indistinguishable from lobotomy neglects the proven efficacy of medications in relieving symptoms of psychosis and in improving, rather than impairing, basic mechanisms of cognition."

Second, the *Charters* court found the degree of harm at stake with medications to be greater than those in *Romeo*, where the modality in question was physical restraint. This conclusion was based on a distorted rendering of the side effects of antipsychotic medication, taken largely from some of the most inflammatory articles in the legal literature and from citations of earlier court decisions. Primary among these distortions is the notion that antipsychotic medications unalterably change the mind in a manner indistinguishable from lobotomy. This neglects the proven efficacy of medications in relieving symptoms of psychosis and in improving, rather than impairing, basic mechanisms of cognition. The risks of physical restraint, including death, are also ignored. More significantly from the point of view of the legal analysis, though, *Romeo* was misconstrued. It dealt not merely with the question of when restraints might be used, but also when their use might be omitted, even at the risk of exposing the patient to serious physical injury. Clearly, the Court was willing to trust professional judgment even when serious injury, perhaps death, is at stake. The lesser side effects of medication should be no obstacle in that regard.

Finally, the court looks to this very risk of physical injury to distinguish the two cases, noting that Charters had not been violent in the facility and invoking patients' traditional right to decide about their care. As before, the violence issue actually cuts in the other direction. If professional judgment is relied upon even where the most serious sort of injury to the patient is involved, it should certainly be adequate in less dangerous circumstances. And though it is undeniable that voluntary patients have the right to decide about their treatment, *Romeo* and the cases that follow it suggest that committed patients lack that power.

The *Charters* decision poses a number of difficulties, including a tangled definition of competence; a lame attempt to distinguish *Johnson v. Silvers*, [742 F.2d 823 (4th Cir., 1984)] which followed *Romeo*; and the prospect of defendants indefinitely avoiding trial by refusing treatment. Beyond all this, however, the Fourth Circuit mistook the essential thrust of *Romeo*. The Supreme Court was not looking to differentiate among circumstances in which professional judgment would and would not be adequate to insure patients' rights. Rather, it sought to remove courts entirely from making decisions about which committed patients should be treated and how. This is precisely where *Charters* falls short of the Court's mandate. Under *Charters*, courts are once more faced with making difficult determinations about patients' mental states and about what form of treatment would be in their best interests.

A Message from the Department of Social Services:

The Code of Virginia designates local departments of social services as the agencies responsible for investigating reports of adult or child abuse, neglect, or exploitation, and for providing protective services to victims.

Under §§63.1-55.3 and 63.1-248.3, mental health professionals are among those who are required to report to local departments of social services when they have reason to suspect that someone might be a victim. All information forming the basis for the suspicion must also be disclosed.

Current law provides for the levying of a fine against persons who are found guilty of failing to report suspected adult or child abuse.

Joy Duke,
Adult Protective Services
Program Manager

A fundamentally flawed opinion

by Richard Bonnie

The opinion by a panel of the Fourth Circuit in *United States v. Charters* is fundamentally flawed. First of all, it is predicated upon a basic misunderstanding of the effects of antipsychotic medication. The panel observed, for example, that the "effects of the drugs at issue here can be comparable" to those of "psychosurgery or lobotomy." The court's "findings" about the effects of these drugs were not based on any factual record established in the district court or even on the extensive body of clinical literature regarding antipsychotic medication; instead, they were derived almost entirely from a handful of exaggerated and outdated law review articles.

I do not mean to imply that the potential side effects of antipsychotic drugs are trivial or that the committed patient who objects to prescribed medication has no "liberty interest" at stake. However, it is clear that the panel's misconceptions about these drugs—which led it to exaggerate their risks and to discount their benefits in the treatment of serious mental illness—also led it to give undue weight to the committed patient's residual liberty interest and to give too little weight to the government's interests in treating the objecting patient.

Second, the panel's legal analysis is flawed by its failure to deal forthrightly with the Supreme Court's decision in *Youngberg v. Romeo*. The panel's conclusion that "*Romeo* did not in any way address" the right-to-refuse-medication issue is belied by the Supreme Court's decision—unmentioned by the panel—vacating and remanding *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981), in light of *Romeo*, 458 U.S. 1119 (1982).

Although space does not permit a detailed critique of the panel's opinion, several specific points about due process should be noted.

Substantive due process

In its amicus brief supporting the government's petition for rehearing *en banc*, the American Psychiatric Association contends that the committed patient has no "substantial [liberty interest] in refusing widely accepted and generally effective medication properly addressed to protecting the patient and others from harm, treating [his or her] illness, and restoring him [or her] to liberty." Thus the APA disputes the proposition that a "competent" patient has a residual liberty interest in refusing medication, *per se;* instead, in the APA's view, the patient's residual interest lies "in protecting against the unnecessary or inappropriate use of medication."

Notwithstanding the APA's view, I am willing to assume, as the panel did, that a committed patient—who has not previously been determined to be incompetent to make medication decisions—retains a residual liberty interest in making his or her own decisions. Is this interest, as a matter of substantive due process, overridden by the government's interests in either preventing harm or improving the patient's condition? The *Charters* panel did seem to accept the general proposition that the patient's interest is overridden when medication is necessary to reduce the risk of imminent danger to self or others. Absent such an emergency, however, the panel concluded that the government's interest in vindicating the therapeutic purpose of involuntary civil commitment is not sufficient to justify the forced medication of a "medically competent" patient. Although this conclusion is controversial, I am willing to accept it for purposes of this comment.

What I am not willing to accept, however, is the panel's conclusion that the government's interest in restoring a committed patient's competency to stand trial "does not justify administering antipsychotic drugs against his will." When a person charged with a criminal offense has been found to be incompetent to stand trial and has been committed for the purpose of restoring his competency, I believe the government has a compelling interest in providing ordinary and customary treatments, including clinically appropriate use of antipsychotic medications, designed to restore the defendant's capacity to understand the charges and assist counsel. (Whether it is permissible to medicate a defendant, over objection, in order to maintain his or her competency to participate in the trial itself is a separate—and, again, controversial—question, which was not before the court.) The existence of a valid criminal charge, together with the finding of "procedural incompetency," provide a sufficient basis for distinguishing these patients from patients who have been committed under ordinary civil commitment statutes.

By discounting the government's interest in restoring the procedural competency of patients committed for this purpose, the *Charters* panel effectively converted the case into a "pure" civil right-to-refuse case, with implications for all involuntarily committed patients in the psychiatric hospitals of Virginia and other states in the Fourth Circuit. The breadth of the opinion is all the more objectionable because the panel need not have addressed the right-to-refuse issue at all in light of its determination, *sua sponte*, that Charters' own detention at Butner was unlawful.

Assuming, *arguendo* that the government is prohibited—under substantive due process analysis—from imposing antipsychotic medication on an involuntarily committed patient who has not been found to be "incompetent" to make medication decisions, the next set of questions concern (i) the definition of competency; (ii) the procedures constitutionally required for making the competency determination; (iii) the consequences of a determination of incompetency; and (iv) the consequences of a determination of competency. These are all difficult and controversial issues. I will focus here only on the second.

Procedural due process

As a practical matter, the most disturbing feature of the *Charters* opinion is the strong implication that a refusing patient is entitled to a *judicial* determination regarding his competency. The court's opinion is not explicit on this issue, however. In

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rejecting the idea, derived from *Romeo*, that the institutional staff should be permitted to make the necessary determination, the panel observes: "Because of the potential for a conflict of interest, the decision whether forcibly to medicate a patient must be made by an independent arbitrator such as a federal court . . ." This language leaves open the possibility that administrative "arbitrators" may be sufficiently independent to satisfy the requirements of due process.

Although the panel's skepticism about the *Romeo* solution (relying only on the professional judgment of the treating physician) may be warranted, it does not follow that judicial decisionmaking should be constitutionally required. Empirical studies on the effect of decisions requiring judicial decisionmaking have consistently demonstrated that these procedures are extremely costly and time-consuming, diverting clinical energies from patient care and delaying needed treatment. (A Massachusetts study found that the average delay between the filing of a petition and the actual hearing date was 4-5 months.) Moreover, there is reason to doubt that judges will exercise sufficiently informed and independent judgment to warrant these costs; empirical studies have shown that when competency hearings have been held, the courts have almost invariably followed psychiatrists' views authorizing treatment over patients' objections.

"Empirical studies have shown that when competency hearings have been held, the courts have almost invariably followed psychiatrists' views authorizing treatment over patients' objections."

This is not to say that independent review is without value. The right to be heard by an independent decisionmaker is worthy of protection in itself, and it provides a valuable check on the exercise of clinical discretion. The key question, however, is whether this independent review must be judicial in nature. In light of the Supreme Court's endorsement of non-judicial decisionmaking procedures in *Parham v. J. R.* and *Youngberg v. Romeo*, I am confident that the Court would hold that a truly independent administrative review is constitutionally sufficient to protect the interests of civilly committed patients who object to antipsychotic medication. Certainly the external review provided by the Human Rights system in Virginia should be satisfactory. To the extent that the *Charters* opinion implies that judicial decisionmaking is required, the decision is unduly costly in light of its marginal value and is out of step with applicable Supreme Court authority. □

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Suicide, Continued from page 5

His study indicates that, in general, psychiatric patients have a higher incidence of suicide than others (or to put it differently, maladaptive people have a higher rate). Nonetheless, the rate for mental patients is probably less or about the same as divorced white male physicians in California.[5]

The following sociological and genetic elements enter into ultimate suicide rates:

- Females become depressed and attempt suicide; men die by suicide, the differential being at least 9-16:1.
- Major affective disorder may have a lifetime probability of 15% to as much as 35%, according to Klerman.[6]
- Although still much below the rate for the elderly, the rate of suicide is increasing rapidly among the young.
- The compounding of substance abuse, including alcoholic intake, is another factor noted in ultimate death by suicide. Klerman suggests that a history of previous attempts is a risk factor for this group.[7]
- Pervasive hopelessness has been recognized as a long-term prognosticator.

An effort has been made to correlate psychobiologic changes with suicidal risk,[8] but at this point in time, such efforts are more theoretical than practical. Mann notes that character psychopathology and hostility relate more to gestures than to failed attempts. Subtle differences such as those claimed in a comparison of bipolar and unipolar depression are also under study, but no definitive conclusions can be made yet.

Himmelhoch says that commitment laws may in fact contribute to suicide by denying hospitalization for the most needy groups.

> In place of well-trained clinicians making treatment decisions grounded in reality, the suicide hotline has flourished, where 'trained volunteers' make nondecisions and pander to the fanciful notions that love and concern can replace competence . . . Ironically, Clayton has pointed out that suicidal hotlines have negligible effects on mortality rates, as is predictable, because hotline customers are predominantly suicide attempters, a group already noted to possess very low lethality.[9]

In my opinion, the most important publication referable to long-term prediction is that of Pokorny[10] who conducted a five-year follow-up on 4,800 patients from a Veterans Administration Hospital. The overall rate of 740/100,000 thought to be at risk for committing suicide translates into a nonoccurrence rate of 99,260/100,000 per year—reflecting the actual small number of suicides per year compared to the potential at risk.

Pokorny and his group attempted to create several predictive systems and then apply them retrospectively to the study group in a blind fashion. With their most successful criteria, they identified 35 of 63 who subsequently

died by suicide—a 55.6% success rate. Unfortunately, these criteria also resulted in 1,206 false positives. Thus, of 1,241 identified as suicidal, only 2.8% were identified correctly in the period studied—or 97.2% incorrectly. Or to put it differently, if one simply predicted that no person who had been a psychiatric inpatient would ever commit suicide in a five-year period, that person would 96.1% accurate.

It has been estimated that three to four percent of the population has attempted suicide and that 15 to 25% of the population have had suicidal thoughts. Thus the potential group at risk (if prior attempt is a valid index) is in the millions—at least six to ten million. Of these, assuming that only one third of those who do commit suicide have a prior history, less than ten thousand people per year will commit suicide out of a potential pool in the millions. This fits in with the Pokorny data which indicate the very limited predictive value of any criteria.

In a review of 32 cases involving litigation,[11] I noted that about 10% of them manifested negligence in accordance with what I would consider to be reasonable legal standards. None in my experience reasonably involved an ability to predict a future behavior. Those which raised a legitimate question were those in which the data indicated an imminent suicidal threat that had been recognized as such, and the efforts in the hospital environment to effectuate control were done negligently, generally with a blatant violation of hospital policy.

The attempt to impose responsibility did not seem reasonable where the argument was that the caretaker should have anticipated suicide and prevented it. This argument should fail for a number of reasons. Based on the foregoing discussion, it is clear that one cannot prognosticate very accurately in an individual case. One can only classify the person as having some of the known risk factors (on which there is increasing disagreement), but recognize that the number of those in any risk group who will indeed commit a successful suicide is small compared to the size of the pool at risk.

In particular one encounters the problem of classification at various steps—initial appraisal, at time of hospitalization, after a variable period of hospitalization, when privileges are given, and discharge—as if one could predict with any exactitude what will occur as treatment and management evolve.

Conclusion

If prediction is questionable, the problems of control raise other issues. As privileges are given, control inevitably lessens. No control exists when the person is outside a hospital (as an outpatient, on leave or privileges, or discharged). Actually the concept of 'control' implies the power to control someone else's behavior—a concept that is reflective more of lay fantasy than medical-scientific reality.

Psychiatrists must treat mental illnesses in accord with established or recognized treatments for the type of psychiatric condition involved. They cannot prevent an ultimate behavior or eliminate a risk. Psychiatric patients do have behavioral problems and are often maladapted to their environment. The risk of misbehavior directed towards self is like the risk of coronary death in a population of individuals with known risk elements: the incidence of morbidity and mortality will be higher than the population at large despite treatment. This is particularly more poignant, however, in the behavioral sciences where the behavior is actually that of the individual, not that of the caretaker or the natural course of a 'disease.'

The idea that psychiatric or mental health intervention in fact affects the suicide rate is, to my knowledge, without any substantiation. A treatment system may affect a mortality rate as, for example, antibiotics can be shown to have lessened the death rate for many classes of pneumonia. Despite the tremendous advances in the neurosciences, no improvement in behavior has been seen in society. Criminality, especially homicide, has increased. Suicide has basically remained the same in incidence since the turn of the century, except for the recent higher rate in younger populations.

Light strongly criticized the pretensions of mental health professionals in dealing with or preventing suicide.[12] Despite the establishment of suicide prevention centers, national organizations and periodicals devoted to suicidology, the goal of a reduced suicide rate has not been met. To the contrary, he suggests that suicide rates may actually have increased in areas with increased availability of 'suicide prevention' services. Hence the irony of the title of Light's article: "Treating suicide: the illusions of a professional movement."

