# DEVELOPMENTS IN MENTAL HEALTH LAW

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## Reducing Underage Drinking: A Collective Responsibility

By Richard J. Bonnie*

[Ed.: The following statement was provided as part of Professor Bonnie's testimony before the U.S. Senate Subcommittee on Substance Abuse and Mental Health Services, Committee on Health, Education, Labor and Pensions on September 30, 2003.]

Good morning, Mr. Chairman and members of the Subcommittee. . . . I served as chair of the Committee on Developing a Strategy to Reduce and Prevent Underage Drinking of the National Research Council and the Institute of Medicine. The National Research Council is the operating arm of the National Academy of Sciences, National Academy of Engineering and the Institute of Medicine, chartered by Congress in 1863 to advise the government on matters of science and technology.

The report of this committee was produced in response to a Congressional request to develop a strategy to reduce and prevent underage drinking. The committee reviewed a wide variety of government and private programs for the purpose of developing a comprehensive national strategy. We relied on the available scientific literature, commissioned papers, testimony and submissions from the public, and the expertise of committee members in public policy, public health, youth interventions, and substance abuse. Our starting point was the current national policy setting 21 as the minimum legal-drinking age.

***Also in this issue:***



Alcohol use by young people is an endemic problem that is not likely to improve in the

* Chair of the Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, National Research Council and Institute of Medicine; John S. Battle Professor of Law and Director, Institute of Law, Psychiatry and Public Policy, University of Virginia. The full report of the Committee, entitled "Reducing Underage Drinking: A Collective Responsibility," can be found at http://www.nap.edu/books/0309089352/html/.

absence of significant new interventions. Many more of the nation's youth drink than smoke cigarettes or use other drugs. And, young people tend to drink more heavily than adults, exacerbating the dangers to themselves and people around them. In the 2002 Monitoring the Future survey, a federally sponsored study, nearly one in five eighth graders and almost half of twelfth graders reported drinking in the last month. More than a quarter of high school seniors reported that they had five or more drinks in a row in the last two weeks. One-in-eight eighth graders reported the same thing. These underlying rates have remained basically unchanged for a decade. The social cost of underage drinking has been estimated at $53 billion each year, including $19 billion from traffic crashes alone. While traffic crashes are perhaps the most visible consequences of this problem, underage drinking is also linked with violence, suicide, academic failure, and other harmful behaviors. Heavy drinking also threatens youth's long-term development.

Although the public is generally aware of the problems associated with underage drinking, the nation's social response has not been commensurate with the magnitude and seriousness of the problem. This disparity is evident not only in the fact that the federal government spends 25 times more on prevention of illicit drug use by young people than on prevention of underage drinking, but also in the lack of sustained and comprehensive grassroots efforts to address the problem in most communities.

Some people think that the key to reducing underage drinking lies in finding the right messages to send to young people to instill negative beliefs and attitudes toward alcohol use. Others tend to focus on changing the marketing practices of the alcohol industry in order to reduce young people's exposure to messages designed to promote drinking. However, the problem is much more complicated than either of these positions would suggest because alcohol use is deeply embedded in the economic and cultural fabric of life in the United States. Annual revenues in the alcohol industry amount to $116 billion. The challenge, then, is how to reduce underage drinking in a context where adult drinking is widespread and commonly accepted and where billions of gallons of alcohol are in the stream of commerce. We believe that will require a broad, multifaceted effort.

The primary goal of the committee's recommended strategy is to create and


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sustain a strong societal commitment to reduce underage drinking. All of us, acting in concert—including parents and other adults, alcohol producers, wholesalers and retail outlets, entertainment media, and community groups—must take the necessary steps to reduce the availability of alcohol to underage drinkers, to reduce the attractiveness of alcohol to young people, and to reduce opportunities for youthful drinking. Underage drinking prevention is everybody's business.

The report emphasizes that adults must be the primary targets of this national campaign to reduce underage drinking. Most adults express concern about underage drinking and voice support for public policies to curb it. Yet behind the concern lies a paradox: Youth often get their alcohol from adults. And many parents downplay the extent of the problem or are unaware of their own kids' drinking habits. Thirty percent of parents whose kids reported drinking heavily within the last thirty days, think their kids do not drink at all. The sad truth is that many adults facilitate and condone underage drinking. We need to change the behavior of well-meaning adults in communities all over the nation – including people who are holding drinking parties for kids in their homes in violation of the law.

As the centerpiece of the committee's adult-oriented strategy, our report calls on the federal government to fund and actively support the development of a national media campaign designed to create a broad societal commitment to reduce underage drinking, to decrease adult conduct that tends to facilitate underage drinking, and to encourage parents and other adults to take specific steps in their own households, neighborhoods and businesses to discourage underage drinking.

The comprehensive strategy we suggest also includes a multi-pronged plan for boosting compliance with laws that prohibit selling or providing alcohol to young people under the legal drinking age of 21. Efforts to increase compliance need to focus on both retail outlets and social channels though which underage drinkers obtain their alcohol. For example, we urge state authorities to require all sellers and servers of alcohol to complete state-approved training as a condition of employment, and to increase the frequency of staged underage purchases by which they monitor retailer compliance with minimum drinking-age laws. The federal government should require states to achieve specified rates of retailer compliance with youth-access laws as a condition of receiving federal funds. And states should beef up efforts to prevent and detect the use of fake IDs by minors who want to buy alcohol.

