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Does competency matter after *Charters*?

by Michael L. Perlin

The en banc *review*

While *Charters I* was *like* contemporary state cases involving civilly committed patients (such as the New York Court of Appeals's *Rivers v. Katz* decision), it was clearly a far cry from most of the decisions that dealt with individuals committed pursuant to the filing of criminal charges. Had the panel decision stood, there is no question that it would have altered significantly the body of law applying to this universe of patients. Thus, when the fourth circuit granted *en banc* review, it was reasonable to draw the inference that it was not simply to affirm—*in toto*—the panel's truly groundbreaking decision.

It did just the opposite: it vacated the panel decision and remanded the case to the district court for further proceedings in accordance with its opinion, holding that the district court had correctly determined that Charters's interests were adequately protected by the exercise of the professional judgment of Butner's medical staff at the time of the decision to medicate, leaving virtually nothing of the panel's original reasoning or holding. I will briefly set out the reasoning that the majority employed in coming to its decision and attempt to unearth some of the "hidden agendas" that I think I can discern in it.

Basically, the *en banc* opinion in *Charters II* suggests that the panel was wrong about almost everything. While it agreed that Charters did possess a constitutionally-retained interest in freedom from bodily restraint (and that this interest was implicated by the forcible administration of psychotropic drugs), and that this interest is protected "against arbitrary and capricious actions by government officials," it recast the issue in dispute:

> [W]hat procedural protection is constitutionally required to protect the interest in freedom from bodily intrusion that is retained by an involuntarily-committed individual after a prior due process proceeding that significantly curtails his basic liberty interest[?]

It rationalized the shift in focus this way: since Charters came "legally into the custody of the United States," the current limitations on his liberty interest were constitutionally acceptable, and his retained freedom-from-bodily-intrusion interest must thus "yield to the legitimate incidents of his institutionalization."

Before it embarked upon its own analysis, the *en banc* court stopped to critique the language of the panel that had cited the potentially "mind-altering" quality of drug treatment, noting that this phrase was rife with "all the images that evoke the use by totalitarian states of 'mind-controlling' psychiatric techniques specifically to curtail individual liberty." In a footnote it pointed out that tardive dyskinesia is the principal side-effect that "may" be threatened and that its pathology, its probability, its susceptability to treatment and its durability "probably cannot be more pessimistically and vividly described than [by] the selected items from the legal and psychiatric literature" in the panel's initial opinion, and that "a much less drastic appraisal of the risk-potential is made "by the responsible elements in the relevant scientific communities."

With this commentary about the relevancy of social science research under its belt, the court proceeded to analyze the case before it. Employing a strict *Mathews v. Eldridge* balancing test, it relied

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Michael L. Perlin, J.D., is Associate Professor of Law at New York Law School and Director of the Federal Litigation Clinic. Mr. Perlin participated in the Twelfth Annual Symposium on Mental Health and the Law in March, 1989. What follows is an excerpt of Mr. Perlin's longer presentation [on the impact of the Fourth Circuit Court of Appeals decision in *U.S. v. Charters*, 863 F.2d 302 (4th Cir. 1988) (*en banc*) (*Charters II*), vacating 829 F.2d 479 (4th Cir. 1987)]. *Charters I* was discussed in 8 *Developments in Mental Health Law* 1. The footnotes have been omitted to save space but are available upon request.

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on the Supreme Court's decisions in *Youngberg v. Romeo* and *Parham v. J.R.* to reach the conclusion that committing "the base-line governmental decision to medicate [to] the appropriate medical personnel of the custodial institution"—subject to judicial review for "arbitrariness"—comported fully with due process, even where the exercise of professional judgment "necessarily involves some interpretation of the disputable 'meaning' of clinical 'facts.' "

While conceding that both *Parham* and *Youngberg* involved "somewhat different types of medical decisions," the court concluded that "their general approval of the basic regime proposed by the government here is plain." It drew particular support from the Court's analysis in *Parham* that, "while medical and psychiatric diagnosis obviously was fallible, there was no reason to suppose that it was more so than would be the comparable diagnosis of a judge or hearing officer," in concluding that such a regime may comport with procedural due process requirements "notwithstanding the absence of any adversarial adjudicative element."

On the other hand, the court rejected Charters's proposal for several reasons. First, that proposed regime would bring with it "all the cumbersomeness, expense and delay incident to judicial proceedings." Under such a scheme the role of institutional medical personnel would be transformed into that of "expert witnesses defending their opinions in judicial proceedings rather than that of base-line decision makers [at which, p]resumably, their opinions. . .would be entitled to no greater deference than the conflicting opinions of the outside expert witnesses *whose testimony surely can be anticipated.*"

By way of support for this proposition the court recounted several unreported cases in which Butner inmates, in the wake of the initial panel decision in *Charters*, withdrew earlier consent to medication (a withdrawal supported by outside expert testimony); in each of these, "[c]onfronted with directly conflicting opinion by two professionally qualified experts," the district court found the inmates competent to refuse medication, thus "according less rather than more deference to the decisions of institutional professionals than to the conflicting opinions of outside expert witnesses." On this point the *en banc* court sympathetically recounted Dr. Johnson's testimony questioning the validity of "any factual inquiry into the competency of schizophrenic patients to make such decisions at particular points in time." [Dr. Johnson, Director of Forensic Services and Clinical Research at Butner, was the only expert witness in the case.]

Such a scheme—apparently reflective of a "greater confidence in the ability of judges and adversarial adjudicative processes than in the capacity of medical professionals subject to judicial review"—flew "directly in the face" of Supreme Court teachings, the court concluded, noting that decisions of this type by institutional personnel should be treated by courts as "presumptively valid," and quoting extensively from former Chief Justice Burger's well-traveled language in *Parham*:

> Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.

Therefore, to require a preliminary factual determination of a patient's competency as to medical decision making would pose "an unavoidable risk of completely anomalous, perhaps flatly inconsistent, determinations of mental competence by different judicial tribunals." Stressing that Charters had already been declared incompetent to proceed to trial—a "solemn judicial adjudication [that] still stands"—and conceding

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that "there may be a difference" between competency to stand trial and competency to engage in medical decision making, such a distinction, the court concluded "must certainly be one of such subtlety and complexity as to tax perception by the most skilled medical or psychiatric professionals."

On the specific issue of side-effects, while the court acknowledged that they "introduce[d] an element in the risk of error that require[d] special concern," it chose to recast the question in terms of whether this risk was "so unique" that it required "skewing the basically approved regime for insuring due process in making medical decisions," and concluded that it did not.

Side-effects were simply "one element" in the "best interests" calculus, and the fact that responsible professionals expressed "wide disagreement. . . as to the degree of their severity, their susceptibility to treatment, their duration, and. . . their probability over the run of cases"—a disagreement reflected in this case through the dramatically-contrasting *amicus* briefs of the American Psychiatric Association and the American Psychological Association—emphasized to the court that the side-effects question was "simply and unavoidably" an element of the "best interests" decision. Stressing that "no scientific opinion is advanced that these side-effects are so highly probable, so severe, and so unmanageable that the antipsychotic medication simply should never be administered. . . even with patient consent," the court concluded that the side-effects threat "can better be assessed and reviewed within the government's proposed regime than by an adversarial adjudicative process."

Similarly the court dismissed Charters's claim that his competency must be determined by a neutral fact-finder, as it was not convinced that giving this determination to "non-specialist judges. . . offers a better protection against error than would leaving it to responsible medical professionals." The patient's competence to make an informed judgment—like the potential for side-effects—was "simply another factor in the ultimate medical decision."

Turning to the government's stake, the court stressed that its role "here is not that of punitive custodian of a fully competent inmate, but *benign custodian of one legally committed to it for medical care and treatment.*" [emphasis added] To accept Charters's proposed regime "would effectively stymie the government's ability to proceed with the treatment—certainly for an interval that might make it no longer efficacious, and probably indefinitely."

Having concluded that the government's planned regime was constitutionally adequate, the court then moved to the issue of how it should be administered. Relying once again on the *Parham* case for the proposition that an "internal adversarial hearing" was similarly not required, it held that "an acceptable professional decision" may be based upon "accepted medical practices in diagnosis, treatment and prognosis, with the aid of such technical tools and consultative techniques as are appropriate in the profession," including, *inter alia*, "the patient's general history and present condition, the specific need for medication, its possible side-effects, any previous reaction to the same or comparable medication, the prognosis, the duration of any previous medication, etc.," all of which must be supported by "adequate documentation."

Side-effects were simply "one element" in the "best interests" calculus.

The "professional judgment standard," the court underscored, was not whether the treatment decision was "the medically correct or most appropriate one," but "only whether the decision was made by an appropriate professional." Under this test, there will be a denial of due process only—quoting *Youngberg* again—where the decision is such a "substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." Thus, there will be *only one question* to be asked of experts in any proceeding stemming from a medication question decision: "*was this decision reached by a process so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one.*" [emphasis added] Such a standard, the court concluded, "appropriately defers to the necessarily subjective aspects of the decisional process of institutional medical professionals," according them "the presumption of validity due them."

In looking at the facts of the case before it, the *en banc* court found that the district court conducted its "careful inquiry" properly, noting:

> Significantly, no evidence was offered that the decision lay completely beyond the bounds of tolerable professional judgment. This undoubtedly reflects the fact that no such evidence was available.

On this point, the court cited two recent scholarly medical articles [including Baldessari and Lipton, *Risks of antipsychotic drugs overemphasized.* 305 NEJM 588 (1982)] that had concluded that antipsychotic drugs were the "cornerstone" and the "primary modality" in the management of acute mental illnesses. Finally, in setting out the limits of its ordered remand, the court concluded by "assuming that medical professionals, *now aware of the standard* to which they are held, may be as willing to proceed without prior judicial approval as are other governmental officials such as those on

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In the Virginia General Assembly—1989

New surrogate decision making measures adopted

Two new surrogate health care decision making procedures were adopted by the 1989 Virginia General Assembly. Both laws were derived from a previous law, § 37.1-134.2. The old law allowed judges to authorize medically necessary non-psychiatric medical treatment for persons incapable of giving consent to the treatment, without appointment of a guardian. The new laws evolved from this in two different directions, although, like the old, they operate without the necessity of appointment of a guardian. For the sake of simplicity the two new laws may be referred to as the judicial approach (enacted by HB 1438, Chapter 591) and the nonjudicial approach (enacted by SB 639, Chapter 513).

Since the legislation assigned both of these laws the same code section, § 37.1-134.3, some change in this designation will occur by the time of their effective date, July 1, 1989.

The judicial approach

The judicial approach is the closer of the two to the old procedure provided under § 37.1-134.2. It allows anyone to seek authorization for treatment from a general district court judge, juvenile and domestic relations district court judge, special justice or circuit court judge. Now the treatment authorized may include psychiatric treatment, although certain restrictions apply to these authorizations.

Psychotropic medication may be authorized for a maximum of 180 days and electroconvulsive therapy for only 60 days. Neither of these treatments can be administered under the authority of this section over the patient's objection unless there is a concurrent order of inpatient or outpatient commitment under §§ 37.1-67.1 *et seq.* While the new law cannot be used to authorize admission to a mental health or mental retardation facility, it can be applied concurrently with the commitment or certification statutes to authorize post-commitment treatments.

The new law also permits the court to authorize detention and transportation of a person whose decision making capacity is impaired, but only where these measures are related to non-psychiatric treatment.

The court-appointed attorney is charged for the first time with looking into his client's preferences regarding treatment and presenting those preferences to the court. The court cannot authorize treatment when the evidence shows it to be contrary to the religious beliefs or basic values of the person unless the treatment is necessary to prevent death or a serious irreversible condition.

The nonjudicial approach

The nonjudicial approach is reserved for non-protesting persons in need of or receiving treatment by a licensed physician. Other than excluding from the treatments that can be authorized under this statute admission to mental health and mental retardation facilities, nontherapeutic sterilization, abortion and psychosurgery, all decisions to give or withhold treatment are made the same way.

Rather than going to a court for a determination of incapacity, a physician who doubts the patient's capacity to give informed consent may refer the patient to a psychiatrist or clinical psychologist for a determination of incapacity. Once that certification is made (and it must be made every 180 days while treatment continues), the treatment provider looks to a person designated by the statute for the treatment decision.

The statute designates surrogate decision makers in a certain order of priority. Thus, if there is an applicable declaration made under the Virginia Natural Death Act which appoints a decision maker, that person must be looked to for the decision. If that person is not readily available or does not exist, then the physician must turn to a guardian if one exists, is available and has authority under the guardianship order to make such a decision.

The next in priority is an attorney-in-fact appointed under a durable power of attorney. While the state durable power of attorney statute does not mention health care decision making, this new law makes the durable power of attorney useful for that purpose and provides an array of additional safeguards appropriate for health care decision making, such as protection of the principal's right to object to treatment, access to a court to challenge a finding of incapacity and automatic authority of a guardian to override the power of attorney.

The priority list continues with the spouse, adult son or daughter, parent, adult sibling and, finally, any blood relative in descending order of blood relationship. Once that list is exhausted the physician may not use this statute, but like always is not precluded from relying on any other common law or statutory authority for treatment authorization.

An earlier version of the nonjudicial bill would have allowed local circuit judges (and in an even earlier version, the state Department of Mental Health, Mental Retardation and Substance Abuse Services) to appoint a pool of "health care representatives" to serve after the list of relatives of the patients is exhausted.

SB 639; Ch. 513; adding § 37.1-134.3. HB 1438; Ch. 591; repealing § 37.1-134.2 and adding § 37.1-134.3 (Note: new sections numbers probably will be changed by the Code Commission.)

Other new laws

Resident rights clarified

Section 37.1-84.1 establishes the basic rights of persons receiving mental health, mental retardation or substance abuse services in the state of Virginia. First enacted in 1974 this statute was amended for the first time this year in two ways which will enhance the regulatory authority of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

SB 598 adds language assuring clients of their right to be free from abuse. HB 1438 makes clear the Department's authority to provide for administrative determinations of incapacity and appointment of persons authorized to give consent to treatment. SB 598; Ch. 459; HB 1438; Ch. 591 amending § 37.1-84.1.

Grounds for limited guardianship narrowed

"Advanced age" can no longer serve as a basis for a finding of incapacity and the appointment of a guardian under Virginia's limited guardianship statute, § 37.1-132. In the past "advanced age" was often used in pleadings and court orders to avoid stigmatizing the ward as mentally ill. It was objectionable, however, to people who felt that the law implied that "advanced age" was evidence of incapacity.

SB 201; Ch. 4; amending §§ 37.1-132 and 37.1-134.2.

Guardianship appeals facilitated

A new law will allow an order to guardianship to be appealed at any time, even if the time for appeals has expired, by request of any party to the original proceeding to have the order reinstated to the docket.

SB 614; Ch. 416; adding § 37.1-134.3.

Temporary detention period extended slightly

When the forty-eight hour period of temporary detention under the state civil commitment law would ordinarily conclude on a weekend or legal holiday, previous law allowed the detention to continue for a total of seventy-two hours. Now when the forty-eight hour period would conclude on a legal holiday which falls on a Friday or Monday, the period of detention may last until the next business day, but in no case longer than a maximum of ninety-six hours. This awkward formulation means that a person detained on the Wednesday before a Friday holiday would have to have his commitment hearing no later than Sunday (rather than Saturday as previously required). A person committed on a Saturday before a Monday holiday would have to be committed on the next business day, Tuesday (which is what would have happened under the previous law).

HB 1773; Ch. 716; amending §§ 37.1-67.3.

Local sheriff's responsibility in civil commitment increased

Code § 37.1-71 was amended to make sheriffs responsible for the transportation of persons from their jurisdiction who are committed by any court within 100 miles of that jurisdiction.

This means that if a sheriff's department executes a temporary detention order and transports the person detained to a psychiatric facility less than 100 miles outside of the sheriff's city or county, and the person is subsequently committed in a hearing held at the psychiatric facility, it is that sheriff's responsibility to then transport that person to the state hospital or other place to which he was committed.

HB 1760 and SB 611; Chs. 534 and 334; amending § 37.1-71.

Department and State Board of Youth Services created

The responsibility of the Department of Corrections for delinquent children and children in need of services has been transferred to a newly created Department of Youth Services. The new department, like the Department of Corrections, will be under the supervision of the Secretary of Transportation and Public Safety. A new title 66 of the Code describes the authority of the Department of Youth Services, which includes making grants to local governments which establish Youth Services Citizens. Section 66-20 requires the Department to provide treatment for any mentally disordered child in its facilities and, where transfer to a state mental health or mental retardation facility is needed for observation or treatment of the child, to rely on the usual adult civil commitment or certification procedures under § 37.1-67.1 *et seq.* or § 37.1-65.1 respectively.

SB 278; Ch. 733; amending §§ 2.1-1.1, 2.1-1.3, 2.1-1.6, 2.1-51.18, 2.1-121, 2.1-700, 2.1-701, 2.1-703, 9-6.25:2, 9-168, 9-268, 9-271, 16.1-222, 16.1-228, 16.1-233, 16.1-238, 16.1-240, 16.1-241, 16.1-246, 16.1-275, 16.1-279, 16.1-284.1, 16.1-286, 16.1-287, 16.1-294, 16.1-295, 16.1-300, 16.1-309, 16.1-310, 16.1-318, 18.2-64.1, 18.2-473, 18.2-477.1, 18.2-480.1, 20-48, 20-49, 22.1-340, 22.1-341, 23-35.3, 29.1-317, 36-99.4, 53.1-31, 54.1-2969, 63.1-248.16 and 63.1-314.3; adding §§ 66-1 through 66-35; repealing §§ 53.1-237 through 53.1-260.

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Civil immunity for clinical psychologists added

Clinical psychologists have been added to the list of health care practitioners who have statutory immunity from civil liability arising from their good faith participation in a variety of peer review committees.

HB 1962; Ch. 729; amending § 8.01-581.13, 8.01-581.16, 8.01-581.19, 8.01-581.19:1 and 8.01-581.20.

Pretrial drug testing made available to criminal defendants

Pretrial services agencies may now offer voluntary drug testing to persons (including juveniles) charged with crimes. The results are made known to the court at the initial bail hearing only after the initial release decision is made and the amount of the bond is set. The results are then considered for the purpose of imposing conditions of release, such as submitting to additional urinalysis which demonstrates abstention from drug use. The new law limits the disclosure and use of the results of the drug testing, so that they can not be used during the guilt or sentencing phases of the proceedings, or otherwise released to the public.

HB 1318; Ch. 369; amending § 19.2-123.

Corporal punishment prohibited

Public primary and secondary school staffs are now prohibited from administering corporal punishment under a new law. The law will permit the use of physical force to prevent injuries to students or damage to school property, or to seize drugs or weapons. The definition of corporal punishment excludes pain or discomfort caused by participation in sports, physical education or extracurricular activities.

HB 1864; Ch. 287; adding § 22.1-279.1 and repealing § 22.1-280.

Virginia Indigent Health Care Trust Fund authorized

A new mechanism has been created for redistributing the cost of charity health care among Virginia's licensed acute care hospitals. Each year the hospitals make a contribution to the Virginia Indigent Health Care Trust Fund in accordance with a formula that takes into account the amount of unreimbursed care provided to persons below the federal non-farm poverty level and the total amount of gross patient revenues. Monies from the fund are then distributed to the hospitals according to a different formula. The new law specifically provides that it is not creating a right to health services on the part of an indigent person.