Hopefully, the factors I have touched upon here will be increasingly considered by those psychiatrists who are asked to evaluate the care offered by those in the frontlines, those who provide management within the confines of professional judgment, current knowledge, and therapeutic limitations. In particular, those who are so ready to accuse others that they 'should have known' must now expect that their own assertions could ultimately be subject to professional review and perhaps even sanction. □

1. Perr, *Suicide responsibility of hospital and psychiatrist*, 9 Cleveland-Marshall Law Review 427 (1960).

2. See Perr, "Legal aspects of suicide." In LD Hankoff and B Einsidler, Suicide: theory and clinical aspects (1979) and Perr, *Suicide and civil litigation*, 19 J Forensic Sci 261 (1974).

3. Klerman, *Clinical epidemiology of suicide*, 48 J Clin Psychiatry 33, Suppl 12 (1987).

4. Pokorny, *Prediction of suicide in psychiatric patients*, 40 Arch Gen Psychiatry 249 (1983).

5. Perr, *Suicide litigation and risk management: a review of 32 cases*, 13 Bull Am Acad Psychiatry Law 209 (1985).

6. Klerman, *supra* note 3.

7. *Ibid.*

8. Mann, *Psychologic predictors of suicide*, 48 J Clin Psychiatry 44, Suppl 12 (1987).

9. Himmelhoch, *Lest treatment abet suicide*, 48 J Clin Psychiatry 44, Suppl 12 (1987).

10. Pokorny, *supra* note 4.

11. Perr, *supra* note 5.

12. Light, *Treating suicide: the illusions of a professional movement*, 25 Int Soc Sci J 475 (1973).

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22901

July - December 1988 Volume 8, Number 2

Developments in
Mental Health Law
Institute of Law, Psychiatry and Public Policy The University of Virginia

A difficult balance: considering a new commitment law for minors

by Kathleen Dawson Shaw

Present Virginia law treats minors and adults identically when the question is one of psychiatric hospitalization. While the law itself may not differentiate by age, recently gathered data suggest that hospitals do, in fact, alter psychiatric admissions procedures when dealing with young patients. Whether those differences reflect a misunderstanding of the current law, or perhaps, its unworkability when applied to children and adolescents, it is clear that the law on the books is not the law uniformly applied when minors are admitted for psychiatric treatment. The 1989 session of the Virginia General Assembly will consider creating a separate set of standards and procedures specifically designed for the psychiatric hospitalization of minors. The culmination of years of study, this legislation must attempt to balance concerns for parental authority and family autonomy with an emerging recognition of children's civil liberties and decision making ability. It is a difficult balance to strike.

The current law

Prior to 1976, the Virginia Code authorized "voluntary" admission of minors to mental hospitals upon application of a parent or someone acting *in loco parentis*. In 1976 the special provisions for minors were dropped and the standards and procedures mandated for adults were applied to minors as well. Any person, regardless of age, may be admitted "voluntarily" to a mental hospital upon his own application, provided that he has a mental illness and is judged to be in need of hospitalization (Virginia Code §37.1-65). If the prospective patient is unable or unwilling to consent to hospitalization, he may be hospitalized only upon a judicial determination that, because of a mental illness, he presents an imminent danger to himself or others, or that he is substantially unable to care for himself, and that no less restrictive alternative than confinement and treatment is suitable (Virginia Code §37.1-67.1 *et seq*).

Application of the post-1976 procedures to children and adolescents has proved troublesome. Former practice in the hospitalization of children, whether for physical or psychiatric treatment, relied upon parental consent and parental decision making to authorize medical care. Current law would appear to divest parents of authority to consent to their children's hospitalization for psychiatric treatment, leaving the decision with the child and, ultimately, the court. Not only does this procedure contrast sharply with near absolute parental authority in other areas of medical decision making, it is difficult to apply in the face of confusion about the ability of younger children to give informed consent. The current statutory law appears to require that civil commitment proceedings be instituted for objecting children of any age, as well as for assenting children who are too immature to give effective consent.

Departmental Instruction No. 60

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has clarified the law for state hospitals in Departmental Instruction No. 60, which explains that a "voluntary" admission requires both the application of the parent or other legal guardian and the informed consent of the child. The

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Also in this issue:

child must specifically understand that he or she is mentally ill, and that the hospital will be treating this mental illness. The child must also be willing to remain in the hospital for such treatment. The staff is to make an individual determination of the child's ability to give such informed consent. If, because of age, intelligence, maturity, or degree of disturbance, the child is incapable of giving valid consent, "voluntary" admission is not possible and commitment procedures must be instituted through the courts. This departmental instruction, which applies only to children admitted to state mental hospitals, has resulted in some sort of judicial intervention for nearly all of the minors hospitalized in DMHMRSAS-operated hospitals.

In addition to the difficulty of obtaining effective consent from minors, the current age-neutral statute has raised several other concerns:

- Is the prior common law of parental authority displaced by the statute?
- Are minors in private hospitals entitled to the same procedural protections as those in state hospitals?

TABLE A-1

DMHMRSAS Hospitals	1987 Total Psych	1987 Psych Minors	March '88 Minors	Avail Beds Minors	Output Serv	Minimum Age
#1	n/a	n/a	20	28	yes[1]	0
#2	156	156	14	60	no	2
#3	1846	151	16	40	no	7
#4	1874	95	13	25	no	14
#5	1341	97	10	15	no	14
#6	911	7	2	96	no	14
#7	n/a	n/a	3	n/a	n/a	n/a
TOTALS	6128	506	78	264		

Total Psych Admissions, 1987; Total Psych Admissions of Minors, 1987; Total Psych Admissions of Minors, March, 1988; Beds available to (but not reserved for) minors.

n/a: Not available. Respondent hospital was unable to provide this information. Two hospitals provided their number of March admissions over the telephone and did not otherwise participate in the survey. These hospitals were not included in determining the response rate.

[1] Outpatient services are available to the general public.

[2] Outpatient services are available only to former inpatients.

[3] Approximate number

- Are the narrowly drawn, libertarian standards for involuntary commitment now in place for adults appropriate for children and adolescents?
- Is a commitment period of 180 days free from any sort of independent review appropriate for minors?

Such concerns led to the appointment of the Task Force on the Commitment Statutes Concerning the Psychiatric hospitalization of Minors in 1984, and eventually to the introduction of HB 414 in the 1988 session of the Virginia General Assembly by Del. Warren Stambaugh.

House Bill 414

HB 414 proposes some significant changes in the commitment laws as they apply to minors. It creates separate commitment laws and places them in Title 16 of the Code along with other laws pertaining specifically to minors. It restores parental authority to consent to psychiatric hospitalization for children 11 years of age or younger, while entitling adolescents 12 and older to a judicial hearing if they object to hospitalization. It requires a judicial review of all psychiatric hospitalizations of minors, whether voluntary or involuntary, after 45 days of hospitalization. Recognizing the inappropriateness of the adult standards for this population, HB 414 provides a somewhat different standard for involuntarily committing adolescents. Emergency detention and treatment of minors up to 72 hours without any judicial intervention would be allowed. The bill creates a non-judicial but independent check on the appropriateness of each hospitalization by requiring that an independent clinical evaluator skilled in the diagnosis and treatment of psychiatric illnesses in children certify each admission.

*The study**

Pursuant to House Joint Resolution 97, a legislative subcommittee has been studying HB 414 as well as the current law to fine-tune the proposal for consideration in 1989. In addition to soliciting extensive comment from all interested constituencies, the subcommittee commissioned a study by the Institute of Law, Psychiatry and Public Policy in order to get a clearer picture of how hospitals, both public and private, understand and implement the existing civil commitment laws as they apply to minors. The Institute, with assistance from the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Hospital Association, developed three survey instruments which were directed to the chief operating officers of all identified psychiatric

*Figures reported in this article are based upon responses received and processed prior to September 12, 1988. Several additional responses have since been received and the final figures will be adjusted to include those responses. No significant changes in the overall pattern of responses are anticipated.

Continued on page 40

In the Virginia General Assembly—1988

Commitment of juveniles to maximum security units

The Commissioner of Mental Health, Mental Retardation and Substance Abuse Services now has explicit statutory authority to place court-referred minor patients in forensic units with adult patients. To be placed in the forensic unit the minor must first be transferred to the circuit court for trial as an adult, or tried and convicted as an adult of a felony. Additionally the Commissioner must find that the placement in the forensic unit is "necessary to protect the security or safety of other patients, staff or the public."

HB 419; Ch. 826; amending §§16.1-275 and 16.1-280.

Involuntary treatment of prisoners

Two new statutes affecting the treatment of mentally disabled prisoners in the custody of the state Department of Corrections were enacted this year. The General Assembly modelled each of these new measures on existing laws.

Section 53.1-40.1 differs from the existing code section it is based on, §37.1-134.2, by allowing judicial authorization of psychiatric treatment, including antipsychotic medication and electroconvulsive therapy, where the patient is a prisoner. The new law applicable only to prisoners also permits the authorization to be based on a showing that the proposed treatment is in the "best interests" of the patient. Section 37.1-134.2 requires evidence that the proposed treatment is "medically necessary."

Despite the broader scope of an authorization under §53.1- 40.1, the procedures for obtaining the authorization are the same as under §37.1-134.2. The authorization may be made by any judge, including a special justice. The evidence may be presented by affidavit in the absence of an objection by the defense attorney. The judicial authorization of treatment may last for an indefinite period of time. Magistrates are allowed to authorize emergency treatment for a period of twelve hours.

A companion statute, §53.1-40.2, is modelled closely on the general civil commitment statutes, §§37.1-67.1 through 37.1-67.3. Some elements of commitment peculiar to the new law for prisoners include:

- Only the Director of Corrections or his designee can petition for involuntary psychiatric admission of a prisoner.
- Magistrates do not have the authority to order pretrial admission. Only judges, including special judges, have that authority where prisoners are involved.
- There is no time limit on pretrial admission. The commitment hearing is required only to be held as soon as possible.
- The prisoner does not have a right to voluntary admission for a minimum period of time.
- While the court is required to consider the existence of less restrictive alternatives, it is not authorized to commit the prisoner to any setting other than a hospital or facility designated by the Director of Corrections and licensed by the state Department of Mental Health, Mental Retardation and Substance Abuse Services. (The Department of Corrections Marion Correctional Treatment Center has recently been licensed by DMHMRSAS.)

Community services boards are not required to provide the court with preadmission screening.

HB 1074; Ch. 873; amending §§17-116.05:1 and 17-116.07, adding §§53.1-40.1 through 53.1-40.8, and repealing §19.2-177.

Involuntary commitment after sentencing

A separate procedure for the involuntary psychiatric hospitalization of persons being held in local jails after sentencing was enacted this year. This new procedure, described in §19.2-177.1, differs from that for jail inmates who have not yet been sentenced. After sentencing the involuntary hospitalization procedure requires a hearing of the kind customarily held in civil commitments under §37.1-67.3. While the new law does preclude the use of voluntary treatment, and does limit commitments to facilities designated by the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, it also incorporates by reference the preadmission screening requirement of the general civil commitment law.

HB 953; Ch. 787; adding §19.2-177.1 and repealing §19.2-177.

Civil commitment

The General Assembly this year prohibited the use of jails as temporary detention facilities in civil commitments. Prior law had permitted the use of jails provided they met certain standards. Few jails were used because of difficulty in meeting these standards.

Virginia civil commitment procedure has long required the court to appoint an expert to examine the person proposed for commitment and report to the court. A 1988 amendment stresses that this examination must be performed "in private" and the court may not rule on the commitment until the examiner

Continued on next page

has presented his or her report. While this has been the practice in most jurisdictions, there have been instances in the past of court-appointed experts performing evaluations during the commitment hearing. A reminder that judgment should not be rendered prior to the presentation of the examiner's report should not have been necessary, because the statute already made the "positive certification" of the expert a necessary condition of commitment.

HB's 312, 645; Chs. 98 and 225; amending §§37.1-67.1 and 37.1-67.3.

Expenses in state hospitals

The legislature made a minor change to the statute governing reimbursement claims against residents of state mental health and mental retardation facilities. Prior language made the resident responsible at most for the "actual" per capita cost of the particular type of service provided. The 1988 amendment changes this ceiling on reimbursement to the "average" per capita cost.

HB 348; Ch. 713; amending §37.1-105.

Suspension of driver's license

Virginia law requires the Commissioner of the Department of Motor Vehicles to suspend the driver's license of a person discharged from a state mental health or mental retardation facility when the facility staff reports to the Department of Motor Vehicles that the resident is "not competent because of mental illness, mental retardation, inebriety or drug addiction to operate a motor vehicle with safety to persons or property." A 1988 amendment removes reference in this section to epilepsy as a basis for a suspension.

HB 373; Ch. 78; amending §46.1-427.

Persons with disabilities

Two cosmetic changes were made to the Virginian with Disabilities Act in 1988 regarding the rights of persons with mental disabilities.

In order to have rights under the Act a mentally disabled person must first meet the definition of "mental impairment." This definition was clarified somewhat in 1988, but still requires a degree of impairment that is quite severe compared with the federal Rehabilitation Act. When the state definition of "mental impairment" is read in conjunction with the definition of "persons with a disability" it excludes most people from the protection of the state law. For example, to be entitled to employment rights under the Act, a "person with a disability" must have an impairment that is severe enough to meet the definition of "mental impairment" and which "substantially limits one or more of his major life activities," but which is at the same time "unrelated to the individual's ability to perform the duties of a particular job or position, or is unrelated to the individual's qualifications for employment or promotion."

Because nobody will be able to satisfy the requirement of severity and "unrelatedness" at the same time, the other 1988 amendment is still meaningless. That amendment changes the definition of "otherwise qualified person with a disability." This definition formerly raised a third, equally insurmountable set of requirements for a person presenting an employment claim under the Act. In addition to meeting the severity and unrelatedness requirements, a mentally disabled person had to be qualified "without accommodation" for the employment in question. In 1988 the "without accommodation" language was removed from this definition.

If the other definitions in the Act were rewritten, this change would prove valuable to mentally disabled persons. It has the potential of creating a significant duty on the part of employers to accommodate disabilities.

SB 418; Ch. 44; amending §51.01-3.□

Subcommittee to study legal guardianship

The General Assembly is currently holding hearings to determine the adequacy of current guardianship and adult protective services laws. House Joint Resolution 171, calling for this study, was due in part to an Associated Press report which appeared in the *Richmond Times Dispatch* in September, 1987, and to the introduction of several proposals related to guardianship introduced in the 1988 session, and carried over to the 1989 session. Among these pending proposals are:

- A requirement that the guardian ad litem in a guardianship hearing interview the proposed ward and his or her family, as well as explore possible conflicts of interest on the part of the proposed guardian (SB 201).
- An expansion of statute permitting judicial authorization of treatment, without the necessity of appointing a guardian. The proposed amendment would permit the use of §37.1-134.2 to authorize psychiatric treatment, such as psychotropic medication and ECT. The proposal would also increase the procedural safeguards afforded the patient under this statute.
(HB 415).
- A new statute, which in the case of a patient whose mental disorder prevents him or her from giving consent to treatment, but who does not object to the treatment, allows the patient's relatives to give consent. Where a relative is not available, a "certified health care representative" is authorized to give consent. In order to become a "certified health care representative" certain standards, set forth in regulation, must be met (HB 413).