The committee also supports specific intervention and education programs aimed at young people as long as those programs have been evaluated and found to be effective. A good start in identifying evidence-based school programs has already been made by the Department of Education and the Substance Abuse Mental Health Services Administration in the Department of Health and Human Services. A recent report sponsored by the National Institute on Alcohol Abuse and Alcoholism has done the same for programs aimed at college students.

Community leaders need to mobilize the energy, resources, and attention of local organizations and businesses to develop and implement programs for preventing and reducing underage drinking. These efforts should be tailored to specific circumstances of the problem in their communities. The federal government as well as public and private organizations should encourage and help pay for relevant community initiatives that have been shown to work.

The alcohol industry also has a vitally important role to play in the strategy we have proposed. The committee acknowledges the industry's declared commitment to the goal of reducing underage drinking and its willingness to be part of the solution. We believe that there is much common ground, and that opportunities for cooperation are now being overlooked. Specifically, we urge the alcohol industry to join with private and public entities to create and fund an independent, non-profit

foundation that focuses solely on designing, evaluating, and implementing evidence-based programs for preventing and reducing underage drinking. Although the industry currently invests in programs that were set up with that stated goal, the results of these programs have rarely been scientifically evaluated, and the overall level of industry investment is modest in relation to the revenues generated by the underage market. We think it is reasonable to expect the industry to do more than it is now doing, and to join with others to form a genuine national partnership to reduce underage drinking.

We also urge greater self-restraint in alcohol advertising. We recognize, of course, that advertising is a particularly sensitive issue. However, a substantial portion of alcohol advertising reaches an underage audience or is presented in a style that tends to attract youth. For example, alcohol ads on TV often appear during programs where the percentage of underage viewers is greater than their percentage in the overall U.S. population. Building on an important 1999 report by the Federal Trade Commission, the committee's report urges industry trade associations to strengthen their advertising codes to prohibit placement of commercial messages in venues where a large portion of the audience is underage. For many years, the industry trade association codes permitted ad placements in media where adults were at least 50 percent of the audience. The FTC recently announced that the beer and distilled spirits trade associations have joined the wine industry to increase the threshold to 70 percent for the minimum proportion of adults in the viewing audience. This is a step in the right direction, but the committee believes that the industry should continue to move toward a higher threshold of adult viewers. In addition, trade associations and alcohol companies should create independent, external review boards to investigate complaints about ads and enforce codes. Furthermore, alcohol companies, advertising firms, and commercial media should refrain from marketing practices that have particular appeal to young people, regardless of whether they are intentionally targeted at youth audiences.

Companies and trade associations in the entertainment sector also have a responsibility to join in the collective effort to reduce underage drinking, and to exercise greater restraint in disseminating images and lyrics that promote or glorify alcohol use in venues with significant underage audiences. Officials in the music, TV, and film industries should use rating systems and codes similar to those used by some industries for drug abuse to reduce the likelihood that large numbers of young listeners and viewers will be exposed to unsuitable messages about alcohol consumption – even when adults are expected to make up the majority of the audience.

The federal government should periodically monitor advertising practices in the alcohol industry and review representative samples of movies, television programs, music recordings, and videos that are offered at times or venues likely to have significant underage audiences. This work should be conducted by the U.S. Department of Health and Human Services, and reported to Congress and the general public on a regular basis. The department also should issue a comprehensive report to Congress each year summarizing trends in underage drinking, and reporting on progress in implementing the proposed strategy and in reducing the problem. A federal interagency coordinating committee, chaired by the Secretary of HHS, should be formed to provide national leadership and to better organize the multiple federal activities in this area. HHS also should create a National Training and Research Center on Underage Drinking and collect more detailed data, including data on brands preferred by youth. State policy-makers should designate an agency to spearhead and coordinate their activities.

To help pay for the proposed public programs and to help reduce underage consumption, Congress and state legislatures should raise excise tax rates on alcohol – especially on beer, which is the alcoholic beverage that

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young people drink most often. Alcohol is much cheaper today, after adjusting for inflation, than it was 30 to 40 years ago. Higher tax rates should be tied to the Consumer Price Index to keep pace with inflation. Research indicates that changes in these tax rates can decrease the prevalence and harmful effects of drinking among youths, who tend to have limited discretionary income and are especially sensitive to changes in price.

In summary, we've proposed a comprehensive strategy that, taken as a whole, would foster a deep, unequivocal societal commitment to curtail underage drinking. As a national community, we need to focus our attention on this serious problem and accept a collective responsibility to address it. This is an admittedly difficult challenge, but the committee believes that our country can do much more than it is now doing. The nation needs to develop and implement effective ways to protect young people from the dangers of early drinking while respecting the interests of responsible adult consumers of alcohol. The committee's report attempts to strike the right balance.

Thank you for your interest and the opportunity to testify to the subcommittee.