HB 1859; Ch. 635; adding § 32.1-332 through 32.1-342.

AIDS infection must be reported

Several measures were adopted to address growing concern about infection with the human immunodeficiency virus. The new sections attempt to balance the need to assure at-risk persons enough confidentiality and fair treatment that they will submit to testing with the need to protect the public through limited disclosure of test results.

Last year physicians were given the discretion to report to the local department of health the fact that a patient tested positive for the AIDS virus. The local department of health, under its general authority to investigate diseases, could then provide counseling and contact tracing.

Beginning this year physicians will be required to report all seropositive patients to the local department of health. In addition the legislature clarified the authority of the local Departments of Health to do contact tracing.

The new law provides that the physician is not liable for failure to warn or notify the third party of the patient's seropositive status, although the physician is authorized to release test results to the patient's spouse, or if the patient is a minor, the patient's parents. Unauthorized disclosures are discouraged by provision for a civil penalty of $5,000 which may be sought by a local prosecutor or city attorney. Patients are also given a right of action for damages and attorney fees.

The concept of "deemed consent" to HIV testing is created by the new law. If either a patient or a health care provider is directly exposed to the bodily fluids of the other, the person whose bodily fluids are involved is "deemed" to have consented to testing and to the release of the results to the person exposed.

With respect to seroprevalence studies in hospitals, patients are also deemed to have consented to HIV testing under some conditions. First, for consent to be deemed, the blood specimens have to have been obtained for other, "routine diagnostic purposes." Second, the seroprevalence study must be "designed to prevent *any* specimen from being identified with *any* specific individual." [Emphasis added.] Strict adherence to these conditions may not be possible if the hospital is to comply with a more general requirement that face-to-face disclosure of results and counseling be offered to every subject of an HIV test. Patients would have to be offered disclosure and counseling and, in effect, taken out of the study if they requested

it. The study then would include only persons who were indifferent to or opposed to testing.

HB 1974; Ch. 613; amending §§ 32.1-36 and 32.1-39 and adding §§ 2.1-51.14:1, 22.1-271.3, 23-9.2:3.2, 32.1-11.1, 32.1-11.2, 32.1-36.1, 32.1-37.2, 32.1-45.1, 32.1-55.1 and 32.1-289.2.

Natural Death Act suggested form altered

Since its adoption in 1983 the Virginia Natural Death Act has allowed a dying person either to direct the withholding of treatment or to delegate that authority to someone else. This year the suggested form set forth in the statute was amended to make it clear that someone using that form could select either alternative. Previously the form only contemplated a directive to withhold treatment. Because of the ambiguities in the Act over when such a declaration applies (i.e., when the declarant is in "the terminal condition"), consideration should be given to using a durable power of attorney, rather than the suggested form of the Natural Death Act declaration to appoint a proxy decision maker.

HB 1443; Ch. 592; amending § 54.1-2984.

Virginia Fair Housing Law protects handicapped persons

The Virginia Fair Housing Law was amended this year to prohibit housing discrimination because of elderliness, familial status or handicap. It continues to prohibit discrimination because of race, color, religious creed, national origin or sex. The change was to bring state law into conformity with Title VIII of the federal Civil Rights Act of 1968. Title VIII was amended recently by the Fair Housing Amendments Act of 1988 to extend its protection to handicapped persons and others. Under the federal law the Secretary of Housing and Urban Development will refer complaints of housing discrimination to state or local agencies which have adopted statutes or ordinances providing rights and remedies substantially similar to federal law. The amendments to Virginia law were necessary to preserve state authority to investigate these complaints prior to HUD action.

The new state law does not define handicap, although it does say that all provisions are to be construed consistently with federal law. The federal definition of handicap is set forth in a new HUD regulation, 24 C.F.R. § 100.201:

> "Handicap" means, with respect to a person, a physical or mental impairment which substantially limits one or more major life activities; a record of such an impairment; or being regarded as having such an impairment. This term does not include current, illegal use of or addiction to a controlled substance. For purposes of this part, an individual shall not be considered to have a handicap solely because that individual is a transvestite.

This definition is quite similar to that which used to prohibit discrimination in federally funded housing subject to § 504 of the federal Rehabilitation Act of 1973, except for exclusions of current drug users and transvestites.

The Virginia Fair Housing Law, like the federal law, provides for three principal means of enforcement: administrative complaints (under state law to the Virginia Real Estate Commission), private suits for injunction and injunctive suits brought by the Attorney General.

The newly amended state law prohibits an extremely broad range of private housing discrimination by owners, brokers and others. The law invalidates, both prospectively and retroactively, all restrictive covenants which restrict occupancy on the basis of elderliness, familial status or handicap. This measure makes unnecessary the provisions of Virginia Code § 36-91(C) enacted in 1986 which invalidated (prospectively) restrictive covenants barring group homes of six or fewer residents and a resident counselor. The new law also in effect overturns the 1984 Virginia Supreme Court decision in *Omega Corporation v. Malloy* (see 4 *Developments in Mental Health Law* 17, July-December 1984), which enforced such a restrictive covenant.

The Virginia Fair Housing Law may in the future prove more effective in reforming local zoning ordinances applicable to group homes than previous state laws. Section 15.1-485.2 of the Virginia Code, which requires local governments to provide for placement of group homes in a family zoning district, has been ignored altogether by some local governments and has seldom resulted in the ability of a group home to locate as a matter of right in a single family zoning district. Both the recently amended state and federal zoning laws now offer persons whose handicap requires group home living a remedy for challenging zoning laws which impede location in a single family zoning district.

HB 1806; Ch. 88; amending §§ 36-87, 36-88, 36-89, 36-90 and 36-91.

Profile of NGRI Patients in Virginia

by Russell C. Petrella, Ph.D. and Tamson L. Six, M.Ed.

Individuals who have been found not guilty by reason of insanity (NGRI) by Virginia courts are committed to the custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, pursuant to Virginia Code § 19.2-181, until it is determined by a court that they are both no longer mentally ill and do not present a danger to themselves or others. They are typically placed in one of the state psychiatric facilities for care, evaluation and treatment purposes.

The complex involvement that NGRI patients have with the mental health system and the criminal justice system poses unique management challenges and requires special clinical and legal attention. The NGRI Patient Monitoring System was developed by the Office of Forensic Services of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to address these needs and facilitate the improvement of NGRI patient management and treatment within state facilities. The system was implemented in August of 1988. What we present here is a profile of the NGRI patient in Virginia from information gathered through the NGRI Patient Monitoring System since its inception. To our knowledge, this is the first time such information has been gathered and compiled on NGRI patients in Virginia.

NGRI Patient Monitoring System

In each of the state psychiatric facilities a clinical staff member has been named Forensic Coordinator. The coordinators are responsible for managing the care of forensic patients as well as for submitting key information to the Office of Forensic Services. This is done through a series of three NGRI Patient Reports: the *NGRI Patient Admission Report, NGRI Status Change Report* and *NGRI Annual Report* which are forwarded to the Central Office within designated time frames. The data base within the NGRI Patient Monitoring System is comprised of the information obtained from these reports.

The *NGRI Patient Admission Report* gathers basic demographic information, a detailed offense description, patient diagnosis, court and attorney information, and original NGRI Commission names for each new NGRI admission.

The *NGRI Patient Status Change Report* serves as notification of:

- NGRI Commission findings
- change in legal status
- transfer to another facility
- movement to a different unit within a facility
- community or overnight visits
- on or off grounds pass
- any unusual incident
- discharge.

NGRI Commission Reports, discharge summaries and release plans are attached when appropriate. This report also documents correspondence between committing courts and facilities regarding changes in patient condition, petitions for hearings and requests for privileges.

The *NGRI Patient Annual Report* summarizes key points of patient progress and future plans for treatment. A copy of the actual report to the court is submitted with the summary.

NGRI Patient profile in Virginia

As of December, 1988, there were 137 NGRI patients on inpatient status in the psychiatric facilities operated by DMHMRSAS. The majority of NGRI patients (95) are located at Central State Hospital, 60 in the maximum security Forensic Unit and 35 elsewhere in the hospital. Of the 42 NGRI patients located in other DMHMRSAS facilities, 19 reside at Western State Hospital, 13 at Eastern State Hospital, 9 at Southwestern State Hospital, and 1 at Piedmont Geriatric Hospital. In reviewing this data we have noted similarities and differences in the demographic character-

Legal standards for NGRI finding in Virginia

1. M'Naghten test of insanity: "The defendant was insane if he did not understand the nature, character, and consequences of his act, or he was unable to distinguish right from wrong." *Price v. Commonwealth,* 228 Va. 452 (1984).

2. Irresistible Impulse: The defendant was insane if his "mind [was] so impaired by disease that he [was] totally deprived of the mental power to control or restrain his act." *Thompson v. Commonwealth,* 193 Va. 704 (1952).

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istics of civil patients in the DMHMRSAS system, inmates confined in the Virginia Department of Corrections (DOC) and NGRI patients in other states.

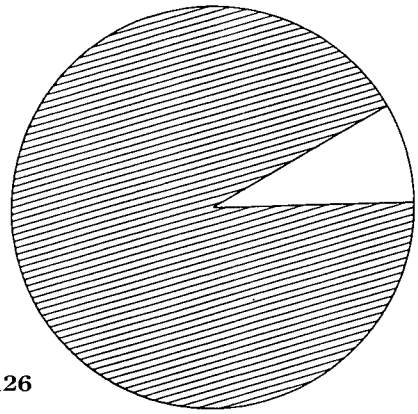
Sex

Ninety-two percent (126) of the NGRI patient population in Virginia state psychiatric facilities is male and 8% (11) is female (Figure 1). This compares to approximately 55% male and 45% female for the overall active patient population in DMHMRSAS facilities.[1] However, 95.8% (12,858) of the confined criminal population in DOC facilities is male and 4.2% (561) is female.[2]

While the available literature suggests that the great majority of NGRI acquittees are males (as are criminal defendants in general), there has been some speculation that women are overrepresented in the NGRI population in comparison to the convicted criminal population.[3] However, as noted by Heilbrun, Heilbrun, and Griffin,[4] the small number of females in NGRI populations makes it difficult to draw meaningful conclusions regarding the representation of women in the insanity defense system in studies conducted to date.

Figure 1

NGRI Patient Census: Male/Female Ratio
December 1988

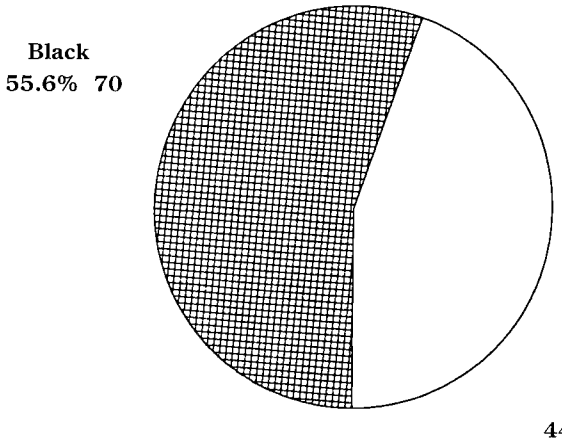


Race

In Virginia 56.9% (78) of the current NGRI population is black and approximately 43% (59) is white. This compares to a ratio of 37.5% black to 61.5% white for the total active patient population in Virginia mental health facilities. The confined population in DOC facilities is 60.4% black and 39.14% white. There is a similar ratio of blacks in both the NGRI population and the confined criminal population. To put this in context it is notable that the projected population figures for 1988 indicate that the Virginia population is 19% black and 78.75% white.[5]

Figure 2

NGRI Patient Census (Male): Race Ratio
December 1988



The ratio for male NGRI patients is 56.6% (70) black to 44.4% (56) white (Figure 2). For females the ratio is 73% (8) black to 27% (3) white (Figure 3).

At the time of this writing there are no NGRI patients in the category of "other" ethnic origin and figures were unavailable for the number of "other" active mental health patients in the system. "Others" compose .44% of the current inmate population and 2.25% of the total Virginia population.

Figure 3

NGRI Patient Census (Female): Race Ratio
December 1988

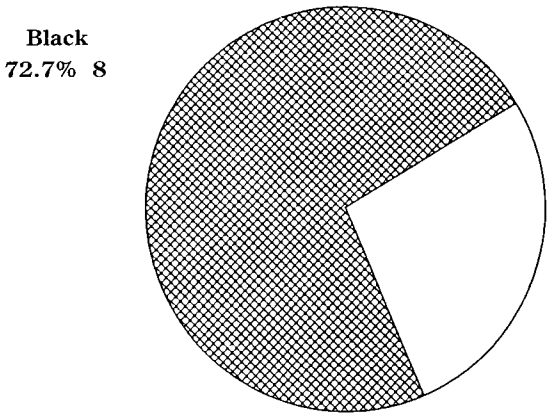


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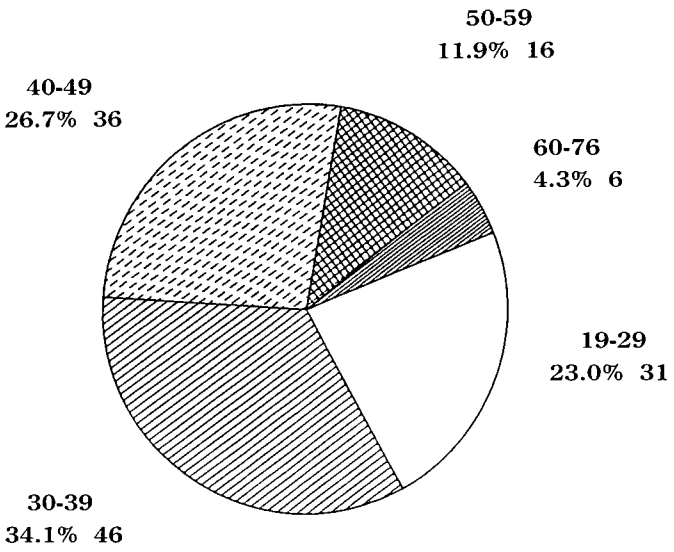
Figure 4

NGRI Patient Current Age
December 1988



Age

The majority of current NGRI patients in Virginia are between the ages of 30-39 (Figure 4). Twenty seven percent (36) are between the ages of 40-49 and 23% (31) are between the ages of 19-29. The range is from 19 to 76 years of age with a mean NGRI patient age of 39.05 years. This compares with a mean age of 32.2 years for current prison inmates in Virginia. Pasewark[6] noted that in some states insanity acquittees have been found to be somewhat older than the general offender population. While figures are not available for patient age at date of acquittal, the current mean age of the NGRI patient population is 7.3 years above that of the current mean age for the confined DOC population.

Length of hospitalization

The average length of stay for NGRI patients currently in DMHMRSAS facilities is approximately 50.3 months (4.18 years). Figure 5 shows that individuals found NGRI for the years 1985-1988 compose the majority, 59% (80), of the current NGRI population in state facilities. Thirty-three individuals found NGRI during 1980-1984 are currently hospitalized. There are 17 individuals found NGRI during 1975-1979 still residing as patients, and five for the period 1966-1974. While it would be interesting to compare the average length of hospitalization for insanity acquittees by offense to the average length of incarceration for individuals found guilty of comparable offenses, that information is not yet available. Pasewark[7] notes that there are few investigations examining length of involuntary hospitalization for NGRI acquittees. Those that do report quite varied lengths of stay, regardless of offense.

Figure 6 displays a census breakdown of patients found NGRI for the period 1985-1988. Thirty-six patients were found NGRI in 1988, 27 in 1987, and 13 and 4 in 1986 and 1985 respectively. There appears to

Figure 5

NGRI Patients in DMHMRSAS Facilities
Census by Year Found NGRI
December 1988

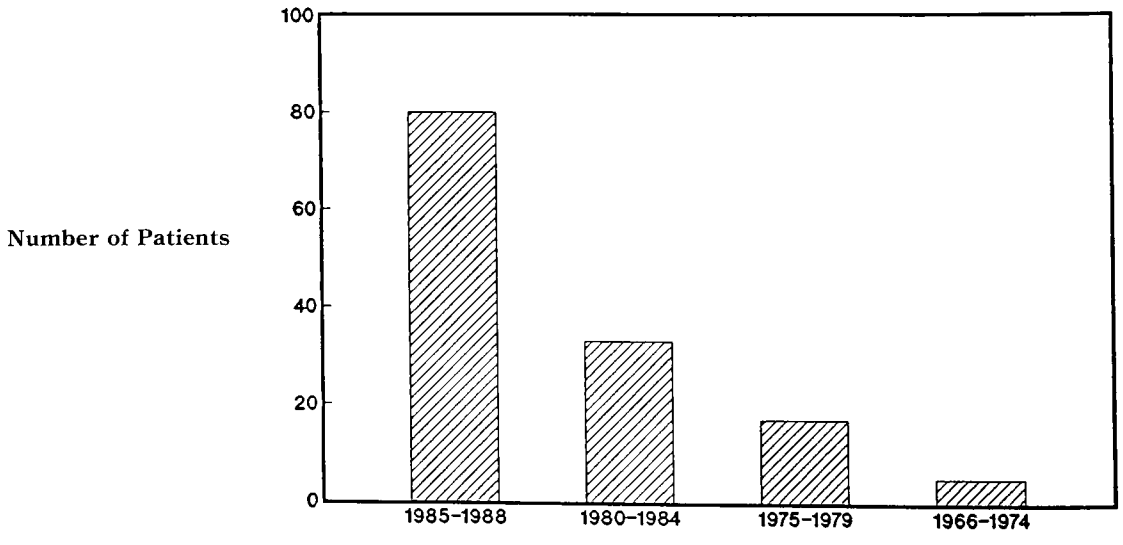
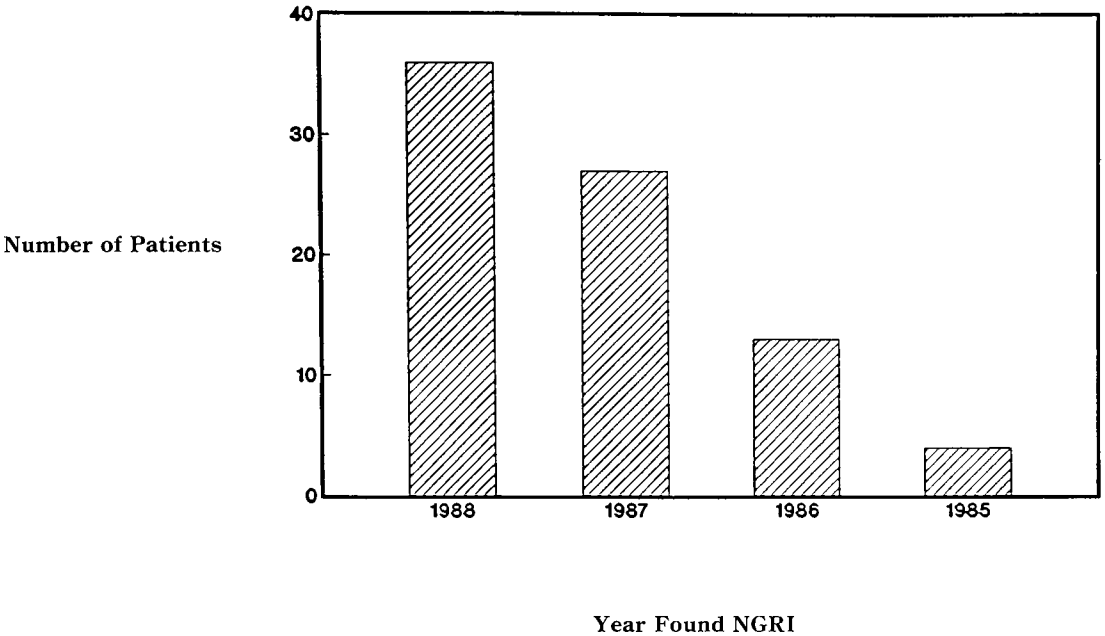


Figure 6

NGRI Patients in DMHMRSAS Facilities
Census by Year Found NGRI (1985-88)



be a marked increase in the number of individuals being found NGRI each year. It has been suggested that judges are utilizing the insanity defense as a means of controlling nuisance cases by maintaining jurisdiction over the patient's discharge.