Veterans lose suit for extension of educational benefits

Alcoholism considered "willful misconduct"

by Nils Montan

***Traynor v. Turnage* and *McKelvey v. Turnage*, ___U.S.___, 56 U.S.L.W. 4319 (April 20, 1988)**

A closely divided United States Supreme Court upheld a Veterans Administration regulation which classifies primary alcoholism as "willful misconduct." Both the majority and dissenting opinions took pains to emphasize that the Court was *not* deciding whether or not alcoholism is a "disease whose course its victims cannot control." Nevertheless, both opinions did, at the very least, focus on the somewhat conflicting views over an individual alcoholic's responsibility for his condition.

The two cases have slightly different procedural histories, but both concern the interpretation of the same Veterans Administration (VA) regulation. Veterans who have been honorably discharged from the services are entitled to receive educational benefits under the G.I. Bill. Under the applicable VA regulation found in 38 CFR §1662, the benefits must be used within ten years following discharge or release from active duty. In 1977 Congress provided that veterans may obtain an extension of the ten-year delimiting period if they were prevented from using their benefits earlier by a "physical or mental disability which was not the result of. . . their own willful misconduct." A separate VA regulation, 38 CFR §3.301 (c)(2), defined primary alcoholism, (where the condition was not caused by an underlying psychiatric disorder,) as "willful misconduct."

Both Eugene Traynor and James McKelvey began drinking at a very early age—Traynor was nine years old and McKelvey was under thirteen. Both developed drinking problems when they were teenagers and continued to drink heavily as young men in the army. They were honorably discharged from the service, but continued to drink and were repeatedly hospitalized for alcoholism and related problems. Both men had stopped drinking and had begun to attend educational institutions near the end of the ten-year period following their separation from the service. After the ten-year period ran out on each of them, they sought extensions of the educational benefits they had been receiving. Both men were denied extensions because their disability, primary alcoholism, was conclusively presumed by the VA regulation to have been caused by their own "willful misconduct." Neither man was allowed by the regulation to establish that in his particular case alcoholism was not willfully incurred.

Traynor and McKelvey sued the VA and its administrator in separate suits in federal court, Turnage in New York and McKelvey in Washington, D.C. The cases differed in the respective findings of the trial courts and the United States Courts of Appeals for the Second Circuit and for the District of Columbia. However, by the time the cases presented themselves to the Supreme Court, two issues remained–

- Was the VA's action subject to court review at all in light of 38 U.S.C. §211(a), which bars judicial review of "the decisions of the Administrator on any question of law or fact under any law administered by the Veterans Administration providing benefits for veterans"?
- Did the VA regulation classifying primary alcoholism as willful misconduct clash with §504 of the Rehabilitation Act of 1973?

The entire Court was able to agree that §211 did not bar judicial review of the petitioners' claims. According to the Court the presumption in favor of judicial review of administrative action may be overcome only upon a showing of clear and convincing legislative intent and in this case the legislative history of §211 provided no clear and convincing evidence of any congressional intent to preclude a suit under §504 of the Rehabilitation Act.

However, the Court was sharply divided in the analysis of whether or not §504 of the Rehabilitation Act, which prohibits discrimination in federal programs against handicapped individuals solely by reason of their handicap, was violated by the VA regulation excluding primary alcoholics from the extension of educational benefits. The majority used legislative history to show that, in its opinion, there was no violation. First, it noted that in 1977 when Congress created the exception for disabled veterans in §1662(a)(1), it did not use the term "willful misconduct" inadvertently. The same term had long been used in other veterans statutes which had construed the term as encompassing primary alcoholism. Indeed, the legislative history confirmed that Congress intended that the VA apply the same test of "willful misconduct" in granting extensions under §1662.

In 1978, when Congress extended §504 of the Rehabilitation Act to apply to programs conducted by federal agencies, it did not affirmatively show any intent to repeal §1662 and the "willful misconduct" presumption. Citing a tenet of statutory construction to the effect that implied repeals of earlier statutes by later statutes are not favored, the Court concluded that Congress intended the "willful misconduct" presumption to continue to apply in §1662 cases.

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In addition to the above, the majority held that its decision did not undermine the central purpose of §504 as it had been elucidated in *School Board of Nassau County v. Arline,* 480 U.S.___ (1987). Unlike *Arline* this case did not represent a program or activity that is alleged to treat handicapped persons less favorably than non-handicapped persons, but rather, concerned a challenge to a statutory provision that treated disabled veterans more favorably than able-bodied veterans. According to the Court, there is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons.

In this case, the Veterans Administration was merely continuing a long-standing policy of differentiating between veterans who bear some responsibility for their disabilities from those who do not. Primary alcoholics are not denied the extension of benefits solely by reason of their handicap but "because they engaged with some degree of willfulness in the conduct that caused them to be disabled."

The Court noted that it might arguably be inconsistent with §504 to distinguish between categories of veterans according to generalized determinations that lack any substantial basis. In other words, if primary alcoholism is not always "willful," then some veterans like the petitioners may be excluded solely on the basis of their disability. *Amici* briefs had been filed by the National Council on Alcoholism, the American Medical Association and the American Psychiatric Association arguing that primary alcoholism is a disease and not willful misconduct. The Court, however, noted that there was "a substantial body of medical literature that even contests the proposition that alcoholism is a disease, much less that it is a disease for which the victim bears no responsibility." In light of these conflicting views the Court found that the VA regulation is reasonable and not in conflict with §504.

Dissenting Justices Blackmun, Brennan and Marshall differed strongly with the majority view of the application of §504 of the Rehabilitation Act to this case and with respect to the "willfulness" of primary alcoholism. They argued that *Arline* mandates an individualized determination based on medical evidence of the causes of the disability. Thus the VA's conclusive presumption of "willful misconduct" violates §504. The dissent also noted that the VA brief relied upon the comments of a number of medical writers to the effect that "volition plays a significant role in the treatment of alcoholism." In contrast, Justice Blackmun pointed to recent medical research which indicates that the causes of primary alcoholism are varied and complex, only some of which could conceivably be attributed to a veterans's will:

> While cure and cause are likely to be somewhat related, the fact that alcoholism is "highly treatable, but . . . will require great responsibility from the patient" . . . provides little assistance in assessing whether the original onset of the disability can always be ascribed to willful misconduct. □

Other Supreme Court actions

Use of screen in child abuse prosecution violates confrontation clause

Coy v. Iowa, **___U.S.___, 56 U.S.L.W. 4931 (June 29, 1988)**

John Avery Coy was charged with sexually assaulting two thirteen-year-old girls. At his trial the state made a request pursuant to a recently enacted Iowa statute asking to allow the children to testify either via closed-circuit television or from behind a screen. The statute, like similar statutes across the country, is premised on the finding by the legislature that a child abuse victim may suffer additional trauma from exposure to the harsh atmosphere of the typical courtroom and from being in the presence of the alleged attacker. The trial court approved the use of a large screen placed between Coy and the witness stand during the girls' testimony. The screen enabled Coy to dimly perceive the girls when they were testifying, but they could not see him at all.

Coy's counsel objected to the use of the screen, arguing that the confrontation clause of the sixth amendment gives criminal defendants a right to face-to-face confrontation. He also argued that Coy's right to due process was violated, because the procedure would make him appear guilty and thus erode the presumption of innocence. The trial court overruled the objections, Coy was convicted, and the conviction was upheld by the Iowa Supreme Court.

The United States Supreme Court reversed Coy's conviction, holding that the use of the screen violated his sixth amendment rights, but it declined to decide the due process claim. In the opinion for the Court Justice Scalia took a historical approach in his review of the requirements of the sixth amendment. He noted that the right of a criminal defendant to be confronted with the witnesses against him ". . . comes to us on faded parchment. . ., with a lineage that traces back to the beginning of Western legal tradition." Relying on such sources as Shakespeare's *Richard III* and a speech by President Eisenhower before the B'nai B'rith Anti-Defamation League, the Court emphatically stated that ". . . we have never doubted. . . that the

Confrontation Clause guarantees the defendant a face-to-face meeting with the witnesses appearing before the trier of fact."

Finding that there is ". . . something deep in human nature that regards the face-to-face confrontation between the accused and accuser as essential to a fair trial," the Court stated its belief that it is more difficult to tell a lie about a person "to his face" than "behind his back."

In the context of this case, the Court found that it was "difficult to imagine a more obvious or damaging violation of the defendant's right to a face-to-face encounter" than the use of the screening procedure utilized by the trial court. Although the Court recognized the importance of the public policy attempting to limit the stress of the court proceeding on the children, it stated that

> face-to-face presence may, unfortunately, upset the truthful rape victim or abused child; but by the same token it may confound and undo the false accuser, or reveal the child coached by a malevolent adult. It is a truism that constitutional protections have costs.

In a lengthy concurring opinion, Justices O'Connor and White emphasized that nothing in the decision necessarily doomed efforts by state legislatures to protect child witnesses by other means.

Involuntary servitude considered

***United States v. Kozminski,* ___U.S.___, 56 U.S.L.W. 4910 (June 28, 1988)**

In considering whether defendants were subject to criminal prosecution for violating the thirteenth amendment rights against involuntary servitude of two mentally retarded men who were laboring on the defendants' farm, the Supreme Court held that involuntary servitude must consist of the compulsion of services through actual or threatened use of physical injury or actual or threatened use of coercion through law or the legal process. Psychological coercion alone does not constitute involuntary servitude under the thirteenth amendment or the statutes making a crime the violation of rights guaranteed by that amendment.

Two mentally retarded men, Robert Fulmer and Louis Molitoris, were found working on a farm operated by defendants Ike Kozminski, his wife Margarethe, and their son John. Fulmer and Molitoris were expected to work seven days a week, often seventeen hours a day, for no pay. The men were denied adequate food, shelter, and medical care. They were in poor health, living in squalid conditions and were kept in relative isolation from the rest of society. The Kozminskis subjected the men to physical and verbal abuse for failing to do their work and directed other employees at the farm to do the same. When the men did attempt to leave the farm they were brought back and discouraged from leaving again. On one occasion, John Kozminski threatened Molitoris with institutionalization if he did not obey.

The government brought a criminal action against the Kozminskis. They were charged with violating federal statutes enacted by Congress to enforce the thirteenth amendment, including conspiracy to "injure, oppress or intimidate" Fulmer and Molitoris in the free exercise and enjoyment of their thirteenth amendment right to be free from involuntary servitude under 18 U.S.C. §241 and with knowingly holding the two men to involuntary servitude under 18 U.S.C. §1584.

At the district court level the jury convicted Ike and Margarethe Kozminski for violating both statutes and John Kozminski for violating §241. The defendants were placed on probation, and ordered to pay fines and restitution to the victims. The instructions that the district court gave to the jury contained a definition of "involuntary servitude" that included "situations involving either physical and other coercion, or a combination thereof, used to detain persons in employment."

The Court of Appeals for the Sixth Circuit reversed the convictions and remanded the case for a new trial on the grounds that the district court's definition of involuntary servitude was too broad because it would bring within the reach of §§241 and 1584 cases involving general psychological coercion. Extreme examples of purely psychological pressure under the trial court's definition of coercion could include an employer's threat to give a poor recommendation to an employee if he leaves his employment or a husband's threat to seek custody of the children if his wife leaves. The Court of Appeals for the Sixth Circuit fashioned its own definition of involuntary servitude which excluded psychological coercion, but which included the use of fraud or deceit in cases where the victim is a minor, an immigrant or mentally incompetent. Various other federal courts of appeals had developed differing standards to define the meaning of involuntary servitude, and the Supreme Court granted the writ of certiorari to resolve the conflict.

The Court affirmed the holding of the court of appeals, but took issue with its definition of involuntary servitude. The Court held that the meaning of involuntary servitude had to be derived from the legislative intent behind the statutes as elucidated in the Court's prior decisions. Examining the legislative history of the thirteenth amendment and the two statutes in question, the Court concluded that the term "involuntary servitude" necessarily means a condition of servitude in which the servant is forced to work for the master by the use or threat of physical restraint or physical injury or by the use or threat of coercion through the law or the legal process. The latter provision involves situations where a victim has no choice but to work or be subject to legal sanction such as subjecting debtors to prosecution and criminal punishment for failing to perform labor after receiving an advance payment.

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In this case the government argued that a broad construction of "involuntary servitude" should be adopted which would prohibit the compulsion of services by any means that, from the victim's point of view, either left the victim with no tolerable alternative but to serve the master or deprived the victim of the power of choice. For the Court, such a sweeping standard would appear to "criminalize a broad range of day-to-day activity," including almost any type of speech or conduct intentionally employed to persuade a reluctant person to work. This would subject individuals to the risk of arbitrary or discriminatory prosecution. Interpreting the statutes to depend entirely upon the victim's state of mind would provide almost no objective indication of the conduct they prohibit and would therefore fail to give fair notice of the nature of the crimes.

The Court also rejected the notion that additional protection should be afforded especially vulnerable classes of victims such as Fulmer and Molitoris. The Court did, however, acknowledge that a victim's special vulnerabilities may be relevant in determining whether the physical or legal coercion or threats thereof could plausibly have compelled the victim to serve.

Although the Court disagreed with the standard applied by the Sixth Circuit, it believed that the record contained enough evidence of physical or legal coercion to enable a jury to convict the Kozminskis even under the stricter standard of involuntary servitude announced by this decision. Accordingly, the Court agreed with the court of appeals that a judgment of acquittal was unwarranted and remanded the case for further proceedings consistent with its opinion.

In a concurring opinion Justice Brennan, joined by Justice Marshall, argued that in addition to threatened or actual physical or legal coercion, Congress intended involuntary servitude to encompass any form of coercion that "actually succeeds in reducing the victim to a condition of servitude resembling that in which slaves were held before the Civil War." Justice Stevens also wrote a concurring opinion in which he advocated leaving the task of defining "involuntary servitude" to case-by-case adjudication. The majority opinion criticized both these arguments as using standards that are too arbitrary and undefined to give notice of what constitutes criminal conduct.

Psychiatric testimony not harmless error

***Satterwhite v. Texas,* ___U.S.___, 56 U.S.L.W. 4470 (May 31, 1988)**

John Satterwhite was charged with and indicted for the capital crime of murder during a robbery in Texas. Satterwhite was subjected to pretrial examinations by psychologists and psychiatrists pursuant to court orders. A letter appeared in the court file from Dr. James Grigson, a psychiatrist who examined Satterwhite, stating that in his opinion Satterwhite had "a severe antisocial personality disorder and is extremely dangerous and will commit future acts of violence." Satterwhite was tried by jury and convicted of murder.