# Virginia Enacts Civil Commitment of Sexually Violent Predators Legislation During 2003 General Assembly

By Allyson K. Tysinger*
& Karen A.D. Walters**

Sixteen states, including Virginia, have laws providing for the civil commitment of sexually violent predators (SVP).[1] Virginia's SVP law was initially enacted in 1999[2] but funds for the program were not appropriated and the law did not become effective. During the 2003 legislative session, amidst heavy publicity surrounding the impending release of a man convicted of a particularly egregious and shocking sexually violent crime, the Virginia General Assembly appropriated funds and made the law effective upon its enactment on April 2, 2003.[3] The 2003 General Assembly also made some substantive changes to the law itself.

Prior to the 2003 session, a "sexually violent predator" was defined as any person who was convicted of a sexually violent offense or charged with such an offense but found unrestorably incompetent to stand trial and who suffered from a mental abnormality or personality disorder.[4] In January 2002, the United States Supreme Court issued an opinion in *Kansas v. Crane*, holding that while it was not necessary to show that a sexually violent predator had a complete lack of control over his behavior, there must at least be proof of serious difficulty in controlling behavior to permit a commitment under an SVP law.[5] To comport with this decision, the 2003 General Assembly amended Virginia's definition of sexually violent predator to mean any person who has been convicted of a sexually violent offense[6] or charged with such an offense but found unrestorably incompetent to stand trial and because of a mental abnormality or personality disorder, finds it difficult to control his predatory behavior which makes him likely to engage in sexually violent acts.[7]

The 2003 General Assembly also made amendments to the procedure used to commit a sexually violent predator. Under the Virginia law, the Director of the Department of Corrections is responsible for beginning the SVP commitment process for prisoners who have been convicted of sexually violent offenses. Prior to the 2003 General Assembly session, the Director of the Department of Corrections was required to review his database of prisoners and refer any prisoner incarcerated for a sexually violent offense and scheduled for release from prison within ten months to the Commitment Review

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* J.D., Assistant Attorney General, Virginia Office of the Attorney General.
** J.D., M.S.W., DMHMRSAS Special Counsel, Virginia Office of the Attorney General.

[1] The states with sexually violent predator civil commitment laws are: Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, North Dakota, New Jersey, South Carolina, Texas, Virginia, Washington, and Wisconsin.

[2] 1999 Va. Acts ch. 946, 985.

[3] 2003 Va. Acts ch. 989, 1018; 2003 Va. Acts ch. 1042, items 331(C)(1).

[4] "Mental abnormality" or "personality disorder" was defined as "a congenital or acquired condition that affects a person's emotional or volitional capacity and renders the person so likely to commit sexually violent offenses that he constitutes a menace to the health and safety of others. VA. CODE § 37.1-70.1 (1999). This definition was left unchanged during the 2003 General Assembly session.

[5] Kansas v. Crane, 534 U.S. 407, 412-13 (2002).

[6] "Sexually violent offense" is defined as "(i) a felony conviction under former § 18-54, former § 18.1-44, §§ 18.2-61, 18.2-67.1, or § 18.2-67.2 or subdivision A 1 of § 18.2-67.3 or (ii) a felony conviction under the laws of the Commonwealth for a forcible sexual offense committed prior to July 1, 1981, where the criminal behavior on which the conviction is based is set forth in § 18.2-67.1 or § 18.2-67.2 or subdivision A 1 of § 18.2-67.3." VA. CODE § 37.1-70.1 (2003). The second prong of this definition was added during the 2003 session, as were convictions under former § 18-54 and former § 18.1-44.

[7] VA. CODE § 37.1-70.1 (2003).

Committee (CRC)[8] for an assessment for possible civil commitment. After the 2003 legislative session, an additional qualification for referral to the CRC was added. Now, only prisoners incarcerated for sexually violent offenses who are scheduled for release within ten months and who receive a score of four or more on the Rapid Risk Assessment for Sexual Offender Recidivism or a similar score on a comparable instrument will be referred to the CRC.[9]

Once a prisoner is referred, the CRC must complete its assessment of the prisoner for possible commitment and forward its recommendation regarding the prisoner to the Virginia Attorney General within ninety days.[10] The CRC assessment must include a mental health examination conducted by a licensed psychiatrist or clinical psychologist designated by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).[11] A provision was added in 2003 providing that if the prisoner refuses to cooperate with the mental health examination, such refusal could be admitted into evidence by the court in a commitment proceeding and the prisoner could be barred from introducing his own expert psychiatric or psychological evidence.[12] Once the CRC receives the mental health examination and reviews the prisoner's institutional history and treatment record, his criminal background, and any other relevant factor, the CRC makes a recommendation to the Attorney General regarding whether the prisoner should be committed as an SVP, conditionally released to a less restrictive alternative, or released because he does not meet the definition of an SVP.[13]

Once the recommendation of the CRC is received, the Attorney General has ninety days to conduct a review of the prisoner and either file a petition for civil commitment in the circuit court wherein the prisoner was last convicted of a sexually violent offense, or notify the Director of the Department of Corrections and the Commissioner of the DMHMRSAS that a petition will not be filed. The Attorney General also has ninety days from receipt of a court order referring a defendant charged with a sexually violent offense who has been found unrestorably incompetent to file a petition for commitment.[14] If a petition for civil commitment is filed, a hearing must be held within thirty days to determine whether probable cause exists to believe that the person named in the petition is a sexually violent predator.[15] At this point, if the person named in the petition is not represented by counsel, an attorney will be appointed for him.[16]