Location and distribution

The locations where NGRI patients were found NGRI appear to be distributed throughout Virginia. The number of findings for any given jurisdiction ranges from 1-8, with the exception of the city of Richmond which has 28. Although there appears to be an exceedingly high frequency of NGRI findings in the city of Richmond (population 216,600), the rate is 1.3/10,000 which is comparable to that of Smyth County (population 33,000) with a rate of 1.2/10,000.[8] The urban areas of Fairfax County (population 739,300) and Virginia Beach (population 350,100) had NGRI finding rates of .054/10,000 and .057/10,000, respectively, and the more rural area of Williamsburg (population 12,000) had a rate of 4.17/10,000. Although figures are not available for the number of times the insanity defense was raised in each jurisdiction, this may lend support to the notion that differing community attitudes and mores and variances in judicial interpretations of the law contribute to the incidence of a successful insanity defense.

NGRI Offenses

Figure 7 presents a breakdown of the offenses for which DMHMRSAS patients were found not guilty by reason of insanity. The NGRI patients currently monitored through the system were charged with a total of 193 offenses for which they were adjudicated not guilty by reason of insanity. Thirty-three individuals were found NGRI on more than one charge. The offenses vary from trespassing and disorderly public conduct to murder and rape, forming a bimodal distribution of misdemeanors and more serious offenses. Crimes against the person comprise slightly more than half of the total offenses (approximately 110) resulting in an NGRI finding, including 30 counts of murder and eight counts of attempted murder. Twenty-nine individuals were found NGRI of the 30 counts of murder. Of this group one was also found NGRI of attempted murder and six were found NGRI of additional charges including assault, robbery, malicious wounding and abduction. Seven individuals were found NGRI of the eight counts of attempted murder. These figures appear to be congruent with a pattern that seems to be emerging in other studies reporting on NGRI offenses. As Pasewark[9] noted, NGRI offenses are usually varied and include misdemeanors. However, crimes against the person seem to be overly represented.

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Informed decision making

The descriptive information on insanity acquittees in Virginia presented here is a first step in developing a comprehensive forensic patient management information system. As suggested by Steadman and Morrissey,[10] "there is clear and urgent need" for each state to develop such a system before questions regarding the administration and reform of the insanity defense can be addressed. Many simple questions regarding characteristics and number of insanity acquittees cannot be answered due to lack of a uniform and centralized management information system.

In Oregon an independent Psychiatric Security Review Board (PSRB) was mandated in order to enhance uniformity and predictability in forensic patient management.[11] Informed decision making regarding insanity acquittees is now possible, because the PSRB has compiled and produced comprehensive data for each person under its jurisdiction.[12]

The recently developed NGRI Patient Monitoring System in Virginia will similarly facilitate informed decision making regarding NGRI patient management. Patients can be monitored for careful reintegration into the community and thoughtful release decisions can be made. This information will also form the data base of information needed to consider future system changes in the management of NGRI patients in Virginia. □

Notes

1. Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services: Office of Management Information Services. *Active Patients at State Mental Health Facilities as of June 30, 1988.*
2. Virginia Department of Corrections. *Statistical Summary of State and Local Adult and Youth Clients: Report for December 1988.*
3. Rogers, Sack, Bloom and Manson, *Women in Oregon's insanity defense system,* The Journal of Psychiatry and Law, Winter, 516-17 (1983).
4. Heilbrun, Heilbrun and Griffin, *Comparing females acquitted by reason of insanity, convicted, and civilly committed in Florida,* 12 Law and Human Behavior 296 (1988).
5. Bureau of Census, U.S. Department of Commerce. *Projections of the Population of States by Age, Sex, and Race 1988-2010 (Series P-25, No. 1017* (1988).
6. Pasewark, *A Review of research on the insanity defense,* 484 Annals of the American Academy of Political and Social Science 106 (1986).
7. *Id.*, p. 109.
8. Center for Public Service, University of Virginia. *Estimates of Population of Virginia Counties and Cities: 1986-1987* (1988).
9. Pasewark, p. 106.
10. Steadman and Morrissey, *The insanity defense: Problems and prospects for studying the impact of legal reforms,* 484 Annals of the American Academy of Political and Social Science 126 (1986).
11. Rogers, Bloom and Manson, *Oregon's Psychiatric Security Review Board: A comprehensive system for managing insanity acquittees.* 484 Annals of the American Academy of Political and Social Science 87 (1986).
12. Rogers, Bloom and Manson, *Oregon's new insanity defense system: A review of the first five years, 1978-1982,* 12 Bulletin of the American Academy of Psychiatry and Law 383 (1984).

Figure 7

Offenses for Which DMHMRSAS Patients Were Found NGRI December 1988**

Facility	Murder	Attempted Murder	Att. Mal. Wounding & Malicious Wounding	Maiming	Attempted Rape & Rape	Felonious Assault & Assault & Battery	Attempted Arson & Arson	B&E, Robbery, Armed Robbery, Stat. Burgulary	Grand Larceny	Petty Larceny	Trespassing	Other*
CSH	26	6	12	6	2	21	9	9	2	2	6	26
ESH	2	1	1	2	1	4	-	-	2	2	2	6
WSH	1	1	3	-	2	6	-	4	1	-	1	7
Piedmont	1		-	-	-	-	-	-	-	-	-	-
SWSH	-	-	1	1	-	6	1	2	1	-	-	4
Totals	30	8	17	9	5	37	10	15	6	4	9	43

* Charges in the "other category" include: Disorderly public conduct, damaging public property, probation violation, possession of a controlled substance, possession of a deadly weapon, abduction, intent to defile, indecent exposure, resisting arrest, and attempted escape.

** The offenses listed above are those committed by the 137 NGRI patients active in the NGRI Patient Monitoring System as of December 1988. A total of one hundred ninety-three offenses were committed by these individuals. Thirty-three individuals were found not guilty by reason of insanity on more than one charge.

Virginia and Federal laws affecting substance abusers

compiled by Nils Montan

There are many laws, statutes, ordinances, rules, regulations and case precedents that may affect substance abusers in the Commonwealth of Virginia. The majority of these laws, both state and federal, are reproduced in summary form below. Some laws are directed specifically at conduct or behavior associated with substance abusers. These are generally found in the area of crimes. Other laws, like many of the anti-discrimination statutes, will affect substance abusers as a sub-class of disabled persons. Finally other laws, such as the anti-dumping provisions of COBRA, affect substance abusers only as members of the public who may be in need of certain services. (Medicaid provisions, some of which cover mental illness and therefore possibly substance abusers, require more in-depth analysis and will be examined in a future issue.) A central theme of all these laws can be seen: while the status of being an alcoholic or a drug addict in itself is not a crime or a reason for discrimination, substance abusers will be required to conform their behavior to law and, even in cases involving discrimination, may be required to actively seek treatment.

INDEX

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Virginia and federal laws affecting substance abusers

General Area	Citation	Summary	Comment
I. Discrimination			
A. Employment			
1. Federal Rehabilitation Act of 1973	29 U.S.C. § 701 through 796	Primary federal law addressing discrimination against disabled; § 791, better known as § 501, mandates affirmative action program plans for the hiring and promotion of handicapped individuals in federal agencies. Section 504, now § 794, states: "No otherwise qualified individual with handicaps. . . shall solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."	Alcoholics and drug addicts are included under the definition of "handicapped person." For purposes of § 504, handicapped person does not include an alcoholic or drug addict whose current use of alcohol or drugs prevents such individual from performing the duties of the job or who constitutes a direct threat to property or safety.
2. Comprehensive Alcohol Abuse and Alcohol Prevention, Treatment and Rehabilitation Act of 1970	42 U.S.C. § 290dd	No person may be denied or deprived of federal civilian employment or a federal professional or other license solely on ground of prior alcohol abuse or prior alcoholism. Alcohol abusers and alcoholics are not to be discriminated against in admission to hospitals or outpatient facilities that receive federal funds. Patient records must be kept confidential.	Overlaps with § 501. This law is the authority for confidentiality regulations under 42 CFR § 2.
3. Federal Drug Prevention Statute	42 U.S.C. § 290ee	Same as 42 U.S.C. § 290dd, but applies to drug abusers.	
4. Virginians with Disabilities Act	Va. Code Ann. §§ 51.5-1 to 46	Prohibits handicap discrimination in any program receiving state financial assistance and prohibits employment and educational discrimination against any "otherwise qualified person." Provides narrower coverage than Federal Rehabilitation Act of 1973 in that it applies only to employers not covered by the federal act. Disability must at the same time be more severe and unrelated to employment, and the employee must be fully qualified to be "otherwise qualified."	Disabled person is defined in a manner different from that of a handicapped person in the Federal Rehabilitation Act of 1973. In connection with § 51.5-41 covering private employers, the term does not include active alcoholism or current drug addiction. Private right of action for injunctive relief and compensatory damages is created.
5. Virginia Human Rights Act	Va. Code Ann. §§ 2.1-714 to 725	Prohibits discrimination in employment on the basis of race, color, age, marital status, and disability. Conduct which violates Civil Rights Act of 1964 or Fair Labor Standards Act is "unlawful discrimination" under this act.	Creates Council on Human Rights within the Office of the Governor empowered to hear complaints of discrimination. No independent or private cause of action to enforce its provisions is created.
6. Local Human Rights Ordinances	Va. Code Ann. § 15.1-37.3:8	Allows municipal and county governments to enact human rights ordinances not more stringent than the Virginia Human Rights Act.	
B. Housing			Some of the above statutes will apply to discrimination in housing. In particular, § 51.5-45 of the Virginians with Disabilities Act states that all persons with disabilities shall be entitled to full and equal opportunity to acquire housing offered for sale, rent, lease, or compensation.

General Area	Citation	Summary	Comment
1. Fair Housing Amendments Act of 1988	42 U.S.C. §§ 3601 through 3619 24 CFR 100	Expands the coverage of Title VII of the Civil Rights Act of 1968 to prohibit discriminatory private housing practices based on handicap and familial status.	The term "handicap" includes a mental impairment which substantially limits one or more of a person's major life activities; a record of such person's major life activities; or being regarded as such an impairment. The term does not include current, illegal use of or addiction to a controlled substance.
2. Federal Rehabilitation Act of 1973	29 U.S.C. § 701 through 796	Section 504 (29 U.S.C. § 794) prohibits discriminatory public housing practices.	
3. Virginia Fair Housing Law	Va. Code Ann. §§ 36-86 to 94	Prohibits discrimination in housing practices because of, *inter alia*, "handicap." Prohibits restrictive covenants executed after July 1, 1986, which seek to prevent ownership or occupancy to, *inter alia*, a group home for no more than six mentally ill persons.	New law effective July, 1989. Substance abusers may qualify under definition of mentally ill set forth in Va. Code Ann. § 37.1-1, which includes under definitions for commitment purposes "any person who is a drug addict or alcoholic."
4. Zoning Ordinances	Va. Code Ann. § 15.1-486.2	Seeks to promote the inclusion of mentally ill and disabled to live in all areas of the community. Local zoning laws for residential districts must provide for foster homes or group homes. Conditions may not be placed on homes unless required to protect residents.	Subject to enhanced reasonable review under the Equal Protection Clause. See *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985).
C. Medical Treatment			
1. Hill-Burton Act (Hospital Survey and Construction Act)	42 U.S.C. §§ 291 to 291c(e); 42 CFR 124.501 *et seq.*	The Act provides federal funds for the construction and modernization of hospitals on the condition that the hospitals provide certain medical care, including emergency care, to certain indigents. Under regulations, hospitals may only transfer a patient when appropriate medical personnel determine that discharge or transfer will not subject patient to substantial risk.	Portions of this Act and regulations were promulgated to prevent "patient dumping" which occurs when a hospital that is capable of providing needed medical care sends a patient to another facility or simply turns the patient away because the patient is unable to pay. Substance abusers are often the victims of this practice.
2. Consolidated Omnibus Reconciliation Act of 1986 (COBRA)	42 U.S.C. § 1395dd	As a condition of participation in Medicare, hospitals must treat all patients in emergency conditions and women in active labor.	Enacted as an "anti-dumping" measure in response to perceived weaknesses of the Hill-Burton Act. But, if a hospital determines that the patient is not in active emergency, it is free to transfer. Furthermore, once a patient is stabilized, COBRA no longer applies.
3. Insurance law	Va. Code Ann. §§ 38.2-3412, 38.2-3413	Individual, group accident and sickness insurance policies providing coverage of a family member of the insured or subscriber must provide coverage for incapacitation by, or physiological or psychological dependence on alcohol or drugs, and offer additional coverage.	In cases of alcohol and drug rehabilitation, § 38.2-3412 provides that benefits may be limited to 90 days of active inpatient treatment in covered person's lifetime. Optional coverage must be made available pursuant to § 38.2-3413, including at least 45 days treatment as inpatient or 45 sessions of counseling as an outpatient during any given policy or calendar year.

General Area	Citation	Summary	Comment
4. HMO law	Va. Code Ann. §§ 38.2 through 4300	Health maintenance organizations must offer substance abuse services.	Section 38.2-4302 conditions the issuance of the required license on the plan's provision of "basic health services." The State Corporation Commission is prohibited from requiring more substance abuse services (by way of defining "basic health services") than are required in insurance contracts. See Regulation No. 28, effective September 1, 1987.
II. Social Security Benefits	42 U.S.C. § 401 *et seq.*	Provides disability payments to individuals prevented from engaging in substantial gainful activity.	
III. Mental Health Laws	Va. Code Ann. § 37.1-37.1, *et. seq.*	Provides for the involuntary detention and commitment of mentally ill, including drug addicts and alcoholics. Sections 37.1-203 through 37.1-223 establish certain substance abuse services.	Creates Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) responsible for administration, planning and regulation of substance abuse services in Virginia. The Department is empowered to encourage general hospitals to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate treatment. Promulgates standards for treatment facilities.
IV. Crimes			
A. Controlled Substances			
1. Alcohol	Va. Code Ann. §§ 4-1 *et seq.*	Regulates the sale and distribution of alcoholic beverages. Section 4-62 prohibits sale of any alcoholic beverages to any person who is believed to be "intoxicated."	
2. Drugs	Va. Code Ann. §§ 18.2-247 *et seq.*; 21 U.S.C. § 801 *et seq.*	Prohibits possession, manufacture, distribution, importation, etc., of certain controlled substances, including heroin, marijuana, cocaine, LSD, etc.	
B. Public Drunkenness	Va. Code Ann. § 18.2-388	Prohibits public drunkenness. May allow transportation of public inebriates to detoxification centers.	Alcoholism is not a defense to a prosecution for public drunkenness.
C. Interdiction	Va. Code Ann. §§ 4-51, 4-62	Following a hearing, a "habitual drunkard" may be subjected to an order or interdiction prohibiting sale of alcoholic beverages to such person.	The term "habitual drunkard" encompasses one who is admittedly in the continual habit of being intoxicated. Does not make status of alcoholism a criminal offense, but makes specific behavior, e.g., purchase of alcohol, unlawful. This section and the Virginia common law do not impose dram shop liability.
D. Vehicles			
1. Motor Vehicles	Va. Code Ann. § 18.2-266	Prohibits operation of motor vehicle, engine or train while operator has a blood alcohol concentration (BAC) of 0.10 percent or more by weight by volume or while such person is under the influence of any narcotic drug.	Provides for revocation of license and participation under certain circumstances in Virginia Alcohol Safety Action Program (VASAP). Pursuant to § 46.1-427, a person discharged from an institution operated by the DMHMRSAS may be subject to having a license revoked if considered not competent because of "inebriety" or "drug addiction." Other statutes, e.g. § 46.1-359, bar the issuance of a license to "habitual drunkards" or addicts.

General Area	Citation	Summary	Comment
2. Motor Boats	Va. Code Ann. § 29.1-738	Prohibits operation of motorboat or vessel while under the influence of alcohol, narcotic drug, or other self-administered intoxicant, which impairs ability to operate the motorboat or vessel safely.	
3. Aircraft	Va. Code Ann. § 5.1-13	Prohibits operation of aircraft while under the influence of intoxicating liquor or of any narcotic or habit-forming drugs.	This is a felony providing for a minimum of one year of incarceration.
E. Firearms	Va. Code Ann. § 18.2-285	It is unlawful for any person to hunt with firearms while under the influence of alcohol or a narcotic drug.	
F. Defense of Crimes	Common Law	Voluntary drunkenness or drug intoxification affords no excuse for crime, but in cases of first degree and capital murder, voluntary intoxification may negate deliberation and premeditation.	
1. Insanity	Common Law	Insanity caused by excessive drinking may excuse an act which would be criminal otherwise if a specific intent were required.	
V. Regulation of Professions			
A. Certified Alcoholism and Drug Counselors	Va. Code Ann. § 54-932	Creates Virginia Board of Professional Counselors which, through drug and alcoholism counselor certification committee, licenses and certifies alcoholism and drug counselors.	Now called substance abuse counselors.
B. Reporting Statutes			
1. Health care practitioners	Va. Code Ann. § 54.1-2907	Requires practictioners of the healing arts in Virginia to report the treatment for alcoholism or drug addiction of persons licensed by the Boards of Dentistry, Medicine, Nursing, Pharmacy, or Psychology.	
	Va. Code Ann. § 54.1-2908	Requires president of associations or societies to report disciplinary actions taken against physicians for conduct involving drug addiction or alcohol abuse.	
C. Consent			
1. Minors	Va. Code Ann. § 54.1-2969 (D)(3)	Authorizes outpatient substance abuse treatment of minors without consent of parents.	

Book Review

Handbook of Forensic Psychology,
edited by Irving B. Weiner and Allen K. Hess.
New York: Wiley, 1987, 725 pages, $52.50.

by Tracy D. Eells, M.A.

A forensic psychiatrist recently commented to me that psychology is "where it's happening in forensics" these days. The publication of *Handbook of Forensic Psychology* and its diverse content support this statement. According to the editors, Irving B. Weiner and Allen K. Hess, their goal is to provide "a comprehensive overview of the central topics in forensic psychology and detailed guidelines for the effective application of psycho-legal knowledge in psychological practice." Further, they hope the text will serve as "a practice manual and a reference guide to significant issues and relevant literature in the field."

To a great extent, the *Handbook* achieves its goals. It does indeed cover a wide range of forensic psychology topics in good depth. The book's strength, however, lies more in its coverage of conceptual issues and relevant research than in the instruction it provides on "nuts and bolts" practical matters such as writing forensic reports, conducting forensic evaluations, setting fees, managing confidentiality questions and communicating with lawyers and judges. Curiously, there is no chapter on the application of psychological testing in legal proceedings. Practical questions are addressed in the text, but often in terms too general to apply to the day-to-day work of a forensic clinician. One exception is the excellent chapter on court testimony. In general, the *Handbook* would be an excellent adjunct to a forensic evaluation workshop, but would not be sufficient as a substitute.