In a separate sentencing proceeding the trial court sentenced Satterwhite to death as required by Texas law, because the jury found that Satterwhite deliberately committed the murder and that there was "a probability that he would commit criminal acts of violence that would constitute a continuing threat to society." Over the objection of defense counsel, Dr. Grigson testified at Satterwhite's sentencing proceeding that he "will present a continuing threat to society by continuing acts of violence." In his closing argument, the district attorney emphasized Dr. Grigson's testimony.

Estelle v. Smith, 451 U.S. 454 (1981), established that defendants charged with capital crimes have a sixth amendment right to consult with counsel before submitting to psychiatric exams designed to determine their future dangerousness. In this case, the Texas Court of Criminal Appeals determined that the state did not provide notice of Dr. Grigson's examination of Satterwhite to his defense counsel. The court of criminal appeals found that defense counsel had no actual knowledge of the motion and order for psychiatric examination. That court also rejected the state's argument that placement of the state's motion and court's *ex parte* order in the court's file gave defense counsel constructive notice of the exam. In an opinion delivered by Justice O'Connor, the Supreme Court wholly agreed with the holding of the court of criminal appeals that neither actual nor constructive notice of the exam was given to defense council.

After disposing of the notice issue, the court of criminal appeals determined that the state's violation of the defendant's sixth amendment rights in this case amounted to harmless error. Under *Chapman v. California,* 386 U.S. 18 (1967), if the prosecution can prove beyond a reasonable doubt that a constitutional error did not contribute to the verdict, the error is harmless and the verdict may stand. Applying the harmless error rule of *Chapman* to this case, the Supreme Court found that the State of Texas failed to prove beyond a reasonable doubt that Grigson's expert testimony on the issue of Satterwhite's future dangerousness did not influence the sentencing jury. The case was reversed and remanded.

By applying the harmless error analysis of *Chapman* to this case, the Supreme Court rejected the stricter standard applied in *Holloway v. Alabama,* 368 U.S. 52 (1963), that was advanced by the defendant and proffered by Justice Marshall in his concurring opinion. *Holloway* stands for the proposition that some constitutional violations by their very nature cast so much doubt on the fairness of the trial process that, as a matter of law, they can never be considered harmless and reversal is automatic. The Supreme Court held that the strict rule of *Holloway* only applies

to sixth amendment violations that "pervade the entire proceeding" such as total deprivation of counsel. The deprivation in Satterwhite's case was limited to the admission into evidence of Dr. Grigson's testimony which, according to the Supreme Court, did not taint the entire proceeding.

In his concurring opinion, Justice Marshall, joined by Justices Blackmun and Brennan, argued that *Holloway* anticipated automatic reversal not only when the deprivation affects the entire proceeding, "but also when the deprivation occurs during a 'critical *stage* in, at least, the prosecution of a capital offense.' " According to Justice Marshall, the sentencing of a capital defendant constitutes such a critical stage where error cannot be risked.

No money damages for improper denial of Social Security benefits

***Schweiker v. Chilicky,* ___U.S.___, 56 U.S.L.W. 4767 (June 24, 1988)**

In 1980 Congress enacted legislation requiring that most Social Security Act disability determinations be reviewed once every three years. Under the "continuing disability review" (CDR) program, numerous benefits were terminated during the next several years following a determination by a state agency that the claimant was no longer eligible. Payments were not available to the terminated claimant during administrative appeals.

Finding that benefits were frequently being improperly terminated with a "meat ax approach" by state agencies under CDR, only to be reinstated by a federal administrative law judge (ALJ) on appeal, Congress enacted reform legislation in 1983 and 1984 that provided standards for termination and for the continuation of benefits through the completion of the appeals process.

The respondents in this case were three individuals whose disability benefits were improperly terminated pursuant to the CDR program in 1981 and 1982. The benefits were restored or partially restored retroactively by subsequent administrative appeals or, in one case, by the filing of a new application. James Chilicky, Spencer Harris, and Dora Adelerte filed suit against one state and two federal officials who were CDR policy-makers, alleging that the officials had violated their due process rights by adopting certain illegal policies that led to the benefits termination. The suits sought money damages for emotional distress and loss of necessities under the constitutional tort theory of *Bivens v. Six Unknown Federal Narcotics Agents,* 403 U.S. 388 (1971). The case was dismissed by the district court, but the Court of Appeals for the Ninth Circuit reversed, holding that it could not be shown as a matter of law that the respondents could prove no facts warranting recovery.

Writing for five members of the Court, with the concurrence of Justice Stevens in the judgment, Justice O'Connor held that the improper denial of Social Security benefits, allegedly resulting from due process violations by petitioners in their administration of the CDR program, cannot give rise to a cause of action for money damages.

The Court first reviewed the constitutional tort theory enunciated in *Bivens.* There the Court held that the victim of fourth amendment violations by federal officers acting under the color of their authority may bring suit for money damages against the officers in federal court. The Court found "no special factors counseling hesitation in the absence of affirmative action by Congress."

In the instant case the Court noted that recent decisions had tended to narrow the *Bivens* remedies in situations where the scope of Congressional authority was broad and where Congress had already created what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration.

Because the elaborate remedial scheme devised by Congress in 1983 and 1984 did not include a money damages remedy for constitutional violations, the Court in this case concluded that Congress presumably appropriately balanced governmental efficiency and individual rights, and decided against such a remedy. Accordingly, the Court declined to interfere with the Congressional scheme and reversed the decision of the court of appeals.

A lengthy dissenting opinion was filed by Justice Brennan on behalf of himself and Justices Marshall and Blackmun. The dissent denied that Congress had precluded recognition of a *Bivens* action for persons whose constitutional rights are violated by those charged with administering the CDR program, or that Congress viewed the CDR remedial process as an adequate substitute remedy for such violations.

Peer-review system subject to federal antitrust laws

***Patrick v. Burget et al.,* ___U.S.___, 56 U.S.L.W. 4430 (May 17, 1988)**

In a unanimous opinion the United States Supreme Court held that the "state-action" doctrine does not immunize Oregon physicians participating on hospital peer-review committees from federal antitrust scrutiny. (Justice Blackmun took no part in the consideration or decision of the case.)

Dr. Timothy A. Patrick, a surgeon from Astoria, Oregon, brought suit against a number of physicians who had initiated and were participating in peer-review proceedings seeking to terminate his privileges at Astoria's only hospital. The physicians alleged that Dr. Patrick's care of his patients was below hospital standards. Dr. Patrick resigned from the hospital before the completion of the termination proceedings and filed suit against the other physicians claiming

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The Civil Rights of Institutionalized Persons Act of 1980: A guide for clinicians

by Shelly Dean

Because of the potential impact of the Civil Rights of Institutionalized Persons Act (CRIPA) on conditions in state mental health and mental retardation facilities, many clinicians are curious about the provisions of the law and the way in which the courts have interpreted it. The following legislative history and case summaries are offered as a guide for clinicians in understanding CRIPA. The specific requirements of the consent decrees currently applicable to some state mental health and mental retardation facilities are summarized in a table on page 32.

Legislative history

Congress enacted the Civil Rights of Institutionalized Persons Act (CRIPA) in 1980, 42 U.S.C. §1997 *et seq.*, giving the United States Attorney General legal standing to bring suit in federal court on behalf of persons institutionalized by the states under unconstitutional conditions.

Institutionalized persons almost always lack the resources and the ability to protect their constitutional and federal statutory rights to adequate living conditions. The Department of Justice, however, has the investigative and legal resources necessary to attack system-wide institutional deficiencies. CRIPA was needed because several federal court cases in the late 1970's denied the Attorney General standing absent express statutory authority. Opponents of CRIPA argued that the Act represented an unwarranted federal intrusion into state matters.

CRIPA applies to the following state institutions: jails, prisons or other correctional facilities, pre-trial detention facilities, juvenile facilities, mental hospitals, mental retardation facilities, nursing homes, and facilities for the chronically physically ill or handicapped. Before filing a CRIPA suit against an institution, the United States Attorney General must conduct a complete investigation of the institution, notify the state officials of the alleged unconstitutional conditions, and make reasonable efforts to eliminate the conditions without resort to the courts. Congress, suggesting that appropriate remedies should be settled upon informally and voluntarily wherever possible, expected state officials to cooperate with the Justice Department in the investigation and correction of any existing unconstitutional conditions.

Section 1997e requires the exhaustion of appropriate state administrative remedies prior to filing a §1983 action. It was adopted in part as a response to the vast increase in §1983 claims brought by state prisoners in federal courts. Congress intended to authorize the Attorney General to act when necessary to protect the constitutional rights of prisoners, but at the same time to minimize the need for federal action of any kind by requiring prior exhaustion. Senator Hatch, a sponsor of CRIPA, stated, "In actions relating to alleged violations of constitutional rights of prisoners, such persons may be required to exhaust internal grievance procedures before the Attorney General can become involved pursuant to [CRIPA]." Congress hoped that CRIPA would improve prison conditions by encouraging state prisons to develop adequate grievance mechanisms pursuant to §1997e(b).

Litigation brought under CRIPA

***Kennedy v. Herschler*, 655 F.2d 210 (10th Cir. 1981)**

A Wyoming prisoner's §1983 action was erroneously dismissed for failure to exhaust all administrative remedies. Pursuant to 42 U.S.C. §1997e(a)(1) the court should have continued the matter for a period not to exceed ninety days to allow the exhaustion of available administrative remedies.

***Patsy v. Board of Regents of the State of Florida*, 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982)**

A §1983 action alleging employment discrimination based on sex and race may be maintained without requiring exhaustion of administrative remedies, in light of the legislative histories of §1983 and CRIPA §1997e. However, §1997e carves out a narrow exception to the general no-exhaustion rule by creating a specific, limited exhaustion requirement for adult prisoners bringing actions pursuant to §1983. Under §1997e(a)(2) exhaustion of administrative remedies is required only if "the Attorney General has certified or the court has determined that such administrative remedies are in substantial compliance with the minimum acceptable standards promulgated under subsection (b)." Furthermore, before exhaustion may be required, the court must conclude that it "would be appropriate and in the interests of justice" pursuant to §1997e(a)(1).

***Owen v. Kimmel*, 693 F.2d 711 (7th Cir. 1982)**

A prisoner's §1983 action was erroneously dismissed for failure to exhaust the Indiana prison grievance procedure. Section 1997e(a)(2) requires the exhaustion

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of all available administrative remedies, but only if the Attorney General or the court has verified that the administrative remedies comply with the standards set forth by §1997e(b). The action was remanded to determine whether the prison grievance procedure was in substantial compliance with the minimum acceptable standards promulgated under §1997e(b)(2). Moreover, before exhaustion may be required, the court must conclude that it "would be appropriate and in the interests of justice" pursuant to §1997e(a)(1).

***Johnson v. King*, 696 F.2d 370 (5th Cir. 1983)**

A Louisiana prisoner's §1983 action could not be dismissed by summary judgment on the grounds of failure to exhaust administrative remedies. As stipulated by 42 U.S.C. §1997e(a)(2) the administrative remedies must be in substantial compliance with the minimum acceptable standards promulgated under §1997e(b). The disciplinary rules under which the prisoner was penalized had not been certified by the Attorney General or a court according to §1997e(a)(2). The case was vacated and remanded for reconsideration under CRIPA.

***United States v. Hawaii*, 564 F.Supp. 189 (D.C. Haw. 1983)**

The state of Hawaii's motion to dismiss was granted on the ground that the United States had not satisfied the notification requirement under §1997b and therefore had no standing to bring suit under §1997a. Pursuant to 42 U.S.C. §1997b(a)(2) Assistant Attorney General William Bradford Reynolds notified the state of his intention to investigate the conditions of two prisons, Oahu Community Correctional Center and Halawa High Security Facility. In the 49-day notice letter required under §1997b(a)(1) the AG provided the state with a list of alleged conditions depriving inmates of their rights; however, he failed to provide supporting facts and to recommend remedial measures pursuant to subsections 1997b(a)(1)(B) and 1997b(a)(1)(C). Furthermore, the AG's noncompliance with the notice provisions of CRIPA was not excused by the state's refusal to permit an inspection of the prisons.

***United States v. County of Los Angeles*, 635 F.Supp. 588 (C.D. Cal. 1986)**

The Justice Department (DOJ), in seeking to conduct its CRIPA investigation, is not subject to the county juvenile court's authority, under California law, to control access to juvenile records because state law is preempted by CRIPA. The CRIPA investigation suffered a considerable delay despite the DOJ's efforts to accommodate the county's legitimate interest in protecting the confidentiality of the juveniles. Consequently, the court granted the government's injunction forbidding the county, the juvenile court judge and county officials affiliated with the juvenile hall system from restricting or denying the DOJ access to the juvenile hall, the juveniles themselves and their records.

Consent decrees approved by federal district courts settling CRIPA actions

***United States v. Indiana* (S.D. Ind. 4-6-84)**

The agreement involves two state mental hospitals and requires the state to implement the following principles:

- all medical treatment decisions must be made with the exercise of professional judgment by qualified staff;
- all hospital residents must be afforded sufficient daily care and medical attention to ensure their constitutional rights to safety and freedom from undue bodily restraints;
- the hospital's physical environment must be maintained to protect residents from undue threats to their personal safety.

The state agreed to increase funding devoted to the mental health system. Additional staff members were to be hired to achieve specific staff-to-resident ratios.

***United States v. Maryland* (D. Md. 1-17-85)**

This is the first settlement under CRIPA involving a mental retardation institution. The state agreed to provide the following for the nine hundred mentally retarded residents of Rosewood Center:

- adequate medical care and treatment guided by professional judgment;
- a safe physical environment free from abuse, neglect, and unnecessary bodily restraints;
- the assessment and placement of residents with severe behavioral problems into training programs professionally designed to protect their personal safety.

By June 30, 1985, the state must achieve established staff-to-resident ratios by hiring more staff or reducing the resident population by transferring them where appropriate to community residences. Additionally, the state must file a detailed plan of action and make a good faith effort to secure enough funds from the legislature to implement its plan.