If probable cause is found, a trial must be held within ninety days of completion of the probable cause hearing.[17] Both the Attorney General and the person named in the petition have the right to a trial by jury.[18] The court or jury must determine whether the respondent is a sexually violent predator. Prior to 2003, this determination was required to be made beyond a reasonable doubt. However, the 2003 General Assembly lowered the evidentiary standard to require that the determination of whether the respondent is a

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[8] The Commitment Review Committee (CRC) is under the supervision of the Department of Corrections and is composed of seven members. Three members are appointed by the Director of the Department of Corrections, three members are appointed by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, one of which must be a psychiatrist or psychologist, and one member is appointed by the Attorney General. The role of the CRC is to screen, evaluate, and make recommendations regarding prisoners in the custody of the Department of Corrections for the purposes of the SVP law. *See* VA. CODE § 37.1-70.3 (2003).

[9] VA. CODE § 37.1-70.4(C) (2003).

[10] VA. CODE § 37.1-70.5(A) (2003).

[11] VA. CODE § 37.1-70.5(B) (2003).

[12] VA. CODE § 37.1-70.2 (2003).

[13] VA. CODE § 37.1-70.5(C) (2003).

[14] VA. CODE § 37.1-70.6(A) (2003).

[15] VA. CODE § 37.1-70.7(A) (2003).

[16] VA. CODE § 37.1-70.7(B) (2003).

[17] VA. CODE § 37.1-70.9(A) (2003).

[18] VA. CODE § 37.1-70.9(B) (2003).

sexually violent predator is to be made by clear and convincing evidence.[19]

If the respondent is found to be a sexually violent predator, the court then determines the nature of treatment the respondent is to receive. If the court finds that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable and that there is no less restrictive alternative to institutional confinement, the court will order that the respondent be committed to the custody of DMHMRSAS for appropriate treatment and confinement in a secure facility. If the court finds that a less restrictive alternative is suitable and that the respondent meets the criteria for conditional release,[20] the court shall order an appropriate course of treatment to meet the needs of the respondent, which can include outpatient treatment, day treatment in a hospital, night treatment in a hospital, and outpatient involuntary treatment with antipsychotic medication. The responsibility for recommending a specific course of treatment and monitoring the respondent's compliance with the treatment was shifted from the various Virginia community services boards to the DMHMRSAS by the 2003 General Assembly.[21]

Once a person is committed, he will be placed in the custody of the DMHMRSAS for control, care, and treatment until such time as his mental abnormality or personality disorder has changed so that he will not present an undue risk to public safety.[22] The committing court must conduct a review hearing twelve months after the date of commitment to assess the need for continued inpatient hospitalization. Such review hearings will be conducted annually for five years and biennially thereafter.[23] At the review hearing, the Commonwealth bears the burden of proving by clear and convincing evidence that the committed person remains a sexually violent predator.[24] In addition to the review hearings, the Commissioner of the DMHMRSAS may file a petition for conditional or unconditional release at any time if the Commissioner believes that the committed person's condition has changed such that he is no longer a sexually violent predator in need of treatment and secure confinement. The committed person may also petition the committing court for release but only once in each year in which no annual review hearing is required.[25]

If a respondent is placed on conditional release, the DMHMRSAS or, if applicable, the respondent's parole or probation officer will implement the court's conditional release orders and submit reports to the court on the respondent's progress every six months.[26] Upon the petition of anyone who has probable cause to believe that a person on conditional release has violated the conditions of release, an emergency custody order can be issued authorizing law enforcement to take the person into custody where he can be evaluated by a person designated by the DMHMRSAS for the purpose of determining the nature and degree of the violation. The person will remain in custody until a hearing can be held to determine if he should be returned to the custody of the DMHMRSAS.[27]

Since the effective date of the SVP law, the Virginia Attorney General has filed thirteen petitions seeking civil commitment. As of the

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[19] VA. CODE § 37.1-70.9(C) (2003).

[20] The criteria for conditional release are: (i) the respondent does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization; (ii) appropriate outpatient treatment and supervision are reasonably available; (iii) there is significant reason to believe that the respondent, if conditionally released, would comply with the conditions specified; and (iv) conditional release will not present an undue risk to public safety. VA. CODE § 37.1-70.13 (2003).

[21] *Id.*

[22] VA. CODE § 37.1-70.10 (2003).

[23] VA. CODE § 37.1-70.11(A) (2003).

[24] VA. CODE § 37.1-70.11(C) (2003).

[25] VA. CODE § 37.1-70.12(A) (2003).

[26] VA. CODE § 37.1-70.13 (2003).

[27] VA. CODE § 37.1-70.14 (2003).

date of this writing, one person has been committed as a sexually violent predator, one has been conditionally released, and the remaining eleven are still pending. The Commissioner of the DMHMRSAS has designated the Virginia Center for Behavioral Rehabilitation as the secure facility of confinement for those committed as sexually violent predators. The facility is located on the campus of the Central State Hospital/Southside Virginia Training Center complex in Petersburg, Virginia.

**Conclusion**

The disposition of sexually violent predators was a topic that gained the attention of both the United States Supreme Court and the media. Recognizing the increased public and judicial interest in this topic, the 2003 General Assembly enacted legislation to direct Virginia's disposition of these individuals.