The 700-plus page book is organized into six sections: the background of forensic psychology, applications in civil proceedings, applications in criminal justice, communicating expert opinions, treatment and professional issues. The breadth of coverage of the *Handbook* is apparent from the following partial list of chapter topics: mediating domestic law issues, assessing educational handicaps, civil competency, assessing and predicting violence, evaluating eyewitness testimony, recommending probation and parole, specific intent and diminished capacity, defining and assessing competency to stand trial, consulting with police, lie detection, forensic uses of hypnosis, psychotherapy with criminal offenders, intervention with victim/survivors, the ethics of forensic psychology and graduate training in psychology and the law.

Because the breadth of issues covered in the text is so great, I will limit most of my subsequent comments to those chapters that most appeal to me and are likely to be of general interest. These include the chapters on prediction of future dangerousness, specific intent and diminished capacity, and assessment of criminal responsibility.

Future dangerousness

The chapter, "Assessing and predicting violence: Research, law, and applications" by Thomas R. Litwack and Louis B. Schlesinger, impressed me as a sophisticated and thorough discussion of the topic. The authors draw greatly from the work of University of Virginia Law Professor John Monahan, but arrive at their own, somewhat more optimistic, conclusions. The ability of mental health experts to make accurate predictions about the future dangerousness of individuals remains an open question in their view.

The authors squarely address critics' claims that mental health professionals have no ability beyond the lay person in predicting future violence, or alternatively, that even in the best of circumstances clinicians are accurate only one out of every three times. The authors assert that no evidence exists to support such claims and that the claims are probably wrong. In supporting this position, they review much of the research that led to the "one-out-of-three rule of thumb" and raise several points suggesting that this rate may be an underestimate:

- Inmates predicted to be violent but nevertheless released are not representative of inmates in general, but are probably marginal cases in which some evidence of future nonviolence is present. (The authors do not address the question of prison overcrowding as a motivation for release.)
- Low rates of apprehended crimes reduce the accuracy of prediction.
- Precautions may be taken against individuals predicted to be violent, thus reducing the observed frequency of subsequent violence.
- The magnitude of subsequent violence for offenders predicted to be violent may be greater than that for individuals predicted not to be violent (but who are nevertheless violent).

Some critics find that even highly accurate tests of future violence will falsely predict violent behavior in an unacceptably large number of individuals when the base rate for such activity is low. The authors, however, argue that this "base rate problem" is overstated. They counter that certain groups in society have base rates of violence far greater than that of the general population and that using these more relevant figures would greatly reduce overpredictions. Secondly, high rates of overprediction may be acceptable when the consequences of a prediction of violence are relatively minimal.

Litwack and Schlesinger also show that research on prediction of future violence has been limited to a relatively narrow range of situations. Factors not taken

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into consideration, for example, are recent history of repeated violence without subsequent confinement and the presence of current intentions to commit violence. These factors, of course, are often critical when clinicians make recommendations about civil commitment or provide testimony.

The authors also point out that predictions of future violence rarely take into account the situational context of that violence. For example, a woman who batters an infant during an episode of postpartum depression may be far less likely to do harm once the depression lifts, but the risk may recur if she has another child. There is a long tradition of research in social psychology demonstrating that clinicians tend to overpredict cross-situational consistency of behavior. Finally, the authors argue that few predictions in the research literature are based on careful clinical examinations. They do not, however, consider Paul Meehl's well-known research indicating that predictions based on clinicians' intuition and reason are overwhelmingly poorer than those based on statistical models.

Having thus "cleared the field" the authors propose clinical guidelines for assessing future dangerousness. On rational and common sense grounds they suggest certain criteria that would justify civil commitment to prevent future violence. These include threats of intentions to commit violence (particularly when motivated by delusional thinking), a recent history of violence and a more distant history of violence, combined with continuing violence-prone attitudes on the part of the potential perpetrator and situational similarities with events that led to violence in the past. The authors also discuss a clinically-based classification system (previously formulated by Litwack) based on environmental, situational and motivational factors.

In this chapter the authors make the "negative case" well: that research has not shown all predictions of future dangerousness to be poor or limited to a one-out-of-three accuracy ceiling. The positive case that prediction can improve, however, is not made nearly as strongly. No research is offered to support it. And while common sense (and experience) dictate that certain individuals in certain situations are more at risk to commit violence, carrying out confirmatory research has obvious ethical problems.

Further, the question can legitimately be raised as to whether the "expert" training such as that acquired by clinicians is necessary to evaluate the above-cited criteria for civil commitment. While clinicians may have special skills in eliciting, detecting and assessing proneness toward violence, the prediction research should not be overlooked or ignored just because a given situation does not exactly match that in a research design. The existing research demonstrating low accuracy rates and a tendency to overpredict violence, plus the potential harmful consequences to individuals who are wrongly predicted to be violent, should humble any clinician offering an opinion on future dangerousness.

The diminished capacity defense

Charles R. Clark's chapter, "Specific intent and diminished capacity," reviews traditional and contemporary views of this rarely used but potentially more popular defense. In addition he discusses conceptual problems with the term "capacity," ultimate issues with regard to the defense and various strategies for testimony on diminished capacity.

The diminished capacity defense as usually conceived is nonexculpatory but if successful, reduces the level of an offense on charges that require the formation of a specific intent. For example, first-degree murder requires not only the *actus reus* of a killing, but also the formation of "malice aforethought" in the mind of the killer. If this component of the crime cannot be demonstrated beyond a reasonable doubt, the defendant may be acquitted of first-degree murder, but still be convicted of a lesser offense, such as voluntary manslaughter. (The authors note a court decision implying that in certain nonhomicide cases where there is no lesser charge, diminished capacity may be a complete, exculpatory defense.)

According to Clark, a key theoretical distinction must be made and traditionally has been made between the insanity defense and the diminished capacity defense. The former involves questions of responsibility whereas the latter, at root, questions whether the crime actually occurred. If the specific intent required for a particular crime was not formed, then that crime, in effect, did not occur. In this regard diminished capacity is more closely related to involuntarism defenses than to the insanity defense. In practice, however, as the defense evolved in California, it took on aspects of an insanity defense. Clark suggests that "the

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fundamental rationale of the California diminished capacity approach was the need to ameliorate the harshness of the M'Naghten insanity rule."

The theoretical distinction between specific intent and the insanity defense has practical consequences in how the clinician proceeds in an evaluation. Before discussing this, however, Clark traces the "rise and fall" of the defense in recent years. The term "specific intent" traditionally provided no room for clinical expertise. It was viewed in the objective or facts-speak-for-themselves sense that if an act was committed, courts assumed by the nature of the act that specific intent was involved. For example, proof that the defendant took a weapon to the scene of a crime would have satisfied any specific intent element of the crime.

Through a series of court decisions in California beginning in 1949, a subjective interpretation of intent was gradually brought into application. That is, the question of whether an individual was capable of forming a mental state required to commit a crime was allowed in testimony, thus creating the opportunity for the input of mental health professionals. Legal standards were articulated to guide decisions. For example, in *People v. Wolff* the California Supreme Court ruled that premeditation requires an individual to reflect "maturely and meaningfully" upon the contemplated offense and that the "quantum of moral turpitude and depravity" needed to be evaluated. In *People v. Conley* the court ruled that an individual must be able "to comprehend his duty to govern his actions in accord with the duty imposed by law" for first-degree murder to have been committed. These standards approach the volitional component of the American Law Institute's Model Penal Code for the insanity defense.

The expansion of the subjective definition of specific intent culminated with the Dan White trial. In November, 1978, the San Francisco supervisor shot and killed at point-blank range San Francisco Mayor George Moscone and fellow Supervisor Harvey Milk after walking into City Hall with a revolver and ten extra rounds of ammunition. White was charged with first-degree murder. Based on earlier California court decisions, however, White's lawyers elicited expert witness testimony that White was manic-depressive and so incapacitated by the consumption of "junk food—Twinkies, cupcakes, and Cokes" that he could not have formed the specific intent required for either first-degree or second-degree murder. White was convicted of the lesser offense of voluntary manslaughter. The jury's agreement with the expert witness led to public outrage and the eventual outlawing by statewide initiative of the diminished capacity defense in California. Consequently, the status of the defense is presently in a state of disarray. Nevertheless, states Clark,

> It lives on explicitly in case law if not statute in a number of jurisdictions and is probably constitutionally implicit in the others. But it lives on. . . through the use of intent constructs explicitly devoid of subtle, subjective, and deeper meaning. As such, diminished capacity is a potentially far stricter approach toward considering mental abnormality than is insanity.

After tracing the history and current status of the diminished capacity defense, Clark discusses the role of the expert witness in providing testimony on the question of specific intent. He points out, first of all, that courts have offered few guidelines to clinicians. The definitions that have been provided are not helpful from the clinical point of view, particularly in defining the bottom limits for intent, i.e., criteria for determining when intent was not formed. Given this state of affairs, one approach taken by clinicians has been to base their testimony on what psychological processes or states they conclude intent ought to require. Such an approach has not been prohibited by law, and, according to Clark, can probably be given without objection. Clark's view is that conclusions based on such speculation are improper, beyond the scope of clinicians' expertise and "appear to remain mere value judgments."

If the traditional "facts-speak-for-themselves" view of intent is used as the standard, a logical dilemma arises for the clinician. Clark explains: "If it appears that something bearing a strong resemblance on its face to the alleged criminal intent was entertained by the defendant, what can be offered on strictly clinical grounds about capacity for intent?" This is a version of the "duck" question facing President Bush about taxes: If a crime "looks like a duck, acts like a duck, quacks like a duck, it probably is a duck;" that is, the unlawful behavior probably does satisfy the specific intent requirement, or at least provides little ground for expert clinical opinion otherwise.

Clark does discuss certain rare cases where expert testimony may be useful in describing individuals who are unable to form specific intent. These include mental retardation below a certain level, crimes committed under the influence of hallucinogens, and offenses motivated by an obsessive-compulsive disorder. In certain cases, however, the insanity defense may be a better alternative. Clark concludes: "The history of diminished capacity and its logic suggest that psychology and other disciplines cannot give relevant responses to every question."

Assessing criminal responsibility

The chapter by Stephen L. Golding and Ronald Roesch on the assessment of criminal responsibility, their second contribution to the *Handbook*, nicely complements that on diminished capacity. They provide considerable information about historical and contemporary approaches to assessing responsibility, the "guilty but mentally ill" finding currently operational

in some states (the authors strongly oppose the standard), the conducting of criminal responsibility evaluations and necessary qualifications of an expert witness.

The authors take the approach that mental health professionals have a legitimate role to play in the courtroom, but that abuses do occur. Blame, however, must be shared by all parties involved. Golding and Roesch illustrate the point with the anecdote that certain outrageous statements given by a prosecution expert psychiatrist, Dr. Grigson, in the landmark *Barefoot* case were not countered by a defense witness. Among Dr. Grigson's claims were that there was a "one hundred percent and absolute chance" that Barefoot would be a continuing threat to society; that on a psychopathy scale of one to ten, Barefoot was "above a ten"; and that these claims were supported by the American Psychiatric Association. This is clearly misrepresentation and exaggeration (not to mention hubris), but it could have been minimized or avoided had a defense counterpart been put on the stand.

Although the article covers much ground, the authors appear to assume some basic familiarity by the reader of insanity standards. For example, the "Durham product test" (i.e., that a defendant is not criminally responsible if his unlawful actions were the product of a mental disease or defect) was discussed before a definition was provided. Furthermore, the clarity of the article might have been improved if the material had been organized into additional and shorter sections.

* * *

These are just a few of the subjects discussed in the *Handbook of Forensic Psychology*. The remaining chapters expand on the range of activities available to mental health professionals in relation to the law. Regardless of one's stances on the topics covered the reader will come away from the book with greater understanding and with an appreciation for alternative points of view. In sum, the book provides an excellent introduction to forensic psychology and an excellent springboard into further reading. The *Handbook* would be of value to the entire range of professions providing mental health services to the legal and correctional systems. □

Charters, *Continued from page 3*

prison disciplinary committees, civil service boards and the like."

In a brief dissent, Judge Murnaghan—the author of the now-vacated panel opinion—stressed the potential for conflict of interests, suggesting that the prospect that the views of the governmental medical officials who administer Butner "may be inclined to coincide with" those of their "fellow employees," the federal prosecutors was "not remote." "Fairness," he concluded, required the "assurance of an unbiased decision," adding, "[o]ne side effectively unopposed is not enough."

* * *

Hidden agendas

Before attempting to answer whether competency still matters after *Charters,* it is necessary to look at the sub-texts of the opinion a bit more closely. Even a fast reading reveals at least half a dozen "hidden agenda" issues that need to be considered—issues where the *en banc* court glossed over serious legal issues with cursory quotations from off-point precedent, ducked important underlying issues of social science and empiricism, and relied on heuristic reasoning devices and an unarticulated notion of "ordinary common sense" in coming to its decision. I will briefly list these issues simply for you to reflect upon before coming to your own conclusion as to whether *Charters II* holds water.

First, in its reliance on *Youngberg,* the court commits two significant errors of omission. It fails to even confront the way the *Charters I* court carefully distinguished *Youngberg* based on some fundamental factual differences between the two cases—the contrast between the "profundity" of the *Youngberg* plaintiff's handicap (severe mental retardation) and Charters's mental illness; the distinction between the treatment modalities in *Youngberg* (temporary soft arm restraints) and in Charters; and the history of numerous prior injuries in *Youngberg* and the utter absence of such a history in Charters's case. In its first important textual reference to *Youngberg,* the *Charters II* court characterizes the plaintiff there as an "institutionalized mental patient." This reference is flatly incorrect: the *Youngberg* plaintiff, Nicholas Romeo, was a severely mentally retarded resident of a state school for the retarded; while the panel had noted the significance of this distinction ("[*Youngberg*] did not consider the rights of a competent patient to determine the course of his medical treatment"), it somehow escaped the *en banc* court on rehearing.

Perhaps even more curious is the court's failure to recognize the existence of the recent fourth circuit decision of *Thomas S. v. Morrow. Thomas S.* involved a mentally handicapped young adult who had been "shuffled" through forty foster homes and institutions after having been given up for adoption at birth. In substantially affirming a district court decision finding that the plaintiff had a right to treatment in a suitable community residence, the fourth circuit stressed that *Youngberg* "did not allow the professionals free rein." Paradoxically in *Thomas S.* the treatment provided to the plaintiff by institutional defendants conflicted with professional judgment; the district court had even

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pointed out that the plaintiff's treatment was modified "to conform to the *available* treatment, rather than to the *appropriate* treatment, for plaintiff's condition." No mention is even made in *Charters II* of the *existence* of the ongoing *Thomas S.* litigation.

Second, the *en banc* court's repeated reliance on *Parham* for the proposition that more relaxed due process procedures might be appropriate is, to say the least, puzzling. *Parham* dealt with the commitment of juveniles, and its holdings were premised on a very specific vision of the way that parents, allegedly, make certain medical decisions for their children with their offspring's best interests at heart. There, for instance, former Chief Justice Burger wrote:

> Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. . . The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically, it has recognized that natural bonds of affection lead parents to act in the best interests of their children.

Putting aside the fact that his assumptions have been virtually universally criticized as lacking an empirical or scientific basis, it strains credulity to believe that the fourth circuit actually felt that the same paternalistic impulses motivate federal correctional institutional officials in their dealings with pretrial detainees. Similarly, its citation to *Parham's* invocation of "common human experience" that suggests the "supposed protections of an adversary proceeding . . . may well be more illusory than real" simply ignores the entire body of post-*Parham* social science literature rebutting the Supreme Court's allegedly common-sensical reading.

An important decade has passed since *Parham* concluded that there was no reason to expect that courts had much to add to the diagnostic work done in public hospitals by mental health professionals. During that period of time there has been ample development —both in the case law and in the social science literature—of the realities of drug management in such facilities: the trial records of cases such as *Rennie v. Klein, Rogers v. Okin, Davis v. Hubbard* and others are eloquent testimony to the sad reality that, unpoliced, a significant number of such hospitals engaged in clear patterns and practice of serious abuse of psychotropic drugs on a regular and repetitive basis.

Third, the *en banc* court's reference to the "cumbersomeness, expense and delay incident to judicial proceedings" tellingly is without citation. Had the court done even the most rudimentary research it would have discovered that, in reality, judicial proceedings in this context are nothing of the sort. As noted in the vacated panel opinion, few patients actually avail themselves of the due process protections available. Also, it ignores the burgeoning data base of empirical studies that has begun to examine what actually happens when there is a right-to-refuse-treatment order entered. The few studies yet conducted—virtually unanimously—belie the fear of the creation of an expensive, time-consuming, counterproductive layer of due process hearings.

* * *

The opinion also ignores, *in toto*, the *advantages* that may flow from due process protections. For at least a decade there has been a modest body of developing literature suggesting that involuntary civil commitment hearings had a therapeutic potential. A recent study conducted by Dr. Francine Cournos and her associates at Manhattan Psychiatric Center, a New York public hospital under the *Rivers* order, concluded that the new procedures offered patients "considerably greater representation and participation," in that it gave them an opportunity to hear a detailed discussion of their physician's reasoning and to present their own views, thus enabling them to, perhaps, "gain a better understanding of the need for treatment through a process that offers this degree of patient involvement." To some extent, such procedures appear to respond frontally to the observation made by Drs. Van Putten and Ray quoted by Judge Brotman in the *Rennie* trial: "Schizophrenics have been asked every question except 'How does the medication agree with you?' Their response is worth listening to."

In addition the court's fear of time-consuming "battles of the experts" is similarly unfounded, and, again, reflects a failure to evaluate studies of the impact of similar decisions elsewhere, again, including the developing data base in *Rivers*, which reveals "quicker decisions" in drug refusal cases which should benefit all concerned. The Cournos study at Manhattan Psychiatric Center concluded that the adoption of more stringent legal procedures "did not delay or diminish requests for or approval of involuntary treatment."

To buttress its argument here, the court engages in selective docket reading, citing an unreported case to support its assertion that, using the panel's due process formulation, medication refusals will be routinely upheld; inexplicably it failed to point out that the one *reported* post-*Charters* case granted the government's motion to forcibly medicate under the very terms of the panel's *Charters* opinion.

* * *

Fourth, the court, like so many others, reflects the unconscious turmoil caused when faced with a case involving a mentally disabled criminal defendant. It throws up its hands and professes institutional inability to sort out "opposing scientific assessments" (indeed, it suggests that these are utterly irreconcilable and that there is not "any possible basis for judicial choice between" such varying positions on issues such as the perniciousness of drug side-effects), notwithstanding the many recent scholarly and thoughtful contributions to this area—most notably by John Monahan and Laurens Walker—on how courts can and should

"read" and weigh social science data. Its criticism of the panel in this regard for relying on "selected items in the legal and medical literature" is baffling. First, the panel cited extensively to standard medical works as well as to survey articles summarizing the important scientific developments in this area over the past two decades. Second, a reading of the cited law review articles illuminates the way that these sources generally relied on standard medical journals and texts, as well as other law review articles by acknowledged medical experts, for their data.