***United States v. South Carolina* (D. S.C. 6-24-86)**

The decree involves the state's largest mental hospital and requires the state to meet minimum staff-to-resident ratios as of July 1, 1989. The state submitted an 82-page report outlining remedial actions mental health officials plan to take to comply with the provisions of the decree. Officials promised a good faith effort to secure sufficient funds from the legislature to carry out this plan, which includes the training and

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MINIMUM STAFF-TO-PATIENT RATIO

Case	Type	Size	Physician	Psychologist	R.N.	Direct care	Other
U.S. v. Md. 9 MPDLR 104	MR	900	1:65	1:20*	1:40		
U.S. v. Colo. 10 MPDLR 355	MH	n/a	1:100	1:30* 1:60	1:40	1:2-10	
U.S. v. Conn. 10 MPDLR 355	MR	1100	1:125	1:30	1:40	1:4 1:8**	LPN 1:40 Nurse Practioner 1:250
U.S. v. Mich. 10 MPDLR 356	MH	n/a	1:150	1:60	1: ward 1:2 wards	1:8 1:10**	Psychiatrists 1:30
U.S. v. Mich. 10 MPDLR 401	MH	650	1:150	1:30		1:8 1:10**	Psychiatrists 1:30

TYPE
MH: mental hospital
MR: facility for mentally retarded

* Residents with emotional and behavioral problems

** Night shift (11pm-7am)

treatment of residents to protect them from unreasonable risks to personal safety and undue bodily restraint, and the requirement of professional judgments for medical treatment, training, care, and administration of drugs.

***United States v. Colorado* (D. Colo. 7-10-86)**

The consent decree involving the Wheat Ridge Regional Center requires the state to meet the following minimum staff-to- resident ratios:

- one physician for every one hundred residents;
- one psychologist with a master's degree for each 30 residents with emotional or behavioral problems, or for every 60 other residents;
- one registered nurse for every 40 residents during the day; at least three nurses for night duty;
- one direct care worker for every two-ten residents.

These ratios must be met over the next two years by either hiring additional staff or reducing the number of residents. In addition, the state must develop a detailed plan addressing the provision of sufficient medical care and protection for the residents, the prescription of behavior management drugs, the use of restraints, and the establishment of training and therapy programs for residents with behavior problems and physical handicaps.

***United States v. Connecticut* (D. Conn. 7-25-86)**

The decree mandates the state to upgrade the care and training given to the 1,100 mentally retarded residents of Southbury Training School. The state is required to offer professionally-designed training programs to all residents in need of such training; to eliminate its practice of using medications, restraints, and seclusion as forms of punishment; and to ensure the safety of the residents by devising an emergency evacuation plan.

The state agreed to several deadlines. By August 15, 1986, the state must outline the steps it plans to take to implement and comply with the decree. Within 30 days of the decree, the state must carry out specific actions to increase staff-to-resident ratios. By February 1, 1987, the state must achieve the following ratios by hiring more staff or reducing the number of residents:

- one physician for every 125 residents;
- one psychologist with a master's degree for every 30 residents;
- one registered nurse and one licensed practical nurse for every 40 residents;
- one nurse practitioner for every 250 residents;
- one direct care worker for every four residents during the day and for every eight residents at night.

***United States v. Michigan* (E.D. Mich. 8-8-86)**

The state agreed to the following mandates involving conditions at the Northville and the Ypsilanti Regional Psychiatric Hospitals:

- residents should be offered professionally-designed training programs to curtail unreasonable risks to personal safety or unreasonable use of bodily restraints;
- decisions about medical treatment, training, and care should be made by qualified professionals;
- patients should be afforded sufficient food, clothing, shelter, and care and be protected from unreasonable risks to their personal safety from staff members or other patients;
- a safe physical environment must be maintained.

The state agreed to several deadlines: within 120 days the state must submit detailed plans outlining its policies and procedures to ensure compliance with the decree; within six months the state must hire additional staff in an effort to start conforming to the minimum staff-to-resident ratios set forth by the decree (and at this time the state will file additional plans with the court concerning procedures to correct the constitutional deficiencies outlined in the decree); within one- two years the state must achieve and maintain the established staff-to-resident ratios.

Additionally the state promised to make a good faith effort to secure enough funds to carry out this plan and to file quarterly progress reports to the Justice Department and the court.

***United States v. Michigan* (W.D. Mich. 10-16-87)**

In a decree involving 650 mentally ill patients, the state agreed to implement the following remedial

actions:

- adequate medical care and treatment based on professional judgment;
- the safe and proper use of bodily restraints and seclusion;
- the prescription and administration of drugs by qualified professionals;
- the protection of patients' personal safety from harm by staff members or other patients.

Allowed two years to comply with the decree, the state agreed to take "prompt action" in remedying some of the shortcomings in care.

The settlement sets forth certain staff-to-resident ratios and requires the state to either reduce the patient population or hire additional professional and direct-care staff. Additionally the state must hire a board-certified psychiatrist to oversee patient care, submit a detailed implementation plan to the court within six months, and inform the Justice Department of its progress via periodic status reports.

Consent decree pending court approval

***United States v. Illinois* (N.D. Ill. 9-30-86)**

The Justice Department requested court approval of a consent decree that would require the state to upgrade its medical care and treatment to the 812 psychiatric patients of the Elgin Mental Health Center. The decree requires the state to protect the patients personal safety from unreasonable risks by providing adequate psychiatric treatment and to ensure the proper prescription and administration of medications by maintaining a sufficient number of qualified professionals on the staff. The state must achieve specified staff-to-resident ratios within four months to one year. During the decree's three-year implementation period, the state must file regular reports indicating its progress.

CRIPA actions filed

***United States v. Massachusetts* (D. Mass. 2-5-85)**

The Justice Department filed a suit under CRIPA on behalf of the mentally ill, mentally retarded, and developmentally disabled hospital residents at Worcester State Hospital, charging that the state failed to provide them with adequate medical care. Due to the lack of appropriate staff, residents were denied timely assessments and diagnoses, and subsequent placement into training and treatment programs. The suit also questioned the substandard record-keeping and the improper use of medications and restraints.

***United States v. Oregon* (D. Ore. filed 7-28-86)**

Unsuccessful in its attempt to arrive at a settlement with the state, the Justice Department filed an action under CRIPA, charging that the state failed to provide adequate and safe care, training, medical treatment, and education to the 1,300 mentally retarded residents of the Fairview Training Center. Negotiations for an agreement will continue despite the initiation of the lawsuit.

The Justice Department seeks to correct the following deficiencies: inadequate medical care; lack of professional judgment on decisions about medical treatment, care, and training; unsafe physical environment; inadequate training programs to protect the residents; threats to personal safety from staff members and other residents; and the failure to provide residents under 21 with a free, appropriate public education.

***United States v. New Mexico* (D. N.M. filed 8-8-86)**

The Justice Department sought an injunction that would prohibit state officials from depriving mentally retarded residents of adequate medical care and treatment at Fort Stanton Hospital and Training School. The DOJ seeks to eliminate the use of bodily restraints as a form of punishment and to require that qualified professionals prescribe and administer medications.

Noncompliance with a consent decree

***R.A.J. v. Miller* (N.D. Tex. April 2, May 15, June 22, and July 9, 1984)**

The federal district court stated in an opinion and order that the Texas Department of Mental Health and Mental Retardation failed to comply with several provisions of a 1981 settlement agreement concerning the state's mental hospitals. The state's noncompliance centered on its failure to provide the patients with individualized treatment programs and enough staff to ensure an adequate level of care and protection.

On May 15, the court approved remedies recommended by the parties, the United States, and the review panel to secure compliance. The state must increase staffing ratios to protect the residents' personal safety and also to improve its planning of individualized treatment programs.

On June 22, the court issued a memorandum and order concerning the procedures for securing patient consent to psychotropic medication and the right of an involuntarily committed patient to withhold consent. Subsequently, the court stipulated that all patients may utilize a two-tiered medical review process to make certain that their treatment decisions are given professional consideration. □

Reevaluating the lie detector test

by Anne Bromley

A woman applies for a job with a county police department and is told she must take a polygraph test to be considered. During the testing she is asked the following questions: Have you ever had an affair? Have you ever participated in an orgy? Have you ever had sex with a dog? We know everyone has sexual fantasies, what are yours?

Sound far-fetched? This happened in Prince William County, Virginia, last year. The Virginia Polygraph Examiners Advisory Board is now investigating the woman's complaint along with seven others that are similar.

Although new regulations were added to those existing for polygraph examiners by the Virginia Department of Commerce, effective September 1, 1988, state and local government agencies remain exempt from the prohibition of asking questions about sex. This exception may prove to be an unfortunate defect in what are otherwise thorough and sound guidelines.

These events have taken place after a long Congressional battle was won to limit the use of the polygraph and a new law passed just this summer. Although this will eliminate almost all preemployment and routine tests by private employers, government agencies and security and drug-related industries remain exempt as long as they do not violate state laws.

This recent legislation may cause one to ask how the polygraph works and why it is so controversial that lawmakers have restricted the conditions under which it can be used.

The polygraph: does it work?

Although its results can be innocuous or devastating, the polygraph simply measures physiological reactions which are supposed to indicate deception to an examiner. The polygraph instrument doesn't actually reveal whether someone is lying or telling the truth. There are no known physiological reactions unique to lying, although societies through the ages have tried various physical tests to prove the truth. For instance, "the Bedouins of Arabia passed a heated blade across the tongue of a suspected liar. If innocent, he would be salivating normally and his tongue would be unburned; if lying, his tongue would be scorched."[1]

The rate and depth of respiration, cardiovascular activity, and galvanic skin response (or perspiration of the fingertips), which are measured by the polygraph instrument, can be attributed to anxiety, anger, fear or humiliation as well as deception. A recent report from the Office of Technological Assessment (OTA) observes that just "being required to take a polygraph test elicits precisely these feelings in many people."[2]

Researchers in the fields of psychiatry and psychology recognize that some types of lying are part of normal development, but the phenomenon is not well understood. Guilty psychopaths or antisocial subjects may escape detection, while innocent neurotics or psychotics will more often be identified as deceptive. The polygraph in particular has not been studied extensively by many psychologists. In 1984, psychologist Benjamin Kleinmuntz declared that "psychology is giving away a socially important tool by default."[3]

The American Psychological Association testified last spring before the House of Representatives that there is no scientific basis for using polygraph testing to screen job applicants, finding the high rate of false positives, where innocent people can be found deceptive, unacceptable. Psychologist Edward Katkin told a subcommittee of the Education and Labor Committee that the polygraph test does not conform to APA's standards, citing poor training of examiners as one reason.

In their 1983 report, "Scientific Validity of Polygraph Testing," the OTA concluded that

> there is some evidence for the validity of polygraph testing as an adjunct to typical criminal investigations of specific incidents, and more limited evidence when such investigations extend to incidents of unauthorized disclosure. However, there is very little research or scientific evidence to establish polygraph testing validity in large-scale screening as part of unauthorized disclosure investigations, or in personnel security screening situations, whether they be preemployment, preclearance, periodic or aperiodic, random, or 'dragnet.'

This conclusion remains unchanged as of their update in a September 1987 report, "The Electronic Supervisor: New Technology, New Tensions."

In pre-screening job applicants, the employer is looking for a prediction of future criminal behavior, of whether this prospective employee will steal from the company. This cannot be answered. There are no studies which follow up on examiners' interpretations of those who never got the job, or those who were fired.

Attorney William E. Hartsfield describes employee claims resulting from polygraph testing, based on emotional distress and outrageous conduct, invasion of privacy, wrongful discharge, unemployment and violations of civil rights and the National Labor Relations Act.[4] The decisions vary from state to state depending on the statutes and the courts. The 1983 OTA report found that courts have disagreed on whether polygraph results should be admitted as evidence and have been inconsistent in interpreting the validity of polygraph testing.

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The University of Virginia
Institute of Law, Psychiatry and Public Policy
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Polygraph, *Continued from page 34*

The accuracy of testing has been difficult to assess scientifically because of different or poor methodologies of research. In the OTA's review rates of accuracy of polygraphs range from zero to one hundred percent, and only two analogous studies cover preemployment screening. Problems with both studies compromise or limit the validity of polygraph testing. The accuracy increases, 86.3% being the average for determining deceptiveness correctly, when the polygraph is used for specific incidents in criminal investigations.

Factors that can affect the accuracy of test validity include:

- the application of the polygraph, e.g., the examiner's background;
- the examinee's personal characteristics, such as emotional instability, intelligence, level of socialization, or even psychopathy;
- the examinee's possible use of countermeasures (using biofeedback, changing breathing, tensing muscles, biting one's tongue, or pressing on a thumbtack concealed in one's shoe);
- the examinee's willingness to be tested;
- the particular setting in which the test is given.

In his article, "Polygraph Policy Model for Law Enforcement," which assumes the validity of polygraph testing and advocates it, Ronald M. Furgerson, a Special Agent with the FBI, stresses that "the examiner must make the ultimate determination concerning the suitability of an individual for polygraph testing," considering the existence of any symptoms of mental or physical fatigue or disability, alcohol or drug addiction or intoxication.[5] In contrast the OTA cautions against seizing new technologies as panaceas to business problems: "Sometimes, however, they are put to use almost immediately, before adequate research can be conducted, as with polygraph testing. . ."[6]

Nevertheless, efforts to cut down employee theft have led to growth of the polygraph industry and made personnel screening the dominant use of polygraph testing, despite the criticism of its validity. Of two million tests given annually, about 98% of them were given to job applicants and employees. "Our criminal justice system presumes that an individual is innocent until proven guilty. The polygraph abuses that principle because it requires one to prove one's innocence," said Congressman Pat Williams in a *Potomac News* story on polygraphs in 1986. Possibly it acts as a deterrent—but through intimidation. Many state legislatures have enacted laws and regulations which prohibit testing, limit questions, require voluntary participation, or spell out training and licensing of polygraphers.

With this perspective on polygraphs, Congress recently passed federal legislation restricting polygraph testing which was signed into law by President Reagan.

The Employee Polygraph Protection Act of 1988

Polygraph testing, used by federal agencies or private employers, has emerged frequently as a subject of Congressional debate for over twenty years. Between 1967 and 1973 a number of attempts to pass bills—either banning the test altogether or restricting the kinds of questions asked—have failed.

In 1982 a select panel of the Department of Defense studied how the polygraph was being used for security screening and found their requirements inconsistent. The panel recommended broader applications of testing, which were later authorized by the president and the Department of Justice the next year, although Congress tried to stall the revised regulations.

A House amendment to ban its use by private employers failed last year. This past session the House and Senate first passed different versions of the Employee Polygraph Protection Act. In an unlikely alliance, Edward Kennedy (D-MA) and Orrin Hatch (R-UT) sponsored the Senate version of the bill. On most labor issues the two senators disagree, but Kennedy has called polygraphs "instruments of intimidation" and Hatch described workers possibly failing the test, whether they lied or not, as carrying a "stigma they'll wear for life like a scarlet letter."

The House bill was broader; the Senate's more specific. The Senate bill allowed testing in post-incident situations as an investigative tool, stipulating strict procedures. Congressman Pat Williams (D-MT), author of the House bill and member of the conference committee, said, "at least 50,000 workers per year are wrongfully denied employment either because they refuse to take the tests or because of the inherent inaccuracies of the test."