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# Megan's Law: Branding Juveniles as Sex Offenders

By Irina R. Kushner*

## I. Introduction

Triggered by public sentiment following a number of well-publicized sexual assaults on children by convicted sex offenders released back into the community and spurred by federal incentives, legislatures across the nation passed sex offender registration and notification statutes. These laws require convicted sex offenders to register with a law enforcement agency upon their release from incarceration.[1] In addition, they also authorize law enforcement officials to notify the community as to a convicted sex offender's presence, disclosing information such as his or her name and address.[2]

Sex offender registration statutes have been the subject of much debate. Legislators' intent when enacting these laws was to enable the community to better protect itself and its children;[3] but what happens when the children are the very ones the community needs protecting from?

For years, juvenile sexual offenses were dismissed as either experimentation or as "boys just being boys."[4] No longer does this hold true. Data indicate that juveniles are offenders in more than one-fourth of all child sexual abuse cases[5] and that they commit twenty percent of the forcible rapes that are reported to the FBI.[6] Furthermore, psychological research reveals that many adult sex offenders engaged in deviant sexual behavior as juveniles.[7] Fostered by the public's perception that the juvenile justice system is ineffective, there has been a shift to a "once a sex offender always a sex offender"[8] mentality and an increased call for punitive measures.

Several states have responded by including juveniles among those sex offenders required to register.[9] Other states have gone as far as to apply the notification provisions to children.[10] The question remains whether the application of Megan's Law to juveniles is appropriate. Should children who commit the equivalent of an adult sex crime be subject to the adult standard of reporting and registration? Or, does the labeling of a juvenile as a registered offender lessen the offender's amenability to rehabilitation and increase the likelihood the juvenile offender will recidivate?

This article will explore the juvenile sex offender's unique role in the ongoing controversy surrounding the sex offender registration and notification statutes, providing an overview of both the juvenile justice system and the origin of Megan's Law. Additionally, this article will examine whether applying

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* M.A., J.D. (anticipated 2004), University of Virginia, J.D.

[1] Michele L. Earl-Hubbard, *The Child Sex Offender Registration Laws: The Punishment, Liberty Deprivation, and Unintended Results Associated with the Scarlet Letter Laws of the 1990s,* 90 NW. U. L. REV. 788, 791 (1996).

[2] *Id.*

[3] Mark J. Swearingen, *Megan's Law as Applied to Juveniles: Protecting Children at the Expense of Children?* 7 SETON HALL CONST. L.J. 525, 526 (1997).

[4] Serena S. Thakur, *Juvenile Sex Offenders: Proposition 21 – The Hope for a Better Solution,* 21 J. JUV. L. 97, 100 (2000).

[5] *Id.* at 97.

[6] *Id.*

[7] *See* Lucy Berliner, *Juvenile Sex Offenders: Should They Be Treated Differently?,* 13 J. INTERPERSONAL VIOLENCE 645 (1998) (discussing studies showing a substantial percentage of sex offenders are juveniles).

[8] Tom Leversee & Christy Pearson, *Eliminating the Pendulum Effect: A Balanced Approach to the Assessment, Treatment, and Management of Sexually Abusive Youth,* 3 J. CTR. FOR FAMILIES, CHILD. & CTS. 45 (2001).

[9] Stacy Hiller, *The Problem with Juvenile Sex Offender Registration: The Detrimental Effects of Public Disclosure,* 7 B.U. PUB. INT. L.J. 271, 278 (1998).

[10] Swearingen, *supra* note 3, at 573.

Megan's Law to juveniles conflicts with basic notions of *parens patriae* and the rehabilitative model traditionally employed for juvenile offenders.

## II. Profile of a Juvenile Sex Offender

A juvenile sex offender may be defined as a "youth ranging from puberty to the age of legal majority who commits any sexual interaction with a person of any age against the victim's will, without consent, or in an aggressive, exploitative, or threatening manner."[11] Some juvenile sex offenders, however, have been as young as six.[12] For years, society wrote off sexually aggressive or violent behavior by juveniles as that of "misguided youthful experimentation,"[13] fearing the stigma the child would face if labeled a pervert.[14] Because of the juvenile's youth and immaturity, most incidents were handled not with punitive measures, but with attempts at rehabilitation.[15] Recently, however, the pendulum has swung towards imposing accountability and punishment on juvenile sex offenders.[16] This has been attributed to better reporting methods and the greater attention juvenile sex crimes have garnered in the media.[17]

Research has revealed that the median age of juvenile sex offenders typically falls between the ages of fourteen and fifteen.[18] An overwhelming number of juvenile sex offenders are male.[19] Juvenile sex offenders are often characterized as loners with few close friends or peers.[20] They may themselves have been victims of sexual abuse.[21] A University of Alabama study also found juvenile sex offenders to be more callous and unemotional compared to other violent offenders.[22] Family environment,[23] difficulty in school,[24] biological abnormalities, and trauma such as loss of a parent,[25] are all factors that may contribute to a juvenile's sexually aggressive behavior.[26]