By characterizing judicial involvement in this area as "already perilous," it reveals the depth of its fears. This rhetoric is not accidental; it reflects the court's almost palpable discomfort in having to confront the questions before it. Its reluctance here is yet one more manifestation of the phenomenon articulated by Judge Bazelon twenty years ago:

> . . . Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed jam on fish life, while they reject a similar scrutiny of the effect of psychiatric treatment on human lives. . . It can hardly be that we are more concerned for the salmon than the schizophrenic.

Thus, the court's refusal to even *weigh* the side-effects evidence leaves the nonexpert reader in a quandary: are there two equal bodies of studies that simply cancel each other out? Are there differences in the methodologies that somehow tip the scales in one way or another? Are all of the values under consideration to be given equal weight? Are there new scientific "breakthroughs" that are "just over the horizon?" The court's refusal to even engage in scholarly discourse offers us no clue as to the answers to these questions, and gives us no description of the new and important developments in such areas as "neuroleptic malignant syndrome" and other recent topics of importance to serious researchers in this area.

The court's use of Baldessarini's "cornerstone of management" quotation, for instance, ignores more recent qualifications by the same author:

- that chronic patients respond least satisfactorily to *any* treatment (including psychopharmacology);
- that the optimal role of such drugs in the long-term treatment of patients "remains a matter of investigation";
- that, in addition to their "uncertain benefits in some conditions," the use of antipsychotic agents" is compromised by common and characteristic forms of early and late-onset neurological side-effects";
- that "*all* of the antipsychotic agents" currently in use "exact some unwanted effects on the central nervous system."

[See *Significance of neuroleptic dose and plasma levels in the pharmacological treatment of psychoses.* 45 Arch. Gen. Psychiat. 79 (1988).] Again the reader has no sense of this, due, in part, to the court's utter abdication of its role in weighing, analyzing and applying the best available social science data to the case before it.

The court's discomfort is reflected in other curiosities in the opinion: its incantation of *Parham's* language as to the use of "accepted medical practices in diagnosis, treatment and prognosis" takes as a given that such practices are actually employed in public psychiatric institutions, an assumption belied by nearly two decades of litigation all flowing from a scandalous abdication of such professional responsibility in facilities across the nation. Its conclusion that the fact that *Charters* offered no evidence that the initial drugging decision lay "completely beyond the bounds of tolerable professional judgment . . . *undoubtedly* reflects the fact that no such evidence was available" suggests a picture of the judges' heads buried deeply in the sand.

Without making any reference to the specific level of counsel made available to *Charters* in this case, it can be said without fear of contradiction that counsel generally provided to involuntarily confined mental patients is grossly inadequate, and that this inadequacy is magnified in cases involving the mentally disabled criminal defendant, a state of affairs further exacerbated by the general lack of funds available to indigent criminal defendants to pay for expert witnesses in cases that do not fall within the strict four corners of *Ake v. Oklahoma.* It is hard to believe that the fourth circuit majority was unaware of this reality.

Finally by applying the most minimalist perspective to *Youngberg* and *Parham* in the sterile context of the *Mathews v. Eldridge* "balancing" calculus, the court creates a standard that, it would appear, is virtually impregnable: a sole test of whether the decision making process was "so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one." Can we conceive of actions that violate the standard? Perhaps if we learned that a doctor intentionally medicated a patient into a coma so that he might amorously pursue the patient's spouse, or if another doctor, in a drunken stupor, injected the wrong medicine into the patient's vein, or another took a bribe from a patient's business competitor to insure his long-term institutionalization, or another was in fact not a doctor but an imposter, we could say with some assurance that these actions met the test. Of course, all of these scenarios would meet tests for medical malpractice and delicensure, and perhaps might violate criminal statutes as well. In short the standard appears to be a non-standard.

The better example might be found in the trial record in *Rennie*: the defendants' medical directors agreed that drugs were used for control, and as a substitute for treatment, and staff members intentionally failed to acknowledge overt physical manifestations of tardive dyskinesia because of "institutional self-interest." Would this behavior come within the *Charters* standard? I wouldn't bet on it.□

Fall forensic symposium

The Institute of Law, Psychiatry and Public Policy's Fall Forensic Symposium will be held Friday, October 27, 1989, at the Boar's Head Inn in Charlottesville, VA. The program has been approved for CME, CEU and CLE credit. For more information, contact W. Lawrence Fitch, Director of the Forensic Evaluation Training and Research Center, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901 (804/924-5435).

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Commitment and recommitment: Shortcomings in the application of the law

by Charles D.H. Parry, Eric Turkheimer and Paul Hundley

The Gap between the letter and the practice of the law

Civil commitment hearings

The changes in civil commitment law over the past twenty years have stimulated much empirical research. These studies[1] have been almost unanimous in concluding that the civil commitment process rarely lives up to its original legislative intent. Some exceptions have been reported, particularly in North Carolina and Florida.

In general, studies have reported low levels of preparation and activity on the part of attorneys representing mental patients. Attorneys rarely call witnesses, object to the admission of evidence, explore the use of least restrictive alternatives (LRA's), or question the conclusions of the clinical examiner. Furthermore, most appear to have limited experience of mental health law and frequently defer to the opinions and recommendations of mental health professionals, functioning more as guardians *ad litem* or as mere bystanders.

In many instances, judges discourage attorneys from taking an active part in commitment hearings. In some cases judges have taken over the role of attorneys in questioning respondents and witnesses. Proceedings are often extremely informal, and judges frequently fail to advise respondents of some or all of their rights. Moreover, judges, like attorneys, have been found to defer to psychiatric opinion in the determination of mental illness and dangerousness.

A few studies have investigated the role of clinical examiners in civil commitment hearings. These studies indicate that the opinions and recommendations of clinical examiners are powerful determinants of hearing outcome. While there is no evidence about the reliability of external clinical examiners, research does suggest that they do not always interview respondents prior to commitment hearings. Furthermore, clinicians are often inaccurate in predicting dangerousness in general. The predictive ability of clinicians is particularly important in civil commitment hearings, since dangerousness is a necessary condition for commitment under many state statutes.

Although much of the reform to civil commitment statutes was informed by a shift from a *parens patriae* to a police power basis for commitment, at least 30 states also allow for involuntary commitment if a person is so gravely disabled as a result of mental illness as to be unable to care for his or her own needs. The grave disability standard entitles the state to protect persons who are unable to care for themselves, while the dangerousness standard authorizes the state to confine individuals for the prevention of harm to the community.

In fact, grave disability is the most frequent basis for commitment. A review of five studies conducted in California and Virginia[2] indicates that a median of 95% of respondents in commitment hearings are committed on the basis of grave disability, typically without a finding of danger to self or others (Table 1). It also appears that civil commitment hearings serve as a means of "bargaining down" the grounds of the judicial order on which the respondent was initially detained from a combination of grave disability and danger to self or others, to grave disability alone at the commitment hearing. Bargaining down may

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result when respondents are less dangerous after expiration of their detention order, or when hearing petitioners realize that the judge is more likely to accept the grave disability criterion than danger to self or others. The problem with extensive use of the grave disability criterion is that it is often vaguely worded, and therefore the hardest criterion for attorneys to defend.

Another gap between the letter and practice of the law is evident in reports of non-compliance with statutory requirements for consideration of treatment in the least restrictive environment. Rates of non-compliance as high as 55% have been reported in a number of jurisdictions in Virginia,[3] and even when LRA's are considered they are rarely used.[4]

Recommitment hearings

The most serious shortcoming of research conducted on the commitment process is that it has typically considered only initial commitment hearings. Recommitment has rarely been the object of empirical investigation. If studied at all, it has been included only as an adjunct to research mainly concerned with initial commitments.[5] The recommitment process has also been given inadequate theoretical consideration. For example, the National Center for State Courts (1986), in its extensive *Guidelines for Involuntary Civil Commitment,* gives scant attention (one out of 105 pages) to recommitments.[6] Only slightly more attention is given to recommitments in the model civil commitment statutes put forward by the American Psychiatric Association and the Mental Health Law Project.[7]

Recommitments are nonetheless an important part of the commitment process. Interpolation of available figures suggests that the number of recommitment hearings exceeds 170,000 per year, and that considerable resources are expended in processing them.[8] Recommitment hearings can help provide an understanding of *why* the civil commitment process has failed to live up to its initial promise for reform.

Only two studies have specifically focused on the recommitment process. Koch et al., observed 29 recommitment hearings and reviewed patient records while on a one-day visit to each of six state hospitals in Virginia. They concluded that "the recommitment practices which have evolved in this context do not ensure that the interests of clients, families, facilities and the community services boards are well served."[9] Parry conducted a prospective study of 190 initial- and 184 re-commitment hearings at a large state hospital in Virginia, covering a rural and urban catchment area with a population of over 2,000,000. The results of this study highlight some basic features of the gap between the letter and practice of the law in commitment hearings.

Respondents in initial and recommitment hearings were found to represent distinct populations varying in age, chronicity, presence of acute psychological symptoms, and treatment history. Every inadequacy that has been reported for commitment hearings in general was as serious, and usually worse, in recommitment hearings (Table 2). Recommitment hearings were essentially non-adversarial. Attorneys were less active and were less likely to confer with their clients, question them, or question the conclusions of the clinical examiner. Clinical examiners were less likely to question the respondent in recommitment hearings. Judges were less likely to consider voluntary admission or explain respondents' right to appeal. Ninety-eight percent of respondents in recommitment hearings were involuntarily committed, compared to 70% of respondents in initial commitment hearings. Recommitments were based almost exclusively on the grave disability standard alone (94%), while 78% of initial commitments were based on this standard alone. CMHC's were substantially less involved in recommitment hearings, although state law requires their participation.

The gap between the letter and practice of the law in civil commitment hearings and the failure of the community mental health movement to live up to its initial promise have both become clichés. A more

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Table 1 Research on Commitment

	Danger to self	Danger to others	Grave disability	Number committed*
Ehrenreich, 1982**	10	8	67	70
Morris, 1988	12	4	58	60
Parry. 1989	20	26	297	313
Warren, 1977	23	30	60	81
Yesavage, 1982	22	22	29	45

*Note: some respondents are committed on more than one criterion.
**See Endnote 2 for list of articles.

interesting problem is why the gap between explicit policy and real-world practices continues to exist. The answer to this question highlights the interrelation between the civil commitment process and broader mental health policy. Civil commitment hearings are not adversarial, and psychiatric treatment not truly community based, because society is unwilling to accept the more difficult consequences of a reformed system. An adversarial commitment process would release non-dangerous yet still disturbed patients back into the community, which would then have to live in proximity to them and coordinate and finance expensive community treatments. The *status quo* pays lip service to legal rights and community care while perpetuating many aspects of a paternalistic inpatient model. *Pro forma* commitment hearings keep patients in the hospital and lessen the demand for community services; the lack of community services provides the major justification for continued involuntary commitment.

On the level of commitment hearings, a system ostensibly designed for legal adjudication of dangerousness continues to operate on the medical standard of *parens patriae*. Indeed it must, because otherwise it would be releasing patients into a community that has no means to care for them, to the detriment of the community and the patients. On the level of mental health policy, adequate community services are not provided, and the system is protected from the consequences of its failure (e.g. homelessness, criminalization) by a commitment process that hospitalizes patients who do not meet statutory commitment criteria.

Recommendations

In recommending changes to current civil commitment procedures, we will define changes that would more accurately reflect the intention of present civil commitment statutes: protection of patients' legal rights, protection of society from the dangerously mentally ill, and provision of care in the least restrictive environment, rather than take a position on whether they ought to be more or less legal as opposed to medical.

Any changes to the civil commitment system which give greater protection to patients' legal rights will result in the release of a greater number of patients. In recommitment hearings, all available data indicate that patients are rarely released under the *status quo*. In most states, failures of the commitment process that favor holding patients, such as inactive attorneys and compliant judges, far outweigh those that favor releasing them. The price of a more adversarial civil commitment process would be that patients would more often be released against the recommendation of the supervising clinician. Release of such patients would no doubt alarm both the clinicians who believe they need treatment and the community which is then faced with caring for them outside of the hospital.

Participants of hearings

Within the civil commitment process itself, there is a need for better training of attorneys, clinical examiners, and judges. All three require instruction and continuing education in mental health law and the roles and responsibilities of hearing participants; judges and attorneys should have additional training in mental health, illness, and alternative forms of treatment. (See the National Task Force on *Guidelines for Involuntary Civil Commitment,* 1986).

Attorneys and clinical examiners need independence from the judicial system, especially in jurisdictions in which they are appointed by the court. There is evidence that full-time independent public defenders perform better than private attorneys appointed by the court from an approved list.[10] Full-time public defenders have access to social workers who can assist them in getting in touch with family members and conducting an independent investigation of LRA's. They are also in a better position to investigate their client's

Continued on next page

behavior in the hospital, identify and prepare credible witnesses and negotiate with clinicians.[11]

A third issue is evaluation. Attorneys representing respondents in civil commitment hearings should be explicitly evaluated in terms of their success in securing their clients' release. Those who are habitually unsuccessful in defending their clients should be replaced. Judges' records of committing and releasing patients should be scrutinized to guard against deference to clinical opinion or unwarranted release of committable patients. Clinical examiners should be evaluated for thoroughness in their examinations. Encouraging attendance of hospital staff, patient advocates, CMHC representatives and members of patients' families would enhance accountability and public confidence.

Commitment Criteria

The majority of commitment patients, especially recommitment patients, are committed under the grave disability standard. The importance of this finding has not received sufficient attention. For better or for worse, the behavior of the system demonstrates a desire to hold non-dangerous patients involuntarily when they need treatment and no other options are available. Nonetheless, the *status quo* is inefficient, and ultimately unethical, because it continues to construe itself as a system for legally based dangerousness commitments. If mentally ill patients who are dangerous neither to themselves nor others must be committed, the commitment should proceed according to carefully specified statutory requirements. The nature of grave disability must therefore be specified in greater detail, and evidentiary requirements established for civil commitment hearings.

Present statutes require that patients be treated in the least restrictive alternative, but provide no means of establishing the presence or absence of LRA's. In addition to specifying what is meant by grave disability, procedures must be set out for demonstrating the absence of LRA's. Such a procedure would serve two purposes. It would protect the rights of patients, especially those hospitalized for long periods, for whom it may be more expedient to provide warehousing in the hospital than to actively seek LRA's. At the same time, it would provide ongoing documentation of the need for community treatments for patients being held under the grave disability without LRA standard.

National Mental Health Policy

No changes to the civil commitment process can be effective without viable alternatives to hospital

Table 2 Behavior of Attorneys, Clinical Examiners, and Judges in Initial and Recommitment Hearings

Behavior of Hearing Participants	Percentage of Initial Commitments N=190	Percentage of Recommitments N=184
Attorneys		
Did not confer	46.3	81.5
Did not review respondent's file	62.1	63.6
Did not question respondent	55.3	82.1
Did not question conclusions of the clinical examiner	89.5	96.7
Low level of activity*	60.5	85.3
Clinical examiners		
Did not question respondent**	1.6	18.5
Did not ask respondent about ability to care for self	32.6	65.2
Judges		
Did not mention possibility of voluntary admission***	79.0	93.5
Did not mention right to appeal	67.9	91.9

*Attorneys were ranked as having a "low level of activity" if they said nothing on behalf of their clients and did not question other witnesses or the clinical examiner, but merely signed the certification papers.

**In these cases the clinical examiners tended to rely solely on written records of the testimony of witnesses.

treatment. Obviously, more money must be spent on community treatment if it is to provide such alternatives. Reallocation of money that is already being spent on mental health services could produce major improvements in funding of non-institutional treatment. At the federal level, enactment of a new Social Security title would combine into a single funding source the billions of dollars now disbursed for care of the mentally ill under other programs such as Medicaid.[12] Stipulations of Medicaid, Medicare, and SSI could be changed to encourage community-based treatment of chronic mental patients.[13] Money from the federal Department of Housing and Urban Development could be allocated to assist mentally ill patients who desire to live in group homes.[14] Incentives should be provided for private insurers to increase coverage of outpatient mental health care.

At the state and local level, reallocation of federal block grants could provide greater support for the needs of this population in the community. Creation of an integrated system of care in which services and money follow the patient would prevent different parts of the state mental health system from competing for limited resources in counterproductive ways.

The need for most of these changes has been recognized for some time. One reason they have not come about is that a compliant civil commitment system continues to house, clothe, and feed the very population the community mental health system was designed to provide for. The modifications we have proposed would result in more patients being released into the community or held for the explicit reason that no LRA's are available. Either outcome would make the shortcomings of current community-based treatment options more difficult to ignore and would pressure policy makers to address the problem directly. There are two options: an explicit return to institutional care or legislative and financial development of community-based alternatives. Failure to face this choice will perpetuate dissatisfaction with the civil commitment process, lessen the impetus for a meaningful community mental health system, and condemn the mentally ill to a choice between long-term institutionalization and inadequate community care.□

Notes

1. *See:* Bursztajn, Gutheil, Mills, Hamm, & Brodsky, *A process analysis of judges commitment decisions: A preliminary empirical study,* 143 Am. J. of Psychiatry, 170-174 (1986); Ehrenreich, Roddy, & Baxa, *Civil commitment in Virginia: Variations between law and practice,* Unpublished manuscript, University of Virginia, Charlottesville, VA (1982); Hiday, *Reformed commitment procedures: An empirical study in the courtroom,* 11 L. & Soc'y Rev., 651-666 (1977a); Hiday, *The role of counsel in civil commitment: Changes, effects and determinants,* 5 J. of Psychiatry & L., 551-569 (1977b); Hiday, *Court decisions in civil commitment: Independence or deference?* 4 Int'l J. of L. & Psychiatry, 159-170 (1981a); Hiday, *The attorney's role in involuntary civil commitment,* 60 N.C. L. Rev., 1027-1056 (1982); Hiday, *Are lawyers enemies of psychiatrists? A survey of civil commitment counsel and judges,* 140 Am. J. of Psychiatry, 323-326 (1983c); Koch, Mann, & Vogel, *Mental health recertification and recommitment practices in Virginia,* Unpublished manuscript, The Office of Quality Assurance, Geriatric Services, & Mental Health Services, Commonwealth of Virginia (1987); Lelos, *Courtroom observation study of civil commitment,* In A.L. McGarry, R.K. Schwitzgebel, & P.L. Lipsitt (Eds.), Civil commitment and social policy, pp. 102-125, (1981); Lipsitt & Lelos, *Decision makers in law and psychiatry and the involuntary civil commitment process,* 17 Community Mental Health J., 114-122 (1981); Monahan, *The prevention of violence.* In J. Monahan (Ed.), Community mental health and the criminal justice system pp. 13-34 (1976); Peters, Miller, Schmidt, & Meeter, *The effects of statutory change on the civil commitment of the mentally ill,* 11 L. & Hum. Behav., 73-99 (1987); Shuman & Hawkins, *The use of alternatives to institutionalization of the mentally ill,* 33 SW. L.J., 1181-1217 (1980).