The statement from the committee of the conference explains why, unlike the House and Senate bills, it defines lie detector and polygraph separately: to broadly include similar devices such as the deceptograph, voice stress analyzer, or psychological stress evaluator on the one hand, and to define clearly the polygraph and its permitted uses on the other.

Although polygraph testing by most private employers is prohibited, both Senate and House provisions sought to exempt federal, state, or local government employers, or employers of the National Security Agency, the Defense Intelligence Agency, and the Central Intelligence Agency. The Act also exempts private businesses that have contracts with any of these agencies or governments. FBI contractors, security services, and drug companies are also allowed to use polygraph testing following strict standards.

On May 17, 1988, the compromise version of the bill was unanimously approved by a House-Senate conference, and both Houses passed the final version. President Reagan signed P.L. 100-347 on June 27, 1988.

The new law covers prohibitions on lie detector use to preserve the individual's right to privacy and to eliminate the possibilities of discrimination by the employer.

> Sec. 3. . .it shall be unlawful for any employer engaged in or affecting commerce or in the production of goods for commerce—
>
> (1) directly or indirectly, to require, request, suggest, or cause any employee or prospective employee to take or submit to any lie detector test;
>
> (2) to use, accept, refer to, or inquire concerning the results of any lie detector test of any employee or prospective employee;
>
> (3) to discharge, discipline, discriminate against in any manner, or deny employment or promotion to, or threaten to take any such action against—
>
> (A) any employee or prospective employee who refuses, declines, or fails to take or submit to any lie detector test, or
>
> (B) any employee or prospective employee on the basis of the results of any lie detector test; or
>
> (4) to discharge, discipline, discriminate against in any manner, or deny employment or promotion to, or threaten to take any such action against, any employee or prospective employee because—
>
> (A) such employee or prospective employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act,
>
> (B) such employee or prospective employee has testified or is about to testify in any such proceeding, or
>
> (C) of the exercise by such employee or prospective employee, on behalf of such employee or another person, of any right afforded by this Act.

A private employer can only request that an employee take a polygraph test if it is suspected that the employee was involved in a theft being investigated.

Rights of examinees

Whenever testing is allowed, certain procedures must be followed to protect the rights of examinees, according to the Act. In a case of investigating theft, the employer must give written notification of the incident and any evidence to the suspected employee. The employer must describe the polygraph test in writing, inform the examinee of the date and location of the test, what equipment will be used, such as a two-way mirror and a tape recorder, and what questions will be asked. Questions may not be asked about religious or political beliefs or affiliations, beliefs or opinions regarding racial matters, beliefs or lawful activities in unions or labor organizations, or matters relating to sexual behavior. The test results, or an employee's refusal to take a test, cannot be used as the sole reason for taking any "adverse employment action."

There are also general requirements for examiners, but their licensure is left to state regulation. The Act will not preempt any other state laws. Liability and court actions employers might be subject to are described by the Act. It also includes a prohibition against waiving the rights protected therein.

In place of using polygraphs as a quick route to making decisions about employees, businesses will have to take the time to verify job applications, to conduct their own evaluations, and to tighten internal controls. Still, it is curious that the compelling interests of government and national security are thought to outweigh employees' privacy interests, rather than to demand solid scientific validity of whether the polygraph or examiners can be consistently accurate before the lie detector is used as a tool in sensitive decision making about individuals.

One opponent of the legislation, Congressman Robert L. Livingston, Jr. (R-LA) argued: "This is just another example of big government stepping in to micromanage commercial enterprises. If lie detector tests are truly ineffective, why not ban them for everyone?"[7] Psychologist David Raskin, who briefed Senate staffers, argued against any exemptions from the ban because of the test's invalidity in employee screening. Exempt groups are still capable of abusing the test, as the recent events in Virginia's Prince William County illustrate.

Sexual questions called 'necessary'

The symbol of the "scarlet letter" used by Hatch is more descriptive than he could have known in light of the situation in Prince William County. Eight women have filed complaints with the Virginia chapter of the American Civil Liberties Union concerning sexually offensive questions they were asked during polygraph examinations given routinely to applicants for county jobs. The women were applying for jobs in corrections or law enforcement. The topics of questions ranged from those about sexual positions to sex with animals, sexual fantasies to infidelity, oral sex to orgies, homosexual tendencies in their husbands to masturbation in public.

County officials have explained that some sensitive questions are necessary to make sure the applicant hasn't engaged in "sexually deviant behavior" which could be used in blackmail or could affect job performance. The *Potomac News* reported that County Executive Robert Noe, Jr. maintained that, "I don't see anything wrong with the dog question. . . .[but] I don't see why we need to know what position. . . a person has sex in."

Intimate questions about sexual activity comprised about 75% of those asked and the examination, administered by one man, lasted over two hours in a small, closed room, according to the women. Although the women were hooked up to the polygraph machine the whole time, apparently it was only turned on for about the last ten minutes. One woman asked for a transcript of her test and the list of questions, both of which she is entitled to request, but they were never sent.

Continued on next page

Joseph Buckley, director of the American Polygraph Association, says these questions violate the association's code, which has a "strict prohibition against questions that are not job-related" and against questions about sexual activity unless it relates to a crime. Agent Furgerson says that questions about sexual opinions and practices should not be asked and stresses that

> [t]he examiner must avoid any suggestion of impropriety or appearance that any part of the examination process is being used to elicit personal information or to satisfy the examiner's curiousity. Historically, the failure of examiners to exercise good judgment in the matters they discuss with examinees has been a primary source of criticism concerning polygraph.[8]

"Historically, the failure of examiners to exercise good judgment . . . has been a primary source of criticism concerning polygraph."

An internal police investigation is underway, which will include listening to the tapes of the polygraph interviews. In the meantime, the county police department has decided not to change any of its polygraph testing procedures. After the Virginia Polygraph Examiners Advisory Board investigates the complaints, the findings will go to the director of the Department of Commerce. So far the Virginia ACLU has not decided whether to pursue litigation on the women's behalf, but will consider it, depending on the outcome of the investigation.

New regulations for polygraph examiners in Virginia

In House Joint Resolution No. 52 the 1986 Virginia General Assembly requested the Department of Commerce to study and consider strengthening regulation of polygraph examiners. The Polygraph Examiners Advisory Board devised new regulations effective September 1, 1988. The regulations seek to provide more safeguards protecting consumers, or examinees. The purpose of these regulations, given in the Department's final statement, "is to create standards for polygraph examiner education, experience, and training to assure only qualified individuals become licensed, and standards of practice to assure only valid polygraph examinations are performed." Changes in standards of practice seek to put what some already consider current ethics into regulatory form.

There are about 275 licensed polygraph examiners in this state. Currently a polygraph examination, (which covers the entire time of contact between the examiner and examinee,) may not be given without the examinee's written permission; the examinee may end the test at any time; and the examiner must let the examinee know what topics will be covered on the test and what information will be given to anyone else. Polygraphers will now have to give written explanation of Sections 3.1-3.8 to examinees which cover standards of practice and the examinee's rights. The new standards include:

- the prohibition of asking questions about sexual behavior, or "lawful religious affiliations, lawful political affiliations, or lawful labor activites";
- the examinee's entitlement to request either a tape recording, for which the examiner may charge not more than $25, or a copy of the examiner's written report of the test results, costing not more than $1.00 per page;
- the requirement that, besides giving his own name, the examiner must also give the name, address, and phone number of the Department of Commerce to the examinee in case of complaint.

The section covering sexual preference or sexual activity questions is not applicable to a polygraph examination required by "any state or local government agency in the Commonwealth or its political subdivisions."

Other new procedures specify that not more than sixteen questions can be asked on a single test, that an interval of ten seconds must be allowed between the examinee's response to a question and the next one, and that a polygrapher shall not perform more than twelve examinations in a twenty-four-hour period.

The examiner must conduct at least two tests repeating the same questions in order to submit a verbal or written report. Under Sec. 3.15 "[e]xaminers shall not make hiring or retention recommendations based solely on the results of a polygraph examination," but they can give a recommendation to the employer. What other criteria such a decision should be based on is not spelled out.

Although there have been few complaints against polygraph examiners, that doesn't mean there haven't been any violations or indiscretions. In its "Summary of Public Comment and Agency Response" the Department notes that

> no other occupation. . . has the same potential for adverse impact on an individual citizen. . . . It is rare that a citizen encounters a polygraph examiner and unlikely that he would have any prior knowledge pertinent to polygraph standards of practice. The polygraph examination is very stressful, as a future employment or a criminal charge is likely to be determined by the results.

However, whether the new regulations will prevent adverse results remains to be seen. The Department does have the authority to fine, deny, suspend, or revoke a license.

Need for more research

Because there are no unique physiological responses resulting from deception, interpretation of the polygraph instrument depends on the examiner. Although some psychologists and psychiatrists have researched polygraph testing, those who developed the machine and schools, and most practicing examiners do not have academic training in what is definitely an area of applied psychology, whether the polygraph is considered a psychological test or an interrogation. Polygraph schools only require anywhere from six weeks to six months for training.

One example of the difference in research methods between psychologists and polygraphers can be seen in the area of behavior symptoms in lying individuals. John E. Reid, a major figure in the development of the business of polygraphy, came up with a list of behavior symptoms based on his experience with polygraph testing, which supposedly distinguishes between truthful and lying subjects. The behaviors include being late for the test, appearing nervous and restless, avoiding eye contact and complaining of the blood pressure cuff being too tight.

Psychologist Bella M. DePaulo and associates have been studying verbal and nonverbal cues to deception in experiments with varied contexts of motivation, but not specifically in the polygraph scenario. Their review of research trying to pinpoint behaviors that occur during deception shows that "liars do not avert their eyes any more than truth tellers do" and "that highly motivated liars exhibit more behavioral inhibition and rigidity."[9]

Reid's behavior symptoms seem to fall into the category of perceived or culturally stereotyped cues, rather than actual cues to deception. Though DePaulo's review show support for the hypothesis that

> "Liars do not avert their eyes any more than truth tellers do."

that lying might be arousing (which the polygraph supposedly measures), it stresses that behind this generality, different types of people show different patterns, that some people are indeed better liars than others.

Usually people are reluctant to lie and reluctant to label others as liars. Deception has been studied in child development and in adults' self-presentation and interaction, in social as well as personal relationships. But about the dearth of serious academic study of the validity of polygraph testing, psychologist David Lykken admonishes

> Perhaps . . . the lie detector now carries a taint of sensationalism which threatens to embarrass the respectable scientist. Psychologists rather should be embarrassed about their ignorance of this important and burgeoning development.[10] □

Notes

1. Englade, *The Business of the polygraph,* Across the Board, October 1982, 20.
2. Kleinmuntz and Szucko, *Lie detection in ancient and modern times,* 39 American Psychologist 766 (1984).
3. U.S. Congress, Office of Technological Assessment, The Electronic supervisor: new technology, new tensions, OTA-CIT-333, (Washington, DC: U.S. Government Printing Office, September 1987).
4. Hartsfield, *Polygraphs,* 36 Labor Law Journal 817 (1985).
5. Furgerson, *Polygraph policy model for law enforcement,* 56 FBI Law Enforcement Bulletin 7 (1987).
6. U.S. Congress, *supra* note 4, at 128.
7. The Washington Post, June 2, 1988, at 5, col. 1.
8. Furgerson, *supra* note 5, at 9.
9. DePaulo, Stone and Lassiter, *Deceiving and Detecting Deceit,* in Schlenker, The Self and Social Life (1985).
10. Lykken, A Tremor in the blood, 43-45 (1981).

Minors, *continued from page 22*

hospitals and general hospitals with psychiatric units in the Commonwealth. Seventy-seven percent of the surveyed hospitals responded, representing a good cross-section of the facilities which provide inpatient, psychiatric care to minors.

The data collected were descriptive in nature and can be divided into three categories: (1) a description of the children and adolescents actually hospitalized for psychiatric treatment in Virginia during a designated time period; (2) a description of the number and types of hospitals which provide psychiatric inpatient treatment for children and adolescents; and (3) statements of hospital policy with regard to procedures for admitting minors for inpatient psychiatric treatment. The study also sought to determine what degree of consensus exists among hospitals as to what the current law actually requires of them when admitting a child for psychiatric treatment.

The patients

Responding hospitals reported 481 psychiatric admissions of minors during the month of March, 1988. Because of variation from month to month in psychiatric admission rates, and because not every hospital responded to the survey, it is difficult to project an accurate annual admission figure. Nevertheless, based upon 1987 aggregate data provided by the hospitals and these March admissions, an annual figure of 4500-5000 psychiatric admissions of minors is probably not too far off the mark.

TABLE A-2

Private Psychiatric Hospitals	1987 Total Psych	1987 Psych Minors	March '88 Minors	Avail Beds Minors	Output Serv	Minimum Age
#1	450	444	54	60	no	0
#2	2850	745	67	88	yes[1]	3
#3	357	341	45	84	yes[1]	4
#4	1736	365[3]	35	51	yes[2]	4
#5	1239	272	32	40	yes[1]	6
#6	455	148	23	48	yes[1]	12
#7	1683	n/a	1	75	no	12
#8	2086	276	32	134	yes[1]	12
#9	n/a	n/a	31	n/a	n/a	n/a
TOTALS	10,856	2,591	320	580		

TABLE A-3

Psych Units/ General Hospitals	1987 Total Psych	1987 Psych Minors	March '88 Minors	Avail Beds Minors	Output Serv	Minimum Age
#1	894	118	21	55	no	0
#2	575	25	2	28	no	0
#3	950	48	4	31	yes[1]	10
#4	373	31	6	25	no	12
#5	1488	152	15	13	no	12
#6	569	60	1	22	yes[2]	12
#7	1196	n/a	9	52	no	12
#8	210	55	5	12	no	12
#9	119	24	2	16	no	13
#10	n/a	n/a	2	28	no	13
#11	n/a	n/a	4	62	yes[1]	13
#12	352	18	3	18	no	13
#13	1151	56	1	40	yes	14
#14	625	27	6	19	no	14
#15	n/a	n/a	0	23	yes[1]	15
#16	494	n/a	n/a	39	yes[1]	16
#17	n/a	n/a	2	12	no	16
#18	288	2	0	15	no	16
#19	n/a	n/a	0	32	no	16
TOTALS	9284	616	83	542		
GRAND TOTALS	**26,268**	**3713**	**481**	**1,386***		

*While all of these beds are available for children and adolescents, depending upon the minimum age policy of the particular hospital, only a total of 525 beds are actually designated for this population among the responding hospitals.

Of these 481 admissions, a patient sample consisting of the first ten consecutive minors admitted for psychiatric treatment beginning March 1, 1988, in each hospital was isolated for study. The inquiry focused on information of particular importance to the civil commitment process such as the age of the minor patient and the length of hospitalization, as well as various factors relating to patient consent and judicial intervention. No general demographic data (eg. race, sex, etc.) was gathered.