A juvenile sex offender's victim is typically a young female around the ages of seven or eight who is unrelated to the sex offender.[27] Moreover, juvenile sex crimes may be more serious than those perpetrated by adult offenders. Sexual offenses by juveniles are more likely to involve intercourse or other invasive sexual conduct, to cause physical injury, and to involve the use of a weapon.[28] The employment of force or threats to keep the victim silent after the threat is also more frequent among juvenile offenders.[29]

It is difficult to comprehend what would lead a child to commit such a heinous act towards another child, but many researchers argue

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[11] Joyce F. Lakey, *The Profile and Treatment of Male Adolescent Sex Offenders*, 29 ADOLESCENCE 755 (1994).
[12] Sander N. Rothchild, *Beyond Incarceration: Juvenile Sex Offender Treatment Programs Offer Youth a Second Chance,* 4 J.L. & POL'Y 719, 719 (1996).
[13] Carter Allen Lee, *When Children Prey on Children: A Look at Hawaii's Version of Megan's Law and its Application to Juvenile Sex Offenders,* 20 U. HAW. L. REV. 477, 480 (1998).
[14] Gail Ryan, Thomas J. Miyoshi, Jeffrey L. Metzner, Richard D. Krugman & George E. Fryer, *Trends in a National Sample of Sexually Abusive Youths,* 35 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 17 (1996).
[15] *Id.*
[16] Leversee & Pearson, *supra* note 8, at 45.
[17] Lee, *supra* note 13, at 481.
[18] Rothchild, *supra* note 12, at 724.
[19] Victor I. Vieth, *When the Child Abuser Is a Child: Investigating, Prosecuting and Treating Juvenile Sex Offenders in the New Millennium,* 25 HAMLINE L. REV. 47, 51 (2001) ("Over 90% of juvenile sex offenders are male.").
[20] Thakur, *supra* note 4, at 99.
[21] *Id.*
[22] Alicia A. Caputo, Paul J. Frick, & Stanley L. Brodsky, *Family Violence and Juvenile Sex Offending: The Potential Meditating Role of Psychopathic Traits and Negative Attitudes Toward Women,* 26 CRIM. JUST. & BEHAV. 338, 353 (1999).
[23] Rothchild, *supra* note 12, at 727.
[24] *Id.* at 726.
[25] Hiller, *supra* note 9, at 282.
[26] *Id.*
[27] Rothchild, *supra* note 12, at 726.
[28] Vieth, *supra* note 19, at 51.
[29] *Id.*

that the courts, clinicians, and society must guard against relying on the assumption that a sexually abusive youth cannot be cured or rehabilitated. As the Association for the Treatment of Sexual Abusers stated, "there is little evidence to support the assumption that the majority of juvenile sexual offenders are destined to become adult sexual offenders."[30]

## III. Juvenile Justice System Overview

### A. *History*

The first juvenile court was founded in 1899 in Chicago,[31] with a juvenile court system ultimately established in every state.[32] Driving the newly founded juvenile justice system was the concept of *parens patriae*[33] with the ultimate purpose being to successfully rehabilitate young offenders into responsible members of society.[34] Thus, the court's focus was not on determining guilt or innocence[35] nor doling out punishment,[36] but rather to provide guidance[37] and to determine "[w]hat is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career."[38] Another hallmark of the juvenile justice system was confidentiality to prevent the young offender from being stigmatized by society.[39]

As conceived, the juvenile court did not offer any of the due process and procedural protections provided adults.[40] Children were perceived as different from adults and not as criminally responsible for their actions.[41] Because imposed sanctions were considered to be rehabilitative rather than punitive, fewer procedural safeguards were afforded juvenile offenders.[42] Beginning in the 1960s, reformers began to question whether the juvenile justice system was achieving its goal.[43] In the Supreme Court case of *Kent v. United States,* Justice Abe Fortas expressed his concern that juvenile offenders were receiving "the worst of both worlds" in that they received "neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children."[44]

In response to such concerns, the Supreme Court began to extend to juvenile offenders some of the due process protections that were normally guaranteed to adults facing criminal charges.[45] The Court, however, has been reluctant to grant the full spectrum of criminal procedural benefits to juveniles,[46] stating, "[I]f the formalities of the criminal adjudicative process are to be superimposed upon the juvenile court system, there is little need for its separate existence. Perhaps that ultimate

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[30] Mark Chaffin & Barbara Bonner, "*Don't Shoot, We're Your Children": Have We Gone too far in Our Response to Adolescent Abusers and Children with Sexual Behavior Problems?* 3 CHILD MALTREATMENT 314 (1998).
[31] *See generally* JUVENILE CRIME, JUVENILE JUSTICE (Joan McCord et al. eds., 2001).
[32] Lisa C. Trivits & N. Dickon Reppucci, *Application of Megan's Law to Juveniles*, 57 AM. PSYCHOLOGIST 690, 691 (2002).
[33] *Id.*
[34] Thakur, *supra* note 4, at 103-05.
[35] Rothchild, *supra* note 12, at 731.
[36] Lee, *supra* note 13, at 497.
[37] *Id.* at 497-498.
[38] Rothchild, *supra* note 12, at 732.
[39] *See generally* JUVENILE CRIME, *supra* note 31.
[40] *Id.*
[41] *Id.*
[42] *See* Kent v. United States, 383 U.S. 541 (1966) (transfer to criminal court without a hearing, effective assistance of counsel, and statement of reasons violated the Due Process Clause).
[43] *See generally* JUVENILE CRIME, *supra* note 31.
[44] Kent, 383 U.S. at 555-56.
[45] *See In re* Gault, 387 U.S. 1 (1967) (extending to juveniles the constitutional right to notice, counsel, confrontation on cross-examination, and protection from self-incrimination); *In re* Winship, 397 U.S. 358 (1970) (raising the burden of proof in delinquency adjudications to proof beyond a reasonable doubt); Breed v. Jones, 412 U.S. 519 (1975) (extending to juveniles protection from double jeopardy).
[46] *See, e.g.,* McKeiver v. Pennsylvania, 403 U.S. 528 (1971) (holding that juveniles are not entitled to a trial by jury); New Jersey v. T.L.O., 469 U.S. 325 (1985) (holding that the Fourth Amendment only accords juveniles diminished protection from school searches).