2. Ehrenreich, *supra* note 1; Morris, *Civil commitment decisionmaking: A report on one decisionmaker's experience,* 61 S. Cal. L. Rev., 291-351 (1988); Parry, *Commitment and recommitment: A prospective study of the interaction between mental health and judicial systems,* Unpublished doctoral dissertation, University of Virginia, Charlottesville, VA (1989); Warren, *Involuntary commitment for mental disorder: The application of California's Lanterman-Petris-Short Act,* 11 L. & Soc'y Rev., 629-649 (1977); Yesavage, Werner, Becker, & Mills, *The context of involuntary commitment on the basis of danger to others: A study of the use of the California 14-Day certificate,* 170 J. of Nervous and Mental Disease, 622-627 (1982).

3. Ehrenreich *supra* note 1; Grouse, Avellar, & Biskin, *A clinical and legal evaluation of the need for involuntary commitment,* 2 Dev. in Mental Health L., 33-34, 42-43 (1982).

4. Hiday, *Court discretion: Application of the dangerousness standard in civil commitment,* 5 L. & Hum. Behav., 275-289 (1981b); Hiday & Goodman, *The least restrictive alternative to involuntary hospitalization, outpatient commitment: Its use and effectiveness,* 10 J. of Psychiatry & L., 81-96 (1982).

5. In addition to Ehrenreich (1982), *supra* note 1, Hiday & Goodman, *supra* note 4, and Peters *supra* note 1, *see* Hiday, *Judicial decisions in civil commitment: Fact and attitudes and psychiatric recommendations,* 17 L. & Soc'y Rev., 517-529 (1983a).

6. National Task Force on Guidelines for Involuntary Civil Commitment, *National Center for State Courts' Guidelines for involuntary civil commitment,* 10 Mental & Physical Disability L. Rep., 409-514 (1986).

7. *See* Parry, *Civil commitment: Three proposals for change,* 10 Mental & Physical Disability L. Rep., 334-338 (1986) and Stromberg & Stone, *A model state law on civil commitment of the mentally ill,* 20 Harv. J. on Legis., 275-396 (1983).

8. *See* Goldman & Morrissey, *The alchemy of mental health policy: Homelessness and the fourth cycle of reform,* 75 Am. J. of Pub. Health, 727-731 (1985) and Rosenstein, Milazzo-Sayre, MacAskill, & Manderscheid, *Use of inpatient psychiatric services by special populations,* In Manderscheid & Barrett (Eds.), Mental Health United States, 1987 (DHHS Pub. No. (ADM)87-1518, pp. 59-97). Washington, DC: U.S. Government Printing Office (1987).

9. Koch, *supra* note 1, at 13.

10. Hiday, 1982, *supra* note 1; Luckey & Berman, *Effects of a new commitment law on involuntary admissions and service utilization patterns,* 3 L. & Hum. Behav., 149-161 (1979).

11. Decker, *Psychiatric management of legal defense in periodic commitment hearings,* 34 Soc. Probs., 156-171 (1987); Hoffman & Dunn, *Beyond Rouse and Wyatt: An administrative-law model for expanding and implementing the mental patient's right to treatment,* 61 Va. L. Rev., 297-339 (1975).

12. Sharfstein, *Reimbursement resistance to treatment and support for the long-term mental patient,* 33 New Directions for Mental Health Services, 75-85 (1987).

13. Price & Smith, *Two decades of reform in the mental health system* (1963-1983), In Seidman (Ed.), Handbook of social intervention, pp. 408-437 (1983).

14. Drinan, *Who will fend for the chronically mentally ill in the community?* 55 Psychiatric Q., 208-214 (1983).

"What's in a name?"

Changing definitions in the Nursing Home Reform Act

by James C. Bumpas

The Omnibus Budget Reconciliation Act (OBRA) (P.L. 100-203) was signed into law on December 22, 1987. This legislation contains statutory requirements for a preadmission screening and annual resident review to determine the appropriateness of nursing facility placement for persons with mental retardation and mental illness. In addition, the Act mandates that assessments be conducted of all persons with mental illness and mental retardation living in nursing facilities to determine whether they require active treatment and if so, to establish provisions for meeting those needs.

The requirements of the Act are aimed at reducing the number of persons admitted to nursing homes whose needs can best be met in other settings and to improve the quality of services for those persons residing in nursing facilities. Nationally, the annual cost for implementing all of the requirements of the OBRA nursing home provisions have been estimated by the American Health Care Association to reach $2.626 billion dollars. The passage of OBRA '87 marks a significant shift in national policy and in funding resources with respect to the provision of residential and long-term care services for persons with mental retardation and mental illness.

Currently there are 15,000 nursing homes nationwide that participate in the Medicare/Medicaid program. It is estimated that 56% to 80% of the 1.5 million residents in long-term care facilities have diagnosable dementias or some degree of cognitive impairment, mental disorder, and/or behavior problems. A study conducted by Pearl German and her associates at Johns Hopkins University in 1986 found that 50% of the respondents in nursing homes have a diagnosable mental disorder or cognitive impairment. A national survey of nursing homes conducted in 1977 found that approximately 80,000 persons with a primary or secondary diagnosis of mental retardation were living in nursing homes and that 42% of this population were 63 or over. In Virginia there are 205 Medicaid-participating nursing homes with 25,000 total residents. Preliminary estimates indicate that 8.5% of this population or 2,100 have diagnoses of mental retardation and 5.5% or 1,375 have diagnoses of mental illness.

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Provisions of the Act

OBRA '87 adds Section 1919, entitled, "Requirements for Nursing Facilities," to the original Social Security Act passed in 1935. This section revises statutory provisions governing certification standards and enforcement procedures applicable to Medicaid-funded nursing homes. As of October 1990, the distinction between skilled nursing facility and intermediate care facilities will be eliminated and uniform requirements will be established for a "nursing facility." The OBRA regulations apply to both Medicaid and private pay residents.

The requirements of OBRA have significant implications for the delivery of nursing facility services. Specifically, these changes have focused on the identification of individual resident needs and the delivery of quality, effective, and essential services for meeting those needs. Under the law each nursing facility must establish a quality assessment and assurance committee consisting of the administrator of the nursing home, a physician, and three other staff members. The purpose of the committee is to identify necessary quality assurance activities and implement plans to correct quality deficiencies.

A Plan of Care must be developed and reviewed quarterly for each resident by a team which includes the individual residing in the nursing home or his or her representative family, the attending physician, and a registered nurse. The Act specifies that a comprehensive, accurate, standardized assessment of each resident's functional capacity and significant impairments must be completed no later than four days after admission and once a year thereafter. Assessments must be reviewed and updated based on progress every three months.

Section 1919 (b)(4)(A) states that nursing facilities must provide 24-hour licensed nursing services and utilize the services of a registered nurse for a minimum of eight consecutive hours a day, seven days a week. States may request a waiver of the provision of nursing and registered nurse services if they are unable to recruit the required staff and if a registered nurse or physician is available to respond to calls. A full-time professional social worker is required to be hired by all nursing facilities with 120 beds or more. The Act requires that all nurse aides employed as of July 1, 1989 complete a state approved training program and competency evaluation by January 1, 1990. The nursing facility must provide performance reviews and in-service education programs for nurse aides on a regular basis.

States are responsible for certifying nursing facility compliance by conducting annual standard surveys.

The survey is designed to assess the nursing facility in the following areas: quality of care, written plans of care, and compliance with residents' rights. Under the provisions of the Act each nursing facility will be surveyed on an average of every twelve months but no longer than fifteen months after the previous survey. The survey is to be conducted without notification to the facility. The Secretary of DHHS will establish the qualifications and the protocol for administration of state surveys by January 1, 1990. Nursing facilities who are found not in compliance at the time of the surveys may be subject to civil or financial penalties.

Target populations

The provisions of OBRA '87 apply to those persons with mental illness, mental retardation, or related conditions who currently reside in a nursing facility or are applying for residence in a nursing facility. Although final federal regulations have not been made available, the fourth draft of the *State Medicaid Manual* (Department of Health and Human Services Health Care Financing Administration, 1989) provides the criteria to be used in determining whether an individual is a member of the target population. As defined by the proposed regulations, an individual is considered to have mental illness if he or she has a current primary or secondary diagnosis of a mental disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R) and does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder. An individual is considered to have mental retardation if a level of retardation (mild, moderate, severe, or profound) is found, as described in the American Association on Mental Deficiency's manual on *Classification in Mental Retardation.* A related condition means the individual has a severe, chronic disability other than mental illness that occurs before age 22 and is found to be closely related to mental retardation, because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation.

The legislation does not allow categorical exclusions for any persons with one of the above diagnoses due to age or medical condition.

Implementation of OBRA '87

OBRA '87 requires the establishment of a Preadmission Screening and Annual Resident Review (PASARR) process in each state. The criteria to be used by states in making PASARR determinations have been established in the fourth draft of the *State Medicaid Manual.* Screenings are to be conducted in a two-step process. First, a Level I screening is required to identify whether individuals may have a mental illness or mental retardation. Second, the Level II process is supposed to determine whether an individual requires the level of services provided by a nursing facility and, if so, whether the individual requires active treatment.

In Virginia a nursing home preadmission screening program to determine whether the individual meets the level of care criteria for nursing facility care was implemented in 1977 and will continue. A second part has been added to correspond to the Level I screening described in the *State Medicaid Manual:* if the care criteria are met, a supplemental checklist is completed to determine if there is evidence of possible mental illness, mental retardation, or related conditions which require further evaluation and possible active treatment. Where there is evidence of mental illness or mental retardation, a Level II assessment must be completed. Based on this second, more comprehensive evaluation, it is determined if there is a diagnosis of mental illness or mental retardation and if active treatment is needed. Persons found to need active treatment may not be placed in the nursing facility.

As a result of the OBRA '87 requirements, emergency regulations were promulgated in Virginia effective January 1, 1989. These regulations add the participation of mental health and mental retardation professionals from local Community Services Boards; they will conduct assessments in those cases where mental illness, mental retardation, and/or related conditions are a factor. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is responsible for reviewing the outcome of these assessments and making the final determination of the need for active treatment. Final regulations incorporating the OBRA requirements into the nursing home preadmission screening process appear in 5 Virginia Register of Regulations 4055 and are to be effective October 25, 1989.

The American Health Care Association estimates that the cost of providing active treatment will be approximately 1,642.5 million annually which must be funded with state dollars.

The Act restricts the placement of any new residents with a diagnosis of mental illness, mental retardation, or a related condition into a nursing facility after January 1, 1989, unless they require the level of care that is provided by a nursing facility and are found not in need of active treatment. By law the responsibility for developing and implementing the preadmission screening program is assigned to the mental health/mental retardation authority in each state. Medicaid funding for any person with mental illness, mental retardation, or related conditions admitted to a nursing home after January 1, 1989, is threatened for states that did not implement preadmission screening programs by that date.

Continued on next page

All current residents of nursing facilities with diagnoses of mental illness, mental retardation, or a related condition must be assessed to verify those diagnoses and to determine the need for active treatment. Nursing home residents who are members of the target population must receive annual resident assessments as long as they remain in a Medicaid-certified nursing facility. As stated earlier, this applies to private pay residents as well as Medicaid recipients.

In addition to determining the appropriateness of the placement, the PASARR also requires the determination of an individual's active treatment needs. The fourth draft of the *State Medicaid Manual* provides the following definition of active treatment:

> A continuous program for each client with mental retardation or mental illness which includes aggressive, consistent implementation of a program of specialized and generic training, and specific therapies or treatments, activities, health services and related services, as identified in an individual plan of care, which has the following characteristics:
>
> For individuals with mental illness, the plan must be developed under and supervised by a physician. The prescribed components of the individualized active treatment program must be provided by a physician or other qualified mental health professionals.
>
> For individuals with mental retardation, the individual program plan must be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client's needs and to designing programs that meet the client's needs.

The purpose of active treatment is to provide individuals with a wide range of services which will assist them with functioning as independently as possible. For individuals with mental retardation, the purpose of active treatment is to direct them toward the acquisition of the behaviors necessary to function with as much self-determination and independence as possible and to prevent or decelerate regression or loss of current optimal functional status.

For persons with mental illness who are experiencing an acute episode of severe mental illness which necessitates 24-hour supervision by trained mental health personnel, the purpose of active treatment is to diagnose or reduce the recipient's symptoms which necessitated institutionalization, to improve his or her level of functioning and, whenever possible, to achieve the recipient's discharge from inpatient status at the earliest possible time. The American Health Care Association estimates that the cost of providing active treatment will be approximately $1,642.5 million annually which must be funded with state dollars.

Nursing facility placement is considered appropriate for persons whose physical condition necessitates the level of nursing and medical care provided. For individuals who require active treatment, a disposition plan must be designed to assure that the active treatment needs are met in the appropriate setting. Persons who have lived in the nursing facility for less than 30 months continuously (admission after October 1, 1987) and who are inappropriately placed must be transferred to an appropriate facility. Individuals who have lived in the nursing facility for more than thirty months and are determined to be inappropriately placed must be allowed to choose whether they would like to remain in the nursing facility or be transferred to a setting where active treatment will be provided. If it has been determined that the individual requires active treatment and has decided to stay at the nursing facility, then arrangements must be made to provide active treatment in the nursing facility.

The Act requires that all residential assessments must be completed and case dispositions made by April 1, 1990. Section 1919 (7) (E) of the Act specifies that a state may enter into an agreement with the Health Care Financing Administration by April 1, 1989 which would permit the state to have an extended period of time for completing the case dispositions. This agreement, termed an Alternative Disposition Plan, is the only opportunity afforded states to gain additional time to come into compliance with the provisions of the legislation. In Virginia an Alternative Disposition Plan (ADP) was submitted and has been approved which extends the implementation date or the case dispositions from April 1, 1990 to July 1, 1993. The Virginia ADP does not apply to persons with mental illness since the number of persons in this category was projected as too small to justify an extension.

Issues related to implementation of OBRA

OBRA creates significant challenges for states, expecting them to implement the complex, far-reaching provisions for a large number of persons in a relatively short period of time. In addition to questioning the adequacy of the resources essential for coming into compliance with the Act, states have expressed concern over not having more precise and timely guidance from the Health Care Financing Administration.

Lawsuits have been filed by four states (Idaho, Arkansas, Louisiana, Texas), arguing that the Secretary of DHHS has violated the Administrative Procedure Act by 1) failing to issue valid implementing guidelines, 2) creating immediate financial harm for nursing facilities, and 3) violating constitutional rights of due process and liberty for private pay individuals. Suits have been filed in the District of Columbia by the American Association of Homes for the Aging (AAHA) and the American Health Care Association (AHCA) seeking declaration that OBRA's preadmission screening requirements are illegal, in violation of the statutory and constitutional rights of plaintiffs, their members, and individuals seeking nursing facility admission. The suit by AAHA and AHCA seeks a nationwide injunction to prohibit the Secretary of DHHS from implementing the preadmission screening requirements until regulations are properly and legally promulgated.

The Act requires that states provide the specialized services to meet an individual's active treatment needs; however, no federal funds have been made available to pay for these services. The *State Medicaid Manual* states that it is not permissible to claim reimbursement for active treatment services as part of the nursing facility's payment rate. The use of other Medicaid coverages to fund active treatment programs is acceptable. Although the inclusion of alternative funding sources is a well-intentioned attempt to clarify the circumstances under which a state may legitimately claim Medicaid reimbursement for such services, the advise also raises more questions than it answers. This is particularly true in Virginia since Rehabilitation and Clinic Services are not currently covered under the State Medicaid Plan for these populations.

The legislation does not clearly define active treatment or differentiate between active treatment and those services residents are entitled to in a nursing facility. In addition, the Act does not spell out the specifics of providing active treatment, particularly the delivery of active treatment by providers other than the nursing facility. The confusion surrounding the distinction between active treatment and nursing facility services clearly has its roots in the mixed messages conveyed in the applicable provisions of the 1987 law. The National Association of State Mental Health Program Directors and the National Association of State Mental Retardation Program Directors have joined with the National Governors Association and organizations representing State Medicaid Directors in calling on Congress to amend the statute in order to eliminate these existing contradictions.

A bill sponsored by Representative Henry Waxman was introduced by the House Energy and Commerce Committee on July 13, 1989. The Medicaid Budget Reconciliation Bill addressed many concerns expressed by advocates and changes the definition of active treatment to "specialized services" to clarify the distinction between nursing facility services and active treatment services. Other key provisions of the bill are to:

a) Exempt private pay residents from review until 24 hours after they are deemed eligible for Medicaid. Also exempt from PASARR would be those individuals readmitted after a hospital stay for less than thirty days of nursing facility care.

b) Protect states from enforcement sanctions if they acted in good faith to implement the PASARR process before regulations were developed.

c) Change the definition of mental illness to a serious mental illness as defined by the Secretary, which would eliminate the screening of persons with certain emotional conditions that are not of a serious nature.

d) Allow the revision of Alternative Disposition Plans by October 1, 1990 upon the approval of the Secretary.

e) Prohibit the subcontracting of the preadmission screening and annual resident review responsibilities of the state mental health/mental retardation authorities to nursing facilities or related entities.

f) Require states to report annually to the Secretary on the number and disposition of individuals with mental illness or mental retardation found to require specialized services but not to require nursing facility care.

The proposed amendments have been passed by the House and the Senate appears supportive of the changes. However, as of October, 1989 inclusion in the Budget Reconciliation Bill is uncertain.

The impact of the Act is viewed as positive in some respects, but negative in others. Positively, it increases the potential for matching a client with appropriate services, provided those services exist. On the negative side, confusion over the intent of the Act, compounded by the lack of final regulations by HCFA, results in frequent debate over the definitions of active treatment and mental illness. As a result, decisions regarding appropriate placement in nursing facilities may be delayed longer than necessary. Issues related to the appropriate placement for older persons have been found to be less complex than those related to children and young adults. Among the younger group, it is agreed that in most instances, nursing home placement may not be the most appropriate placement alternative. However, when the presence of medical and physical conditions justifies nursing home level of care, the determination that active treatment is needed may not only block nursing home placement but also result in the individual being determined ineligible for personal care services since these services are tied to a Personal Care Waiver.

In Virginia assessments of current residents in nursing homes are being conducted statewide; this process will be completed by April 1990. The true impact of OBRA will not be recognized until this process is completed and placement alternatives are identified.

Special Justice Training

The Institute of Law, Psychiatry and Public Policy at the University of Virginia is planning a training program in civil commitment for special justices June 4 & 5, 1990. The schedule will begin at 1 p.m. on Monday and end at noon on Tuesday. This training is provided under contract with the Supreme Court of Virginia. Efforts are currently underway to develop a roster of all special justices in the state. Any special justice or individual working with a special justice is encouraged to contact the Institute. For more information, call or write: Sandra Carter, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901; 804-924-5435.

In the Virginia Supreme Court

Proof of intentional tort required

***Ruth v. Fletcher,* 237 Va. 366, 5 VLR 1915 (1989).**

A plaintiff suing on the grounds of intentional infliction of emotional distress must establish adequate proof that the defendant set out intentionally or recklessly to cause emotional distress. In reaching its decision, the Virginia Supreme Court relied on its earlier decision in *Womack v. Eldridge,* 215 Va. 338, 210 S.E.2d 145 (1974), to determine the proper elements necessary for establishing prima facie evidence of an intentional infliction of emotional distress unaccompanied by physical injury.

Patricia Ann Wilson Ruth was accused of having sexual relations with two men, the plaintiff and a bartender, within less than a week. She conceived a child and convinced the plaintiff that the child was his. He provided emotional support during the pregnancy and birth, and later agreed to provide monetary support. The unmarried couple established a schedule of visitation with the child, who came to recognize the plaintiff as his father. When the mother married a third man and her husband wished to adopt the child, the plaintiff would not consent to the adoption. The mother then disclosed what she had suspected or known for a long time: that the child was the biological product of her union with the bartender. She cut off the plaintiff's visitation rights and proved that he was not the child's father. The plaintiff sued for emotional distress and the case was tried before a jury.