The patient sample thus obtained consists of 273 children ranging in age from 6 to 17. More than half of these were older adolescents, 15 to 17 years of age. Only 11% were under 12 years of age.

Once admitted to the hospital, most of the sample patients (54%) remained hospitalized between four and 30 days. The mean length of stay was 22 days. DMHMRSAS-operated hospitals reported the largest number of juveniles staying longer than 30 days, while general hospitals reported the largest number of patients staying three days or less.

Affective disorders accounted for almost half of all primary admitting diagnoses in the patients sampled. Undifferentiated depression was the single most frequently cited primary admitting diagnosis.

About one-third of the sample had a recorded prior psychiatric hospitalization. Minors in DMHMRSAS-operated hospitals were more likely than those in other types of hospitals to have a recorded prior hospitalization.

The vast majority of the patients sampled (86%) were reported to be in parental custody. With only two exceptions, hospitals articulated identical psychiatric admission policies for minors in state custody as for those in parental custody. Length of stay did not differ according to custody. As would be expected, minors in state custody were more likely to be hospitalized in DMHMRSAS-operated hospitals. They were also twice as likely to be hospitalized pursuant to court process as minors in parental custody.

Within the patient sample, 64% of all minors were "voluntary" admissions; that is, there was no court involvement in their admission. Written consents had been signed by 54% of the minors in the sample. Among minors initially hospitalized as "voluntary" patients, very few (2%) experienced any judicial intervention during the course of the reported hospitalization. By contrast, nearly a third (29%) of minors initially admitted pursuant to court order experienced some sort of legal status change during the course of the reported hospitalization. A "legal status change" for purposes of this survey was defined as any change from "voluntary" to court-ordered status, from court- ordered to "voluntary" status, or a change from one type of court-ordered status to another.

Younger children in the sample were somewhat more likely to be judicial admissions than were their older counterparts. Thirty-nine percent of the sample who were 11 years old or younger had been admitted pursuant to court order, as compared with 29% of the 12 to 14-year-old group and 29% of the 15 to 17-year-old group. This unexpected difference may be explained by the fact that fully one third of the sample aged 11 or younger were patients at DMHMRSAS-operated hospitals. DMHMRSAS policy results in judicial admissions for most, if not all, children in this youngest age group who are hospitalized in DMHMRSAS-operated hospitals.

TABLE B

Sample frequencies of response to admission policy hypotheticals

HYPOTHETICAL	Parental consent	Judicial process	Deny-refer	Other
1. objecting 8 year old	4	7	19	1
2. assenting 8 year old	6	3	20	1
3. objecting 11 year old	7	7	16	1
4. assenting 11 year old	9	3	16	2
5. objecting 15 year old	6	19	3	2
6. assenting 15 year old	16	6	4	5
7. 8 year old wants release	6	6	18	1
8. 11 year old wants release	7	7	16	1
9. 15 year old wants release	9	17	4	1

"Parental consent" indicates the number of hospitals which responded that they ultimately relied upon the parents' consent rather than that of the minor in making a voluntary psychiatric admission. The hospital may or may not have sought the consent of the minor or may have presumed it from his assent.

"Judicial Process" indicates the number of hospitals which responded that they felt it necessary to resort to court process, either involuntary civil commitment or temporary detention orders, in order to admit or to retain the minor in the hospital.

"Deny-Refer" indicates the number of hospitals which, because of their minimum age policy, did not accept minors of the age posed in the hypothetical.

"Other" responses were explained in a variety of ways. When they specified denying admission because of the minor's age, the response is charted here under "deny-refer." Some hospitals specified under "other" that they relied upon the local community service board to make any decisions with regard to the necessity for instituting judicial process. Many of the "other" responses on line 6 were explained by the hospitals as a requirement that the minor or the minor and his parents sign a consent to hospitalization.

The actual responses indicate slightly more variation that what this table would indicate. Questions 1,3, and 5 included two different approaches to invoking judicial process which have been collapsed into one figure for this table. Similarly, questions 2, 4, and 6 contained two responses ultimately relying on parental authority and these responses have been collapsed into one figure for this table.

Minors hospitalized in the Richmond/Petersburg area were somewhat more likely than those in other geographic areas to be hospitalized pursuant to some sort of court order. Thirty-eight percent of the minors sampled in the Richmond area hospitals were judicial admissions. This compares with 34% in the western area of the state, 29% in the Tidewater area and 24% in the Northern Virginia area.

The policies

In addition to gathering patient information, the survey also sought to elicit hospital policies concerning the legal aspects of psychiatric admissions of minors. Under what circumstances would a hospital feel it necessary to seek judicial authorization for an admission? Policies were determined from responses to a series of hypothetical situations involving the admission of minors of varying ages to inpatient psychiatric treatment. Possible responses ranged from complete reliance on parental consent to insistence upon invoking some sort of judicial intervention. There was enormous variation among the hospitals in admissions policies as expressed by their choices. Not only do

Continued on next page

stated policies vary widely, but actual practice, as measured by the patient sample, may vary from the stated policy. The likelihood of judicial involvement in a minor's hospitalization may depend upon such factors as the type of hospital making the admission decision, the age of the minor, whether the minor is objecting to or assenting to hospitalization and the geographic region of the state in which the hospital is located. Even when these variables are controlled, practice is by no means uniform, although some trends do emerge.

Hospitals operated by DMHMRSAS are both most likely to express a policy of invoking judicial process when admitting a minor to psychiatric hospitalization and to follow such a practice, as evidenced by the very large proportion of their admissions which were judicially involved (89%). Conversely, responding general hospitals with psychiatric units were very unlikely either to express a policy of invoking the judicial process, or to follow such a practice. Only 23% of all juvenile psychiatric patients sampled in general hospitals had undergone some sort of judicial process. Private psychiatric hospitals expressed policy choices which strongly supported the use of judicial process for minors who objected to hospitalization. Private psychiatric hospital policy choices for assenting minors, however, reflected a willingness to forego judicial involvement. In practice, only 21% of all sampled minors in private psychiatric hospitals were admitted pursuant to judicial process.

Conclusions

These data confirm that the current civil commitment statute, as applied to minors, leads to inconsistent results. Hospitals have made their peace with the law, but it is a different peace for private hospitals than for public hospitals, for psychiatric hospitals than for general hospitals. No law should be so varied in application. Hospitals should be able to proceed with confidence in the legality of their admissions procedures. Children as well as parents should be assured that their rights are protected.

The data further reveal that the majority of psychiatric hospitalizations of minors occur without any independent review or judicial intervention. If we fear that parents and doctors may abuse psychiatric hospitalization of minors for motives of their own, these data confirm the need for creating mandatory checks, checks that will apply to private as well as to public hospitals. Unfortunately the data do little to define the best sort of check. HB 414 looks to an independent, qualified evaluator and judicial review after 45 days of hospitalization as the appropriate check. Yet many clinicians who admit and treat the minor are comfortable with their professional clinical judgment as the ultimate check, while civil libertarians would require extensive judicial involvement, or the possibility of it, at every age and at every stage of the process. Recent trends in third party payment, such as preadmission certification and intensive utilization oversight, may provide a disincentive for inappropriate hospitalization, thereby lessening the need for judicial oversight. A study of the nature and effect of such pecuniary checks on the admission of minors for psychiatric care would provide useful additional information in constructing the best judicial checks.

The data also provide interesting information specific to provisions in the current draft of HB 414. Only 11% of the patient sample were aged 11 or younger. Even though it reaffirms the supremacy of parental authority for these younger children, HB 414 would continue to provide the opportunity for judicial intervention to almost 90% of the children actually hospitalized.

TABLE C

Policy hypothetical responses grouped by hospital type

HYPOTHETICAL	Parental consent	Judicial process	Other
1. objecting 8 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	75% (N=3)	25% (N=1)	
Private Psych Hospitals	20% (N=1)	80% (N=4)	
2. assenting 8 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	100% (N=4)		
Private Psych Hospitals	66% (N=2)	33% (N=1)	
3. objecting 11 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	83% (N=5)	17% (N=1)	
Private Psych Hospitals	34% (N=2)	66% (N=4)	
4. assenting 11 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	100% (N=6)		
Private Psych Hospitals	60% (N=3)	20% (N=1)	20% (N=1)
5. objecting 15 year old			
DMHMRSAS Hospitals	17% (N=1)	50% (N=3)	33% (N=2)
General Hospitals	31% (N=4)	69% (N=9)	
Private Psych Hospitals	13% (N=1)	87% (N=7)	
6. assenting 15 year old			
DMHMRSAS Hospitals	17% (N=1)	50% (N=3)	33% (N=2)
General Hospitals	87% (N=13)		13% (N=2)
Private Psych Hospitals	25% (N=2)	37% (N=3)	37% (N=3)
7. 8 year old wants release			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	80% (N=4)	20% (N=1)	
Private Psych Hospitals	40% (N=2)	60% (N=3)	
8. 11 year old wants release			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	66% (N=4)	33% (N=2)	
Private Psych Hospitals	50% (N=3)	50% (N=3)	
9. 15 year old wants release			
DMHMRSAS Hospitals		83% (N=5)	17% (N=1)
General Hospitals	50% (N=7)	50% (N=7)	
Private Psych Hospitals	25% (N=2)	62% (N=5)	13% (N=1)

Percentages have been calculated based upon the number of hospitals which admit a minor of the age designated in the hypothetical. Those hospitals which responded "Deny/refer" were omitted for the purposes of this calculation.

When choosing time frames for procedural reviews, it is helpful to know how many children will be affected by those choices. Nearly a quarter of the patient sample stayed in the hospital 72 hours or less. Those children could all be hospitalized without judicial intervention under the 72-hour emergency provision of HB 414. Another quarter or so of the sample stayed in the hospital 45 days or longer. All of those children would receive judicial review whether their initial status was voluntary or involuntary. Whether such results are desirable is a matter of political choice.

But these data do not shed any light on possible resolutions to other controversial issues raised by HB 414. What should the qualifications of the "qualified evaluator" be and how can independence be assured? At what age is a minor capable of giving legally meaningful consent to psychiatric hospitalization? What standard for involuntary commitment best addresses the needs of children and adolescents? Such questions must ultimately be answered in an arena of political debate and compromise if we are to make new and better laws for the psychiatric hospitalization of minors in Virginia. □

Civil commitment training

The Institute of Law, Psychiatry and Public Policy will offer three two-day seminars in civil commitment on March 20–21, April 3–4 and May 1–2, 1989, in Charlottesville. This training has been made possible by a grant from the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

The seminars cover the constitutional and statutory aspects of civil commitment, guardianship and confidentiality. The instruction will be provided by Willis Spaulding and other members of the professional staff of the Institute. The instructional materials have been developed with the assistance of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Office of the Attorney General.

Each seminar is limited in enrollment to twenty students. Priority will be given to employees of Virginia community services boards, actively engaged in pre-admission screening. If space is available, registrations will be accepted from judges, lawyers, law enforcement personnel and others interested in civil commitment. Persons or agencies may register for a seminar by writing or calling the Institute no later than thirty days prior to the date of the seminar. A confirmation of registration, agenda and materials will be sent to persons upon admission to a seminar.

There will be a $10.00 charge for the training materials.

Supreme Court, *Continued from page 29*

that their actions violated §§1 and 2 of the Sherman Act because they were taken with the intent of reducing competition rather than of improving patient care.

Like the majority of the hospital's medical staff, Dr. Patrick had also been an employee of the Astoria clinic. In 1973, a year after he began working at both places, Dr. Patrick was asked to join the clinic's partnership. He declined the invitation, preferring instead to establish an independent practice in competition with the clinic. After Dr. Patrick established his practice he encountered numerous difficulties with the clinic physicians, culminating in their initiation of and participation in the peer-review proceedings against him at the hospital.

In the district court, the jury returned a verdict in favor of Dr. Patrick and awarded him damages in the amount of $650,000 which the court trebled. The Court of Appeals for the Ninth Circuit reversed, holding that the defendants' peer-review activities constituted state action and were thus immune from federal antitrust laws under *Parker v. Brown,* 317 U.S. 341 (1943), and its progeny.

The Supreme Court reversed this holding, finding that no state actor in Oregon "actively supervises" hospital peer-review decisions. Under *Parker* and later cases, the conduct of a private party will constitute state action, immune from federal antitrust laws, only if the challenged restraint is clearly articulated as state policy and the anticompetitive conduct is actively supervised by the state itself.

According to the Court, the Oregon statutory scheme failed to satisfy the second requirement of the *Parker* test because the statute did not establish a state program of active supervision over the decisions made by hospital peer-review committees. Although Oregon's Health Division was empowered to review a hospital's peer-review procedures and the state Board of Medical Examiners regulated the licensing of physicians, no state official with ultimate authority over private peer-review determinations actively reviewed those determinations to assure that they were in accord with state policy. Access to judicial review in the state court to appeal physician privilege termination decisions was also held not to constitute active state supervision.

The Court noted the defendant's policy argument that antitrust scrutiny discourages effective peer-review. This argument, however, according to the Court, essentially challenged the wisdom of applying the anti-trust laws to the sphere of medical care, and as such is properly addressed to Congress. In a footnote to the decision, the Court took note of the fact that this issue was addressed by Congress in its consideration and passage of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. §§11101-11152 (Supp. 1987). That act, which did not apply retroactively to the events at issue in this case, immunizes certain medical peer-review action from federal antitrust liability if such action was taken " 'in the reasonable belief that [it] was in furtherance of quality health care.' "

Continued on next page

Out-of-court identification allowed

***United States v. Owens,* ___U.S.___, 56 U.S.L.W. 4160 (Feb. 23, 1988)**

In a six-to-two decision the Court held that neither the confrontation clause of the sixth amendment nor Rule 802 of the Federal Rules of Evidence is violated by the admission of a prior, out-of-court identification statement of a witness who is unable, because of memory loss, to explain the basis for the identification.

In 1982 John Foster, a correctional counselor at the federal prison in Lompoc, California, was attacked and beaten with a metal pipe. His skull was fractured, and he remained hospitalized for nearly one month. Foster was visited by an FBI agent in the hospital on two separate occasions. On the first visit Foster was lethargic and unable to remember his assailant. On the second visit, Foster was able to describe the assault and named Owens as the attacker from an array of photographs.

At Owens's trial, Foster was able to recall the broad factual outline of the attack and testified that he remembered identifying Owens as the assailant during the second FBI interview. On cross-examination, however, Foster admitted that he could not remember seeing his assailant nor could he explain why he had previously identified Owens. Although hospital records showed that he received numerous visitors, Foster also admitted that he could only remember the second visit of the FBI agent. A medical expert testified that Foster's inability to remember the details of the assault was attributable to a gradual and selective memory loss caused by his head injuries.