disillusionment will come one day, but for the moment we are disinclined to give impetus to it."[47]

B. *Current Trends*

Despite these Supreme Court rulings, the juvenile justice system attempted to maintain its philosophy of treating the offender rather than focusing on the offense.[48] However, changing public sentiment in the wake of some highly publicized incidents involving juvenile offenders has led to a greater emphasis on the punishment of juvenile offenders and shifted the focus away from rehabilitation.[49]

The rising crime rate in the 1980s led states to enact legislation lowering the upper age limit of juvenile court jurisdiction,[50] mandating that youths be charged as adults for certain crimes, and providing prosecutors and judges with the ability to waive juveniles into the adult court system.[51] Every state allows juveniles to be transferred to adult criminal court.[52] However, complaints have arisen that younger adolescents are being adjudicated as adults even though nothing about their offenses distinguished them from other adolescents who were adjudicated in the juvenile court system.[53] In addition, more and more states are including juveniles among the offenders subject to the registration and notification provisions as set forth in the various versions of Megan's Law.[54]

## IV. Megan's Law

A. *An Overview*

In July of 1994, seven-year-old Megan Kanka was brutally raped and murdered.[55] The perpetrator was Megan's neighbor, Jesse Timmendequas, a convicted pedophile.[56] The outrage upon discovering that, although Timmendequas was a twice-convicted sex offender, he was allowed to move anonymously into the community triggered the New Jersey legislature to pass what was the most stringent sex offender registration act in the United States at the time.[57]

Megan's Law was "designed to give people a chance to protect themselves and their children"[58] and consisted of registration and community notification provisions.[59] The registration requirement set forth that sex offenders "who are convicted, adjudicated delinquent, or found not guilty by reason of insanity [must] register with local law enforcement agencies."[60] The level of community notification was based on the offender's risk for re-offense.[61] Specifically, when the risk of re-offense was low, only law enforcement officials were notified of the offender's presence in their community; when the risk was moderate, institutions and organizations responsible for the care and supervision of children and women were notified; and when the risk was high, those

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[47] McKeiver, 403 U.S. at 551.
[48] Thakur, *supra* note 4, at 104.
[49] Trivits & Reppucci, *supra* note 32, at 693.
[50] Rothchild, *supra* note 12, at 737.
[51] *Id.*
[52] Kirk Heilbrun et al., *A National Survey of U.S. Statutes on Juvenile Transfer: Implications for Policy and Practice*, 15 BEHAV. SCI. & L. 125, 144 (1997); Aaron Kupchik, Jeffrey Fagan, & Akiva Liberman, *Punishment, Proportionality, and Jurisdictional Transfer of Adolescent Offenders: A Test of the Leniency Gap Hypothesis*, 14 STAN. L. & POL'Y REV. 57, 57 (2003) (in the past two decades, nearly every state has expanded the transfer of offenders from juvenile court to adult criminal courts).
[53] E-mail from Mario Dennis, Ph.D. (April 2, 2003, 14:56 EST) (copy on file with author).
[54] *See* Michael L. Skoglund, *Private Threats, Public Stigma? Avoiding False Dichotomies in the Application of Megan's Law to the Juvenile Justice System*, 84 MINN. L. REV. 1805, 1818-21 (2000).
[55] *See* James Popkin et al., *Natural Born Predators*, U.S. NEWS & WORLD REP., Sept. 19, 1994 (detailing Megan Kanka's death).
[56] Hiller, *supra* note 9 at 272.
[57] Trivits & Reppucci, *supra* note 32, at 690.
[58] Doe v. Poritz, 662 A.2d 367, 372-73 (N.J. Sup. Ct. 1995).
[59] *Id.* at 374.
[60] *Id.*
[61] Swearingen, *supra* note 3, at 528.

members of the public likely to encounter the offender were notified.[62]

Underlying the legislature's decision to enact this law was a determination that sex offenders had higher rates of recidivism than other offenders and thereby posed a heightened danger to the community.[63]

B. *The Federal Response*

In response to a similarly heinous offense, in September of 1994 Congress enacted the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act,[64] linking federal funds to the establishment of state registration of sex offender programs.[65] Congress hoped to facilitate the identification of suspects whenever a child was harmed or abducted. Additionally, it was believed that inclusion in the registry and the assistance this would provide in locating suspects would deter sex offenders from re-offending.[66]