Since 1974, Virginia recognized in *Womack* that a cause of action exists for emotional distress—provided that four elements are shown:

> One, the wrongdoer's conduct was intentional or reckless. This element is satisfied where the wrongdoer had the specific purpose of inflicting emotional distress or where he intended his specific conduct and knew or should have known that emotional distress would likely result. Two, the conduct was outrageous and intolerable in that it offends against the generally accepted standards of decency and morality. This requirement is aimed at limiting frivolous suits and avoiding litigation in situations where only bad manners and mere hurt feeling are involved. Three, there was a causal connection between the wrongdoer's conduct and the emotional distress. Four, the emotional distress was severe.

At trial, the jury returned a monetary verdict for the plaintiff. The Virginia Supreme Court reversed the judgment of the trial court and entered a judgment in favor of the defendant. In applying the facts of the present case to the test employed in *Womack,* the court could not find for the plaintiff since they beieved he failed to meet the requisite elements of an intentional infliction of emotional distress.

Testator must be found "enfeebled in mind"

***Jarvis v. Tonkin,* ___Va.___, 380 S.E.2d 900 (Va. 1989).**

A unanimous Virginia Supreme Court reversed a chancellor's decree and found that an elderly woman's will was not procured by undue influence allegedly exerted by the principal beneficiary. In siding with the adopted daughter of the deceased, the court made it clear that a will may be challenged and set aside in Virginia only when the undue influence amounts to coercion or duress.

The controversy surrounded the legitimacy of a will executed in 1981 by 86 year old Ella Myers Wood of Portsmouth. That will, executed when Mrs. Wood was in poor physical health but mentally competent, superseded an earlier will which had divided her property equally among her adopted daughter, Mary Ella Wood Wickers Jarvis, and two foster children, Julie Pierce and Nadir Tonkin. Instead, the 1981 will left $3,000 to each of the foster daughters and left the bulk of the estate to Mary Ella. The foster daughters contested this will, arguing that Mary Ella exerted undue influence upon her mother in getting the 1978 will changed.

The court pointed out that while the 86 year old woman was "physically feeble"—she had been diagnosed prior to executing the will at issue as suffering from congestive heart failure, swollen ankles, weakness, and impaired breathing—Mrs. Wood was not mentally incapacitated. In fact, Justice Russell wrote, the record was devoid of any evidence that Mrs. Wood was "enfeebled in mind" when she executed the 1981 will. Moreover, her adopted daughter exerted no undue influence under Virginia law when she secured an appointment with a lawyer at her mother's request. That lawyer—Richmond attorney Lee R. Gordon— testified that Mrs. Wood was specific in stating her wishes about changing the will, and when she executed the will, it was "obvious that she was an adult of sound mind and knew what she was doing."

The supreme court reaffirmed the test it established last year in *Martin v. Phillips,* that a presumption of undue influence may arise in the case of a will where the contestant proves by clear and convincing evidence that

> (1) the testator was enfeebled in mind when the will was executed;
>
> (2) the requisite confidential or fiduciary relationship was accompanied by activity in procuring or preparing the favorable will;
>
> (3) the testator previously had expressed a contrary intention to dispose of his property.

235 Va. 523, 528, 369 S.E.2d 397, 400 (Va. 1988). Only where the first requirement is met—i.e., the testator is found to be "enfeebled in mind" when executing the document—will the court even consider a presumption of undue influence.

However, the opinion provides little guidance in determining what factors may be considered in assessing the mental state of persons like Mrs. Wood. Evidence that the testator is merely "old" or physically incapacitated is surely not enough to set aside a will under Virginia law. A working definition of "mental weakness" sufficient to raise a presumption of undue influence will have to wait for later case law to develop.

Court finds "individualized education plan" suitable

***School Board of Campbell County v. Beasley,* ___Va.___, 380 S.E.2d 884 (Va. 1989).**

In this case, the Virginia Supreme Court considered whether the School Board of Campbell County failed to provide handicapped student Darren Scott Beasley with a "free and appropriate" public education as required by the federal Education of the Handicapped Act (EHA), 84 Stat. 175, as amended, 20 U.S.C. § 1400 *et. seq.* (1982 ed. and Supp. V).

Under the Act, in order to qualify for federal funds, a state must demonstrate that it "has in effect a policy that assures all handicapped children the right to a free appropriate public education." 20 U.S.C. § 1412(1). The "free appropriate public education" required by the EHA is designed to meet the unique needs of the handicapped student by means of an "individualized educational program." (IEP) 20 U.S.C. § 1401(a)(18). As implemented in Virginia, if a school district is unable to provide such an education to a handicapped student, it must, under certain circumstances, reimburse the student and his parents for the reasonable tuition cost at a private school. Code § 22.1-218(A).

Although the appeal arose in a procedural context, in which the court was asked to determine the narrow issue of whether the court of appeals had applied an incorrect standard of review to the circuit court's original decision in the case, the Justices nevertheless reviewed the various provisions of the EHA as well as Virginia's statutory protections available to the handicapped student and his parents.

At the time of suit, 14 year old Darren Beasley was a seventh-grader in the Campbell County School System. He was diagnosed as suffering from a severe reading disability. Refusing to keep him in the public school system, Darren's parents transferred him to the Oakland School, a private institution in Boyd Tavern. The Beasleys then filed for a due process hearing, pursuant to Virginia Code § 22.1-214(B), to have school officials pay for Darren's private residential schooling.

After a hearing officer ruled in favor of the Beasleys, finding that the school district's IEP was unsuitable, the school board filed a civil action in the circuit court of Campbell County, attempting to reverse the hearing officer's finding that the Beasleys were entitled to tuition reimbursement for the costs of private schooling, since the school district had not offered Darren a "free and appropriate" public education as required by law.

The circuit court ruled in favor of the school board, but a panel of the Virginia Court of Appeals unanimously reversed the trial court. *Beasley v. School Board,* 6 Va. App. 206, 367 S.E.2d 738 (Va. Ct. App. 1988). Noting the importance of the substantive issue raised by the appeal, the Supreme Court agreed to hear the case.

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In the United States Supreme Court

No constitutional duty to protect child

***DeShaney v. Winnebago County Dept. of Social Services,* ___U.S.___, 109 S.Ct. 998, (1989).**

In one of the most emotionally charged cases of last term, the Supreme Court, in a 6-3 vote, held that a social services agency in Wisconsin and several of its employees did not violate the constitutional rights of an abused child when they failed to remove him from his violent father's custody. While the majority and two dissenting opinions agreed that the agency and its employees did little to protect the abused child after learning of repeated acts of abuse, the Court was bitterly divided over the question of when such protection from "private abuse" can rise to a constitutional level.

As Chief Justice Rehnquist pointed out early in his majority opinion, "[t]he facts of this case are undeniably tragic." Ten year old Joshua DeShaney is, as a result of repeated abuse by his father, severely brain-damaged and destined to spend the rest of his life confined to an institution for the profoundly mentally retarded.

His tragedy began at an early age. In January 1982, when Joshua was two years old, authorities in Winnebago County, Wisconsin, first learned the child might be a victim of child abuse. After complaints by his father's second wife to local police, Winnebago County Department of Social Services (DSS) interviewed the father, Randy DeShaney, but he denied the accusations, and DSS dropped the matter. One year later, Joshua was admitted to a local hospital with multiple bruises and abrasions. DSS was notified and immediately obtained a court order from a Wisconsin Juvenile Court Judge placing Joshua in the temporary custody of the hospital. However, three days later, a county-convened ad hoc "Child Protection Team"—consisting of a pediatrician, a psychologist, a police detective, the county's lawyer, several DSS caseworkers, and various hospital officials—decided there was insufficient evidence of child abuse to retain Joshua in the court's custody. The young boy was thus returned to the custody of his father, who agreed to undergo counseling.

One month later, however, emergency room personnel called the DSS caseworker handling Joshua's case to report that he had once again been treated for suspicious injuries. The caseworker concluded there was no basis for action. During the next six months, the caseworker visited Joshua at his home and observed a number of suspicious injuries. She dutifully noted her observations and continuing suspicions that someone in the DeShaney household was abusing Joshua, yet she took no other action. In November 1983, DSS was notified for the third time that Joshua was treated for child abuse-related injuries. The caseworker attempted to visit Joshua twice more but was told he was too ill to see her. The caseworker took no action. In March 1984, Randy DeShaney beat four year old Joshua so severely that he fell into a life-threatening coma. Emergency brain surgery revealed a series of hemorrhages caused by traumatic head injuries inflicted over a long period of time. Randy DeShaney was subsequently convicted of child abuse.

The caseworker's reaction to the news of Joshua's last and most devastating injuries (which Justice Brennan dissenting, took pains to point out) was predictable, given the knowledge of the boy's predicament: "I just knew the phone would ring some day and Joshua would be dead."

Joshua and his mother filed suit under 42 U.S.C. § 1983 in the United States District Court for the Eastern District of Wisconsin against Winnebago County, DSS, the caseworker, and other individual employees. The complaint alleged that DSS and the other defendants deprived Joshua of his liberty without due process of law, thus violating the fourteenth amendment, by failing to intervene to protect him against a risk of violence at his father's hands of which they knew or should have known. However, the district court granted summary judgment for the defendants, and the Court of Appeals for the Seventh Circuit affirmed the dismissal. Two reasons were given for dismissing the lawsuit:

> (1) the due process clause of the fourteenth amendment does not require a state or local governmental entity to protect its citizens from "private violence, or other mishaps not attributable to the conduct of its employees;
>
> (2) the causal connection between the County's conduct and Joshua's injuries was "too attenuated" to establish a civil rights violation under 42 U.S.C. § 1983.

However, at least two other circuits had reached opposite conclusions. In *Estate of Bailey by Oare v. County of York,* 768 F. 2d 503, 510-511 (3rd Cir. 1985), and in *Jensen v. Conrad,* 747 F. 2d 185, 190-194 (4th Cir. 1984), *cert. denied,* 470 U.S. 1052 (1985), it was argued that once the state learns that a child is in danger of abuse from third parties and actually undertakes to protect him from that danger, a "special relationship" arises between the state and the child, which imposes an affirmative constitutional duty to provide adequate protection. To resolve this conflict among the circuits, the Supreme Court granted certiorari to resolve the following issue: "When, if ever, does the failure of a state or local governmental entity or its agent to provide an individual with adequate protective services constitute a violation of the individual's due process rights?"

While obviously sympathetic to Joshua's plight, especially in light of the failure of DSS and its employees to protect him from repeated abuse by his father, the majority, led by the Chief Justice, sided squarely with the Seventh Circuit that the fourteenth amendment due process clause imposes no affirmative obligation on the state to protect its citizens from "private" violence. While the state itself may not deprive individuals of life, liberty, or property without due process of law, the majority reasoned that the fourteenth amendment does not require the state to guarantee minimal levels of private safety or security. "Its purpose was to protect the people from the State, not to ensure that the State protect them from each other."

The majority distinguished earlier cases in which the Court had found that, in certain circumstances, the Constitution imposes upon the state affirmative duties of care and protection with respect to particular individuals. Such cases, the majority argued, involved incarcerated prisoners, involuntarily committed mental patients, and others who are technically in "state custody" and thus unable to care for and protect themselves from "State" abuse. Had the state placed Joshua in a state-run or sponsored foster home, the majority argued in a footnote, an affirmative duty to protect him might have arisen. However, in a passage which the three dissenting Justices bitterly assailed, the majority stated "[W]hile the State may have been aware of the dangers that Joshua faced in the free world, it played no part in their creation, nor did it do anything to render him any more vulnerable to them."

In a strong dissent, Justice William Brennan took issue with the Court's assertion that the state "stood by and did nothing" with respect to Joshua. Through its child-protection program, Brennan argued, "the State actively intervened in Joshua's life and, by virtue of this intervention, acquired ever more certain knowledge that Joshua was in great danger." By failing to act, given its awareness of the danger, the state effectively condemned Joshua to suffer abuse at his father's hands, Brennan argued. Thus, "children like Joshua are made worse off when persons and entities charged with carrying out [Wisconsin's child protection program] fail to do their jobs."

Justice Blackmun, who separately submitted an angry and emotional dissent, complained, "poor Joshua! Victim of repeated attacks by an irresponsible, bullying, cowardly, and intemperate father, and abandoned by [DSS] who placed him in a dangerous predicament. . ." Blackmun disagreed with the majority that DSS was merely a passive observer to Joshua's tragedy and argued that its "active intervention" triggered a constitutional duty to aid him once DSS learned of the danger to his life. Blackmun concluded: "[I]t is a sad commentary upon American life, and constitutional principles—so full of late of patriotic fervor and proud proclamations about 'liberty and justice for all,' that this child, Joshua DeShaney, now is assigned to live out the remainder of his life profoundly retarded."

Supreme Court rules on execution of the mentally retarded

Penry v. Lynaugh, ___U.S.___, **109 S.Ct. 2934 (1989).**

The United States Supreme Court has ruled that mentally retarded criminal offenders may be sentenced to death, but only if the sentencing jury has been permitted to consider and give effect to evidence of mental retardation offered by the defense in mitigation of penalty. Because the instructions under which Penry was sentenced to death provided no opportunity for the jury to take into account Penry's evidence in mitigation, Justice Sandra Day O'Connor concluded, they were defective. Penry's sentence was vacated for violation of the eighth amendment's prohibition of cruel and unusual punishment.

The defendant in this case, Johnny Penry, was charged with capital murder in the rape-killing of a woman in Texas. An evaluation of Penry's competency to stand trial revealed that he was mildly to moderately retarded, with an I.Q. of 54 and a mental age of 6½ years. Nonetheless, he was found competent to stand trial.

At his trial, Penry raised the defense of insanity and presented the testimony of a psychiatrist, Dr. Jose Garcia. Dr. Garcia testified that Penry suffered from organic brain damage and moderate mental retardation, which impaired his impulse control and rendered him unable to learn from experience. Dr. Garcia testified further that, because of his disability, Penry was unable to appreciate the wrongfulness of his conduct or conform his conduct to the requirements of the law. The prosecution presented two psychiatrists who testified that although Penry was a person of extremely limited mental ability and seemed unable to learn from his mistakes, nonetheless he was sane under Texas law. Moreover, these psychiatrists diagnosed a coexisting antisocial personality disorder. The jury convicted Penry of capital murder.

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At Penry's sentencing hearing, the judge instructed the jury to answer three "special issues": (1) whether the killing was deliberate, (2) whether Penry was dangerous, and (3) whether the killing was unreasonable in response to the provocation, if any, of the victim. If the jury's response to each issue was "yes," the sentence was to be death; otherwise, Penry would be sentenced to life in prison. Penry's attorney objected to these instructions, arguing, first, that the jury should not be permitted to impose the death penalty in light of Penry's mental retardation and, second, that, even if Penry's mental retardation were no absolute bar to a sentence of death, the judge's instructions were defective because they provided no opportunity for the jury to take into account ("give effect to") Penry's evidence in mitigation. These and other defense objections were overruled, the jury unanimously responded in the affirmative to all three special issues, and Penry was sentenced to death.

The Texas Court of Criminal Appeals affirmed Penry's conviction and sentence, and both a federal district court and the United States Court of Appeals for the Fifth Circuit rejected Penry's habeas corpus claim. The United States Supreme Court agreed to review the case to answer two questions: (1) whether the jury instructions afforded the jury an adequate opportunity to consider and give effect to Penry's evidence in mitigation, and (2) whether the death penalty may be imposed on a mentally retarded person with Penry's reasoning ability.

Addressing the first of these questions in her opinion for the Court, Justice O'Connor cited a line of prior Supreme Court decisions holding that "punishment should be directly related to the personal culpability of the criminal defendant."

> "[E]vidence about the defendant's background and character is relevant because of the belief, long held by society, that defendants who commit criminal acts that are attributable to a disadvantaged background, or to emotional and mental problems, may be less culpable than defendants who have no such excuse." [Quoting from *California v. Brown* 479 U.S. 538, 545 (1987)]

None of the three special issues the jury was instructed to answer in Penry's case, O'Connor reasoned, allowed the jury to express its "reasoned moral response" to Penry's evidence in mitigation: Penry may have acted deliberately and unreasonably in response to any provocation and, moreover, might be dangerous; yet, because of his mental retardation, poor impulse control, and history of childhood abuse, he might reasonably be regarded as "less morally culpable than defendants who have no such excuse." The jury may have recognized such reduced culpability yet "have believed that there was no vehicle for expressing the view that Penry did not deserve to be sentenced to death based upon his mitigating evidence." Therefore, Justice O'Connor concluded that the instructions to the jury were defective, and Penry's sentence was vacated for violation of the eighth amendment's prohibition of cruel and unusual punishment.

Justice O'Connor's opinion on the second question, however— whether mental retardation *per se* bars imposition of the death penalty—was less charitable. She acknowledged the common law rule that "idiots" and "lunatics" were not subject to punishment for criminal acts, but she explained that the level of disability contemplated by these conditions was far greater than that suffered by Penry. Indeed, she observed, "idiocy" at common law "correspond[ed] to what is called 'profound' or 'severe' retardation today." Given the availability of the insanity defense in most states today, she concluded, anyone so disabled "is not likely to be convicted or face the prospect of punishment." Mentally retarded persons, on the other hand, "vary greatly" in their abilities and experiences, O'Connor observed; thus, "it cannot be said on the record before us today that all mentally retarded people, by definition, can never act with a level of culpability associated with the death penalty."

Finally, Justice O'Connor reviewed several public opinion polls suggesting that Americans opposed the death penalty for mentally retarded offenders but concluded that, since only one state's legislature had acted to preclude the death penalty for such persons (Georgia's), no national consensus could be found that executing the retarded so conflicts with "evolving standards of decency" as to violate the eighth amendment's ban on cruel and unusual punishment.

Justice Brennan, joined by Justice Marshall, concurred with O'Connor's opinion that the instructions presented to the jury at the sentencing stage of Penry's trial were inadequate but dissented from her opinion that mental retardation *per se* is no bar to a sentence of death. Justice Brennan expressed sensitivity to "the risk of false stereotyping and unwarranted discrimination" that may result from treating persons with mental retardation as a homogeneous group, but argued nonetheless that, because *all* mentally retarded persons suffer "substantial disability in cognitive ability and adaptive behavior," none can be viewed as sufficiently culpable to deserve the penalty of death.

> The impairment of a mentally retarded offender's reasoning ability, control over impulsive behavior, and moral development in my view limits her culpability, so that, whatever other punishment might be appropriate, the ultimate penalty of death is always and necessarily disproportionate to her blameworthiness and hence is unconstitutional.

In a separate opinion, Justice Stevens, joined by Justice Blackmun, concurred with Brennan and Marshall, condemning imposition of the death penalty on any mentally retarded offender.