Owens was convicted and sentenced to twenty years' imprisonment. On appeal, the Ninth Circuit reversed the judgment of the district court based upon challenges using the confrontation clause and Rule 802 of the Federal Rules of Evidence which precludes the admission of hearsay evidence.

In an opinion by Justice Scalia, the Supreme Court reversed the Ninth Circuit decision. The Court noted that the confrontation clause of the sixth amendment gives the accused the right "to be confronted with the witnesses against him," and that this right had long been read as giving the accused an adequate opportunity to cross-examine adverse witnesses. In this case, although Foster could not remember the basis of his prior identification of Owens in the photographic array, he was present at trial, and counsel for Owens was given the opportunity to conduct a cross-examination and to probe the unreliability of Foster's memory.

Relying on *Delaware v. Fensterer,* 474 U.S. 15 (1985), and *California v. Green,* 339 U.S. 149 (1970), the Court held that the confrontation clause only guarantees an opportunity for effective cross examination; that opportunity is not denied when the witness's past belief is introduced and he is unable to recollect the reason for that past belief. The Court then stated that the "weapons available to impugn the witness's statement when memory loss is asserted will of course not always achieve success, but successful cross-examination is not the constitutional guarantee."

Turning to the hearsay objection, the Court noted that Foster's testimony involved an out-of-court identification that would traditionally be categorized as hearsay and therefore barred by Rule 802. Rule 801(d)(1)(C), however, provides an exception to the general rule where the declarant is subject to cross-examination concerning the statement. According to the Court, Rule 801(d)(1)(C), which specifies that the cross-examination need only "concern the statement," does not require more.

Prison physician acted under color of state law

***West v. Atkins,* ___U.S.___, 56 U.S.L.W. 4664 (June 21, 1988)**

In a unanimous opinion the Supreme Court held that a private physician under contract to provide orthopedic services at a state prison hospital on a part-time basis is acting under color of state law and is thus subject to suit pursuant to 42 U.S.C. §1983. To state a claim of action under §1983, a plaintiff must allege the violation of a right secured by the Constitution and laws of the United States and show that the alleged deprivation was committed by a person acting under "color of state law."

Quincy West, a prisoner at a North Carolina state prison, was injured while playing volleyball. West was ultimately treated by Dr. Samuel Atkins, a private physician who provided orthopedic services to inmates on a part-time contractual basis with the state prison hospital. West claimed that although Dr. Atkins acknowledged that surgery would be necessary to treat him, the physician refused to schedule it and discharged West before his injury was healed.

Estelle v. Gamble, 429 U.S. 97 (1987), established that a state has a constitutional obligation under the eighth amendment to provide adequate medical care to those whom it incarcerates. Indifference to a prisoner's medical needs by a prison physician breaches that obligation, giving rise to a cause of action against the physician under §1983. West sued Dr. Atkins pursuant to §1983, alleging that Dr. Atkins violated West's eighth amendment right to be free of cruel and unusual punishment, because he was deliberately indifferent to West's serious medical needs and failed to provide treatment.

The district court granted Atkins's motion for summary judgment on the grounds that he was not acting under color of state law. A divided Court of Appeals for the Fourth Circuit eventually affirmed the district court's dismissal of West's complaint, concluding that a professional who acts "within the

bounds of traditional discretion and judgment does not act under color of state law." To support its holding, the court of appeals relied on *Polk County v. Dodson,* 454 U.S. 312 (1987), a case in which the Supreme Court held that a public defender does not act under color of state law when performing a lawyer's traditional function as counsel to a defendant in a criminal proceeding. The court of appeals read the holding in *Polk County* to apply to all professionals acting in their professional capacity.

The Supreme Court rejected the court of appeal's conclusion and distinguished the conduct of a public defender from other professionals on the grounds that a public defender is obliged to perform his duties in opposition to the state. A public defender does not act under color of state law because he "is not acting on behalf of the State; he is the State's adversary." There is, however, no adversarial relationship between a state and a physician working at a state prison hospital.

Moreover, the fact that Dr. Atkins was not an employee of the state, but was under contract to provide medical services, did not alter the Court's analysis: "It is the physician's function within the state system, not the precise terms of his employment, that determines whether his actions can be fairly attributed to the State." The Court concluded that Dr. Atkins worked as a physician at the prison hospital and was obliged under the eighth amendment and state law to provide essential medical care to the state's prisoners.

In a brief concurring opinion, Justice Scalia noted that in his opinion, a physician who with deliberate indifference fails to provide adequate medical care to a person in state custody violated not the eighth amendment, but the fourteenth amendment's protection against the deprivation of liberty without due process.

Legality of religious use of peyote questioned

***Oregon Dept. of Human Resources v. Smith,* ___U.S.___, 56 U.S.L.W. 4357 (April 26, 1988)**

In a five-to-three decision delivered by Justice Stevens, the Supreme Court refused to uphold a decision by the Oregon Supreme Court that the denial of unemployment compensation to defendants who had used peyote for sacramental purposes in a ceremony of the Native American Church infringed upon their exercise of religious freedom in violation of the first amendment.

Alfred Smith and Galen Black had been employed as counselors at the Douglas County Council on Alcohol and Drug Abuse Prevention and Treatment (ADAPT), a non-profit corporation that provides treatment for drug and alcohol abusers. ADAPT had a policy that required its counselors (who, including Smith and Black, have themselves had drug or alcohol dependencies) to totally abstain from any use of alcohol or nonprescription drugs. Smith and Black were fired for violating that policy by a single act of ingesting a small amount of peyote as part of a religious ceremony of the Native American Church.

Smith and Black applied for unemployment compensation benefits from the Employment Division of Oregon's Department of Human Resources. After a series of hearings and appeals, the Employment Division rejected their constitutional argument that denial of benefits would constitute a substantial burden on their first amendment free exercise of religion. The Employment Division denied their applications on the grounds that they had been discharged for work-related "misconduct" (statutorily defined in Oregon as a "willful violation of the standards of behavior which an employer has the right to expect of an employee").

The Oregon Court of Appeals considered the constitutional issue and reversed the Board's decisions, holding that the State's interest in protecting the employment fund from depletion was insufficient justification for denial of benefits for engaging in a religious act. The Oregon Supreme Court upheld the decision of the court of appeals, relying on three prior Supreme Court cases which held that an employee who is required to choose between fidelity to religious belief and cessation of employment may not be denied unemployment compensation: *Sherbert v. Verner,* 374 U.S. 298 (1963), where the appellant was discharged for refusing to work on Saturday, the Sabbath Day of her faith; *Thomas v. Review Bd., Indiana Employment Security Div.,* 450 U.S. 707 (1981), where a man whose religious beliefs prevented him from participating in the production of war materials was discharged for refusal to work on military tanks; and *Hobbie v. Unemployment Appeals Comm'n,* 480 U.S.___ (1987), where an appellant whose religion precluded work between sundown on Friday and sundown on Saturday was discharged for not working all scheduled shifts.

The Supreme Court granted certiorari in this case in order to clarify that *Sherbert, Thomas,* and *Hobbie* did not stand for the proposition that the first amendment protects any exercise of religion. The Supreme Court suggested that this case may be distinguishable from previous cases on the grounds that Smith and Black may have violated Oregon's criminal code and as such, may be unprotected by the federal constitution. According to the Court, the protection that the first amendment provides to legitimate claims to the free exercise of religion does not extend to conduct that a state has validly proscribed. The Court concluded, "if the Oregon Supreme Court's holding rests on the unstated premise that respondents' conduct is entitled to the same measure of federal constitutional protection regardless of its criminality, that holding is erroneous." Accordingly, the case was vacated and remanded for a determination of whether or not Oregon is among the states that exempt the religious use of peyote from statutory controlled substances prohibitions. If so, Smith's and Black's conduct may well be entitled to constitutional protection.□

LETTERS

Whose interest is served?

A response to W. Lawrence Fitch's "A poorly charted decision"

Mr. Fitch:

Some of your comments in the recent *Developments in Mental Health Law* (Vol. 8, No. 1) have me puzzled and worried. In *civil* cases, you suggest that medication should be imposed only when (a) the defendant is unable to make a rational choice and has not made a rational choice against medication in the past, and (b) the judge rules that such treatment is in the patient's best interests. Regarding *criminal* cases, however, your position is very different:

> The state *does* have a legitimate—and compelling—interest in resolving criminal cases, and to allow that interest to be frustrated by an incompetent defendant who can articulate a rational objection to treatment (e.g., "I don't want to get well, be tried, and go to prison") is highly undesirable To deny the state its opportunity to try a defendant because the treatment necessary would not serve the defendant's best interests is equally inappropriate. . . . Indeed, the risk of permanent injury as a result of short-term use of antipsychotic medication is exceedingly small.

Problem 1: Your parenthetical insertion in the first sentence suggests that all defendants who "articulate a rational objection to treatment" are guilty. Problem 2: You seem more concerned with "greasing the wheels" of the criminal legal process than you do with assuring a just outcome. Problem 3: Even more troubling, you seem ready to deny personal autonomy in order to "grease" those wheels.

Maybe I am being "legally naive," but I really do not see "risk of permanent injury" as the issue here. The issue is, instead, personal autonomy. When someone is a defendant in a criminal case, does that standing automatically deprive him of any right to decide what is best for himself? Is the state legally able to do with him as they wish? I don't know (and therein may lie at least part of my "legal naivete"), but you seem to believe that the answer to both questions is (or at least should be) "yes."

Put yourself in the shoes of the "incompetent" defendant who has, in some way or another, articulated a rational objection to treatment. Now, imagine yourself—for the sake of legal "expediency" (your word) and that only—being drugged against your will and hauled into a courtroom. Whether you are guilty or not and whether the outcome is in your "best interests" or not are not the points here. The point is, instead, that your person has been violated, against your will, all because the state finds it "desirable" and "palatable" (your words again) to get on with things.

If we go that far, where do we stop? How far do we go in the name of "legal expediency"? A few years ago when I was being trained as a "mental health aide" for Norfolk's Mental Health Services, I observed an incident where someone went *quite* far. The scene was the "backstage" of the morning commitment hearings. There I heard the attorney assigned to represent the interests of the so-called "mental cases" declare aloud that he wanted "commitments across the board" that day so he could leave in time to pick up a gift for his daughter's birthday. His "wish" shocked me at the time and angers me today, but nothing he suggested shocks or angers me quite as much as what you have suggested. That attorney's "wish" may have affected four or five people that day. *Your* suggestion, because you argue it should become part of criminal legal process, could, if adopted, affect thousands.

The crux of the matter here is simple: instead of shaping our criminal legal processes according to ideals of "justice," "fairness," "humane treatment," and the like, you are suggesting we shape those processes more in keeping with an ideal of "expediency." If you doubt this, please read through what you wrote again because that is *exactly* what you suggest. Maybe it is yet another sign of my naivete, but I believe there is probably a much better way to shape such important processes.

Sincerely,
Doyle Hull

Mr. Fitch replies:

My piece on the *Charters* decision generated considerable response, nearly all negative. Interestingly, the bulk of the criticism was aimed at my "libertarian" view that civil patients should have the right to refuse treatment with antipsychotic medication (if able to articulate an informed, rational objection). Only Mr. Hull was critical of my view that criminal defendants should have no right to refuse short-term treatment to restore competency to stand trial.

I *do* believe that psychiatric patients, whether voluntary or involuntary, should be permitted to refuse treatment that is offered solely for their benefit, so long as their judgment is informed and their reasoning is rational. But I reiterate my belief that where the treatment is intended to serve other interests as well, all the relevant interests must be weighed before deciding whether to abide by the patient's choice.

The law is clear that defendants who are incompetent to stand trial may not be tried. It also is clear that in the majority of cases in which the defendant is found to be incompetent, psychosis lies at the heart of the incompetency. Finally, it is clear that for most of these defendants, antipsychotic medications relieve the symptoms of the psychosis and, thus, enhance the defendant's competency.

Mr. Hull suggests my concern in advocating forced medication of psychotic, incompetent defendants is one of expediency, to "grease the wheels" of the legal process, and that I have no concern for "justice, fairness, humane treatment, and the like." He is mistaken. As a practical matter, nearly all criminal defendants found incompetent to stand trial ultimately are tried. Most courts simply are unwilling to cancel a prosecution except in the most compelling of cases (though they frequently postpone cases to enable defendants to receive treatment to enhance their competency.) In those cases that do not go to trial, the defendant typically remains hospitalized in a secure, "forensic" facility, often for far longer than he or she would have been imprisoned if convicted of the charges. If the defendant is going to be forced to proceed to trial or else remain in a secure psychiatric setting for an extended period, I believe anything that can be done to enhance the defendant's capacity to proceed should be done, so long as it does not involve a significant risk of harm to the defendant. Anything less would be *un*just, *un*fair, and *in*humane.

Now, of course, Mr. Hull's main argument is that, even if the consequences of refusing treatment are undesirable, out of respect for personal autonomy we should allow the rational defendant the choice. And, again, if the interests of the defendant were all that was at stake, I would agree. But the state has an interest in the matter as well. If the defendant is guilty, the state has an interest in conviction and punishment. If the defendant is not guilty, the state has an interest in acquittal and the go-ahead to pursue other suspects. Thus, the state clearly has an interest in resolving these cases, and resolving them accurately. If the defendant is incompetent, these interests are frustrated.

Just as no defendant has the autonomy to choose not to be tried, no defendant should be permitted to refuse a procedure that would enable the trial to proceed in a timely and meaningful fashion, at least where the procedure carries with it no significant adverse consequences for the defendant. Of course, treatment with antipsychotic medication carries a risk of serious medical complication. Therefore, the defendant's interests in avoiding such treatment are legitimate. But the state's interests are legitimate as well, although, I would concede, not sufficiently great to justify exposing the defendant to a significant risk of serious injury. Fortunately, as I noted in my article, the risk of serious injury as a result of treatment with antipsychotic medication is exceedingly small so long as the period of treatment is brief. (Long-term treatment with antipsychotics may be a different matter.)

Thus my proposal, reflecting a balance of interests: that short-term treatment be permitted, without regard for the defendant's choice, but that long-term treatment against the defendant's will be proscribed. My suggestion that the trial proceed expeditiously upon restoration of the defendant's competency is not for the purpose of "greasing the wheels," as Mr. Hull suggests, but rather is to assure that the period of treatment with medication is kept brief, thereby minimizing the risk of injury to the defendant.

Ultimately, assuring the defendant's ability to participate meaningfully in a trial—to understand the proceedings, to work with counsel, and to assist in the defense—is in everyone's interest. If such assurance can be made without subjecting the defendant to significant risk of harm, then I'm all for it.□

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, Mental Retardation and Substance Abuse Services. 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 twice a year. 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.

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