Justice Scalia, joined by Justices Rehnquist, White, and Kennedy, dissented, concluding that the Constitution neither precludes the death penalty for mentally retarded offenders nor requires jury instructions more directly responsive to mitigating factors than those presented in Penry's case. Indeed, Justice Scalia declared, Justice O'Connor's position allowing jury consideration of a wide range of evidence at sentencing was inconsistent with prior decisions of the Court calling for restrictions on jury discretion at the penalty phase of a capital trial. In Justice Scalia's view, the three special issues the jury was directed to address in Penry's case provided ample opportunity for the jury to give effect to Penry's evidence in mitigation and, moreover, represented just the kind of structure the law should impose on jury sentencing in capital cases.

—W. Lawrence Fitch

Civil commitment training

The Institute of Law, Psychiatry and Public Policy will offer three two-day seminars in civil commitment on January 17 & 18, February 20 & 21, and June 18 & 19, 1990, 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 $20.00 charge for the training materials.

Mandatory drug testing allowed

***National Treasury Employees Union v. Von Raab,* ___*U.S.*___, 109 S.Ct. 1384; *Skinner v. Railway Labor Executives' Association,* ___*U.S.*___, 109 S.Ct. 1402 (1989).**

In two of the most closely watched and eagerly anticipated cases of last term, the Supreme Court rendered its first decisions on testing for drug and alcohol abuse in the American workplace. In *National Treasury Employees Union v. Von Raab,* a closely divided Court held, 5-4, that the United States Customs Service may impose mandatory urine tests to check for drug or alcohol abuse by employees seeking drug enforcement positions. Writing for the majority, Justice Anthony Kennedy argued that, while a drug-screening program requiring urinalysis constitutes a search within the meaning of the fourth amendment, such tests do not violate privacy rights even where there is no evidence in advance of individual employee abuse. Moreover, Justice Kennedy argued, the government has a compelling interest in detecting drug use among Customs Service employees eligible for promotion to sensitive positions. In the second case, *Skinner v. Railway Labor Executives' Association,* the Court, in a 7-2 opinion (authored again by Justice Kennedy) held that mandatory blood and urine tests for railroad workers involved in accidents do not violate the fourth amendment prohibition against unreasonable searches and seizures.

In *Von Raab,* the Court was confronted with an unusual situation, in that the Commissioner of Customs, William Von Raab, admitted that "Customs is largely drug-free." Despite the apparent lack of a drug or alcohol abuse problem, Customs decided to proceed with a testing program in the belief that "there is no room in the Customs Service for those who break the laws prohibiting the possession and use of illegal drugs." Therefore, drug tests were made a condition of employment for positions that involved drug interdiction, carrying a weapon, or handling classified material. Employees who test positive for drugs and who offer no satisfactory explanation are subject to dismissal from the Service.

A group of federal employees and a union official brought suit in federal district court in Louisiana, alleging that the Customs Service drug-testing program violated the fourth amendment. The district court agreed and enjoined the program. A divided panel of the United States Court of Appeals for the Fifth Circuit vacated the injunction, finding that the drug tests were reasonable under the fourth amendment and noted that such tests were an aspect of the employment relationship. The Supreme Court affirmed the circuit court's opinion except as it related to the testing of applicants who handle classified material. There, the majority found that the record in the lower courts was inadequate and remanded that part of the case.

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Justice Kennedy argued that the government has a "compelling interest in ensuring that front-line interdiction personnel are physically fit and have unimpeachable integrity and judgment." The Court was not troubled by the apparent lack of suspicion of drug use among Customs employees, finding that the government's need to conduct so-called "suspicionless" searches outweighs the privacy interests of employees engaged directly in drug interdiction and those who are required to carry firearms on the job.

While the Court's decision in *Von Raab* does not directly affect most private employment, it is likely to send a strong signal to employers who impose or plan to impose drug and alcohol tests. The Court also did not address the constitutionality of random drug tests.

In dissent, Justice Scalia argued that the Customs Service drug testing program is a "kind of immolation of privacy and human dignity in symbolic opposition to drug use." Scalia pointed to the fact that there appears to be no drug problem among employees at Customs and dismissed the program as an empty if symbolic gesture. Justices Kennedy, Marshall, and Brennan also dissented, with Marshall submitting a separate dissent.

In *Skinner,* Justice Kennedy found that Federal Railroad Administration regulations governing drug and alcohol testing of railroad employees were constitutional. The majority held, as it did in *Von Raab,* that "[t]he government interest in testing without a showing of individual suspicion is compelling," and that employees' expectations of privacy were not enough to overcome this interest.

Unlike *Von Raab,* where the Court admitted that no drug or alcohol problem plagued the Customs Service, the majority noted that on-the-job intoxication is a significant problem in the railroad industry. As a result of mounting evidence of such a problem, the Federal Railroad Administration promulgated regulations that mandated breath, blood, and urine testing of employees involved in certain train accidents. The Railway Labor Executives' Association brought suit in the United States District Court in San Francisco, seeking to enjoin the testing, but the district court granted summary judgment for the government and dismissed the action. A divided panel of the Court of Appeals for the Ninth Circuit reversed, holding that the breath, blood, and urine tests are searches for purposes of the fourth amendment. The Ninth Circuit argued that "particularized suspicion" is necessary before toxicological testing of employees may occur, and since the FRA regulations did not require such suspicion, they violated the fourth amendment's prohibition against unreasonable searches.

In reversing, the Supreme Court argued that while the testing did indeed constitute a fourth amendment search, the government's interest in promoting railway safety overcomes the privacy interests of employees. Requiring railroads to point to specific facts giving rise to a reasonable suspicion of impairment before testing an employee would frustrate the government's "compelling" interest in safeguarding the public against accidents. Finally, Justice Kennedy argued that railroad workers have a diminished expectation of privacy by virtue of their employment in a heavily regulated industry where safety is dependent upon the health and fitness of employees.

In a bitter dissent, Justice Marshall, joined by Justice Brennan, noted that requiring an employee to produce a urine sample on demand is one of the most serious of intrusions upon individual privacy; he argued that mandatory urine tests do not measure current impairment and therefore cannot differentiate on-duty impairment from off-duty use which may have no effect on job performance. Justice Brennan complained that "the majority's acceptance of dragnet blood and urine testing ensures that the first, and worst, casualty of the war on drugs will be the precious liberties of our citizens."

States cannot be sued for EHA violations

***Dellmuth v. Muth,* ___U.S.___, 109 S.Ct. 2397, (1989).**

The United States Supreme Court, in a 5-4 decision, held that the state of Pennsylvania is immune from a tuition reimbursement suit in federal court under the Education of the Handicapped Act (EHA), 84 Stat. 175, as amended, 20 U.S.C. § 1400 *et. seq.* (1982 ed. and Supp. V).

Writing for the court, Justice Kennedy did not take issue with the broad purposes of the EHA, which enacts a comprehensive scheme to assure that handicapped children may receive a free public education appropriate to their needs. Rather, the majority found that EHA was not intended to abrogate the state's eleventh amendment immunity from being sued in the federal courts. Justice Kennedy argued that Congress may set aside a state's immunity from suit only when it makes its intent to do so "unmistakably clear" in the language of the statute.

The EHA authorizes federal financial aid "to assist States and localities to provide for the education of all handicapped children." 20 U.S.C. § 1400(c). To be eligible for such aid, a state must develop a plan for the education of all handicapped students, and establish certain procedural protections, including giving parents the right to participate in the development of an "individualized education program" (IEP) for their child. In addition, parents may challenge the IEP in an administrative hearing with subsequent judicial review.

Russell Muth requested such an administrative hearing on behalf of his son Alex, who is handicapped by a language learning disability and related emotional problems. Alex was enrolled in public school in Central Bucks School District in Pennsylvania from 1980 to 1983. In the summer of 1983, Russell Muth

challenged the School District's IEP for Alex, but shortly before the hearing, enrolled the child in a private school for learning disabled children for the coming school year.

The administrative hearing examiner found that Alex's IEP was deficient in several respects. Both the Muths and the School District appealed the decision to the State Secretary of Education, as provided under Pennsylvania law. The Secretary remanded the case with instructions to the School District to revise Alex's IEP. The District did so, and the revised IEP was approved shortly thereafter.

While the administrative proceedings were underway, Russell Muth filed suit in federal court in the Eastern District of Pennsylvania against the School District and the Secretary of Education. The complaint alleged that the IEP was inappropriate and that Pennsylvania had violated the EHA in several respects. Muth also sought reimbursement for Alex's private school tuition as well as attorney's fees.

The district court found in favor of the Muths, agreeing that the EHA abrogated Pennsylvania's eleventh amendment immunity from suit. The United States Court of Appeals for the Third Circuit affirmed. In order to resolve a conflict among the circuits, the Supreme Court granted certiorari.

In holding that Congress failed to make it "unmistakably clear" in the language of the EHA that it intended to subject the states to suit in federal court, and thus abrogate eleventh amendment immunity, the majority rejected arguments that EHA's frequent references to the states, as well as its emphasis on the states' important role in establishing educational opportunities for handicapped children, amount to an authorization for suit in the federal court. Notwithstanding the states' vital role in securing appropriate educational programs for the handicapped, the majority argued, Congress did not explicitly direct that the states be answerable for violations of the EHA in federal court. Since the language of the statute does not even refer to the eleventh amendment or to the states' sovereign immunity from suit, the Court refused to substitute its judgment for that of the Congress.

In dissent, Justice Brennan argued that, since the EHA imposes substantial obligations upon the states, as well as on local educational authorities, Congress intended that disabled students have an enforceable substantive right to a public education. Federal financial assistance is expressly conditioned upon a state's compliance with the various substantive and procedural requirements of the EHA. Therefore it makes sense to believe that Congress intended the states to be subject to suit in the federal court for violations of the EHA. Indeed, wrote Brennan, a contrary interpretation renders substantive rights under the EHA unenforceable in cases where a state forum is unavailable.

Congress may have the final word in this area. After the Supreme Court held in *Atascadero State Hospital v. Scanlon,* 473 U.S. 234 (1985) that § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, contained no "unmistakable language" abrogating the states' constitutional immunity from suit, Congress amended the statute. It did so, Justice Brennan maintains (perhaps as an invitation to Congress to once again overrule the Court), because "[i]t would be inequitable. . .to mandate state compliance with its provisions and yet deny litigants the right to enforce their rights in Federal courts when State or State agency actions are in issue."

Municipality's failure to train must reflect "deliberate indifference"

***City of Canton v. Harris,* ___U.S.___, 109 S.Ct. 1197, (1989).**

In April 1978, 52 year old Geraldine Harris was driving her teenage daughter to school when she was stopped by a Canton police officer for speeding. After Harris allegedly became uncontrollably upset and uncooperative, she was arrested and placed in a police wagon. At the police station, Harris slumped to the ground on at least two occasions and was left on the floor by police, who did not summon medical attention. An hour later, she was released from custody and her family transferred her to a hospital, where she was diagnosed as suffering from gross stress reaction, anxiety and depression, with symptoms including immobility and respiratory difficulty. After being hospitalized for a week, Harris received outpatient psychiatric treatment for a year. She later claimed that had the police supervisor been properly trained, he would have recognized her need for immediate medical attention.

Harris brought this action under 42 U.S.C. § 1983, alleging that the city had violated her rights guaranteed by the due process clause of the fourteenth amendment in failing to provide her with proper medical attention.

In an opinion written by Justice White, the Supreme Court clarified the level of fault necessary to hold a municipality liable for constitutional violations resulting from failure to adequately train employees. The Court held that a municipality's failure to train must be a policy or custom that reflects "deliberate indifference" to a person's rights. There must also be a direct causal link between the policy or custom and the plaintiff's alleged injury or deprivation.

The district court submitted the case to the jury, which found the city liable based on a standard of gross negligence. The Court of Appeals for the Sixth Circuit affirmed, holding that a lack of training must be so reckless or grossly negligent that constitutional violations are likely to result. The Supreme Court concluded that this low threshold of fault was inconsistent with *Monell v. New York City Dept. of Social Services,* 436 U.S. 658 (1978) (holding that *respondeat superior* or vicarious liability would not suffice for § 1983 liability,

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but a municipality may be held liable if a policy or custom causes the injury). A grossly negligent standard also would open municipalities to much more liability and would force federal courts to evaluate numerous employee training programs.

Justice White argued that the policy—here the failure to train—must have proximately caused the deprivation. Second, the training policy must amount to "deliberate indifference" to the detainee's rights, meaning that the city was aware that the training program was so deficient that it was likely to violate constitutional rights. Otherwise, the majority argues, municipalities would be subjected to unlimited liability. The Supreme Court vacated the court of appeal's judgment and remanded the case, giving the court the obligation to determine if Harris should have the opportunity to try and establish liability under the "deliberate indifference" test.

All Justices agreed on the "deliberate indifference" standard, but Justices O'Connor, Scalia, and Kennedy disagreed with the majority's decision to remand the case. O'Connor argued that this training deficiency was not one so blatant as to warrant a finding of "deliberate indifference," given the unusual and infrequent nature of the circumstances. She also argued that this one isolated incident does not establish a custom or policy necessary for liability. If § 1983 claims could be based on one event, O'Connor claimed that the allocation of city services would be greatly influenced—not necessarily leading to a desirable result. She concluded that because Harris failed to present any evidence that established the high threshold of fault required by the "deliberate indifference" test, there was no reason to remand the case.

Investigative detention based on "drug courier profile" permitted

***United States v. Sokolow,* ___U.S.___, 109 S.Ct. 1581, (1989).**

In considering whether federal drug agents had reasonable suspicion to believe that a traveler was transporting illegal drugs through an airport, the Supreme Court held that a variety of factors may, taken together, justify an investigative detention—even if, taken separately, such factors would be consistent with innocent travel.

In a 7-2 opinion written by Chief Justice Rehnquist, the majority found that Drug Enforcement Agents did not violate the fourth amendment's prohibition against unreasonable searches and seizures when they stopped Andrew Sokolow upon his arrival at Honolulu International Airport and found more than one thousand grams of cocaine in his carry-on luggage. In stopping Sokolow, the DEA agents relied on the following factors:

(1) he paid $2,100 for two airplane tickets from a roll of $20 bills;

(2) he traveled under a name that did not match the name under which his telephone number was listed;

(3) his original destination was Miami, and he stayed there for only 48 hours, even though a round-trip flight from Honolulu to Miami takes 20 hours;

(4) he appeared nervous during his trip;

(5) he checked none of his luggage;

(6) he was about 25 years old, was dressed in a black jumpsuit and wore gold jewelry.

Taken together, the DEA agents believed, and the majority agreed, that these factors were consistent with the "drug courier profile" used to nab suspected smugglers in airports.

In previous cases, the Supreme Court has said that police may stop and briefly detain a person for "investigative purposes" without having probably cause, as long as the officer has "reasonable suspicion supported by articulable facts that criminal activity may be afoot." In determining whether reasonable suspicion exists, the Court looks at the totality of the circumstances. While the entire Court agreed that any one of the factors mentioned above is not by itself proof of illegal activity, and indeed, is consistent with innocent travel, the majority and dissenters split over whether all factors combined raised a "reasonable suspicion" that the defendant was engaged in illegal drug activity.

The dissenting justices—Marshall and Brennan—argued that the fourth amendment protects innocent persons from being subjected to police harassment on the basis of "imprecise stereotypes of what criminals look like" or other "irrelevant" characteristics. In this case, the dissent maintained all of the facts used to stop Sokolow describe a large number of presumably innocent travelers—many people eschew using credit cards, or wear black jumpsuits and gold jewelry, or bring only carry-on luggage. Evidence that a passenger is acting nervously is perfectly understandable, given the recent numbers of plane crashes, near-collisions, and air terrorism acts, maintained Justice Marshall.

However, it is extremely unlikely that the dissenters' views will command anything close to a majority on the Court in the near future. The Rehnquist Court has made it clear that police reliance upon such investigative techniques as the "drug courier profile" is within the bounds of the fourth amendment as it construes it, and drug defendants in particular will have an exceedingly difficult time raising a successful challenge under search and seizure principles where, as in this case, the Court permits the "totality of the circumstances" to raise reasonable suspicion that illegal activity has occurred.□

Subject Index of Virginia Laws

This index lists laws in Virginia, by subject and in alphabetical order, that have been reported in Developments in Mental Health Law. *Subheadings as originally given in the newsletter may appear under a subject heading. The newsletter volume and page number follow the titles.*

Index of Cases

The following index lists in alphabetical order all of the cases that have been covered in Developments in Mental Health Law. *The volume numbers and page numbers in boldface indicate those cases that have been discussed in detail, whereas the other cases are referred to in light of another case or subject. The citations given are updated as of September, 1989.*

Virginia Court, continued from page 35

The Court begins its analysis with a discussion of *Board of Education v. Rowley,* 458 U.S. 176 (1982). There, the United States Supreme Court held that, under the EHA, a "free and appropriate" public education requires "educational instruction specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child to benefit from the instruction." *Id.* at 188-89. With *Rowley* as its guide, the Virginia high court reasoned that a local school district satisfies federal law when it provides "personalized instruction with sufficient support services to permit the child to benefit educationally from that instruction."

In this case, the supreme court found that the evidence supported the decision by the circuit court judge that Campbell County had complied fully with the EHA, and that the IEP developed for Darren was "reasonably calculated and designed to provide the handicapped child with educational benefits." The court agreed with expert testimony presented at trial that the program designed for Darren was not only appropriate to his needs, but also resulted in "consistent improvement" in his reading ability. Because Campbell County school officials had provided Darren with a "free appropriate public education" within the meaning of EHA, the supreme court found that the school district did not have to reimburse his parents for the costs of private instruction.

Burden of proving mental competency given less stringent requirement

***Nelms v. Nelms,* 236 Va. 281, 5 VLR 883 (1988).**

Parties are not required to meet the "clear and convincing" standard when faced with showing that a grantor of certain property possessed the mental capacity to convey the land. Instead, the correct standard of proof is by the "greater weight of the evidence." The court should make the presumption in favor of the sanity of every person until evidence indicates an unsound mind.

Joseph Eugene Nelms, Sr. devised his home in equal shares to three sons. Less than one year later, he executed a separate deed of gift conveying the same property to one son. Mr. Nelms, who suffered from diabetes, decided to formalize the conveyance and allowed a medical witness to conduct an examination of him at the time of the ceremony. He was concerned that one of his other sons from the earlier conveyance would contest the re-executed deed. After asking Nelms various questions in order to determine his competency, three witnesses were unanimous in concluding that he was mentally competent at the time he executed the deed of gift.

However, that deed was later contested on the basis that the maker was senile and subject to undue influence. The witnesses called by the defendants testified that, following a heart attack, Mr. Nelms began to exhibit symptoms of progressive senility. The chancellor ruled that there was no evidence to support the allegation of undue influence, and he instructed the jury on the law of mental competency. Through an interrogatory, the jury found that Mr. Nelms did not possess the mental capacity to leave his home to his one son and, therefore, the deed of gift was considered "null and void." The plaintiff argued that the chancellor failed to properly instruct the jury. On appeal, the Virginia Supreme Court agreed and stated that the jury was misinformed on the burden of proof and the chancellor's reliance on the verdict was misplaced.

The Virginia Supreme Court followed the general rule that "where the evidence of equally credible witnesses for and against the presumption is equally balanced . . . the presumption of sanity will prevail." Under this rule, if the jury in this case had found the evidence of Mr. Nelms's mental capacity in equipoise, the presumption of sanity would have prevailed, but the jury was instructed that the deed was valid only if the evidence of sanity was "clear and convincing." This instruction by the court was erroneous. Thus, the Virginia Supreme Court reversed the decree and remanded the case for a new trial.□

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