Under the minimum standards required by the Wetterling Act, sex offenders must register for at least ten years and update their information annually.[67] Lifetime registration requirements are imposed on individuals classified as a sexually violent predator, individuals with more than one conviction for a sexual offense against a minor, or individuals convicted of aggravated sexual assault.[68] Mandated registration information typically includes the offender's name, address, fingerprints, and a photograph.[69] In addition, offenders who do not comply with the registration requirements are subject to criminal penalties.[70] In1996, the Wetterling Act was amended to call for the "release of relevant information . . . necessary to protect the public."[71]

Because the federal law imposed only minimum standards, states were free to adopt harsher measures, such as expanding the list of eligible sex offenses or lengthening the required registration period.[72] In particular, states retained the "discretion to make judgments concerning the circumstances, and extent to which the disclosure of registration information to the public is necessary to promote public safety."[73]

C. *Current Registration Laws*

A 2003 survey shows all fifty states have enacted sex offender registration legislation.[74]

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[62] Poritz, 662 A.2d at 374.
[63] Swearingen, *supra* note 3, at 527.
[64] Leversee & Pearson, *supra* note 8, at 49 (federal act was passed in the name of 11-year old Jacob Wetterling, who was kidnapped in 1989 and has yet to be found).
[65] Wayne A. Logan, *A Study in "Actuarial Justice": Sex Offender Classification Practice and Procedure,* 3 BUFF. CRIM. L. REV. 593, 598 (2000) (states were required to implement some version of Megan's Law by October 1996 or lose ten percent of their federal crime control funding).
[66] Earl-Hubbard, *supra* note 1, at 795-96.
[67] Hiller, *supra* note 9, at 274-76.
[68] Trivits & Reppucci, *supra* note 32, at 691.
[69] Leora Sedaghati, *Megan's Law: Does It Serve to Protect the Community or Punish and Brand Sex Offenders?* 3 J. LEGAL ADVOC. & PRAC. 27, 29-30 (2001).
[70] Lee, *supra* note 13, at 483.
[71] 42 U.S.C. § 14071(f)(1)(1996).
[72] Sedaghati, *supra* note 69.
[73] Poritz, 662 A.2d at 378.
[74] *See* ALA. CODE §§ 13A-11-200 to -203 (2003); ALASKA STAT. §§ 12.63.010 to -100, 18.65.087 (Michie 2003); ARIZ. REV. STAT. ANN. §§ 13-3821 to -3825 (West 2003); ARK. CODE ANN. §§ 12-12-901 to -920 (Michie 2003); CAL. PENAL CODE § 290 (West 2003); COLO. REV. STAT. § 18-3-412.5 (2003); CONN. GEN. STAT. ANN. §§ 54-250 to –261 (West 2003); DEL. CODE ANN. tit. 11, § 4120 (2003); FLA. STAT. ANN. §§ 775.21, 944.606 (West 2003); GA. CODE ANN. § 42-9-44.1 (2003); HAW. REV. STAT. ANN. § 846E-1 (Michie 2003); IDAHO CODE §§ 18-8301 to -8326 (Michie 2003); 730 ILL. COMP. STAT. ANN. 150/1-11 (West 2003); IND. CODE ANN. §§ 5-2-12-1 to -13 (West 2003); IOWA CODE ANN. § 692A (West 2002); KAN. STAT. ANN. §§ 22-4901 to -4910 (Supp. 2002); KY. REV. STAT. ANN §§ 17.500-.540 (Michie 2003); LA. REV. STAT. ANN §§ 15:540-549 (West Supp. 2003); ME. REV. STAT. ANN. tit. 34-A, §§ 11201-11202 (West 2002); ME. REV. STAT. ANN. tit. 34A § 11222 (West 2002), *amended by* 2002 Me. Legis. Serv. 553 (West); MD. CODE ANN., CRIM. PROCEDURE § 11-703

The statutes, however, vary greatly with respect to the types of offenses that subject an individual to registration, the registration procedures, and how future risk is determined.[75] In particular, states differ widely regarding their community notification procedures. Some states notify the community through the use of flyers, radio announcements, and newspaper advertisements. Other states use a more circumspect approach, such as utilizing a three-tiered assessment system of low, moderate, and high-risk sex offenders and then, dependent on how the offender is classified,[76] officials determine to whom the information should be disclosed.[77]

Alternatively, states have employed toll-free hotline numbers through which the public can find out whether or not a specific person is a registered sex offender.[78] Some states have also implemented Internet registries, giving access to not only the community at risk, but also the entire nation.[79] These sites, which routinely contain the offender's name, photograph, home address, name of employer, and a physical description, tend not to distinguish between high and low risk sex offenders.[80]

D. *General Criticisms*

Since its enactment, Megan's Law and its progeny have been the center of controversy.[81] The purpose of Megan's Law was to arm the public with knowledge, enabling it to better protect its most vulnerable members, the children.[82] Critics, however, have challenged the efficacy of the registration and notification statutes, arguing that the system is not only over- and under-inclusive[83] but that sex offenders subject to the provisions "suffer severe, disruptive, and perhaps intolerable consequences."[84]

Registration statutes may encompass individuals that no longer pose a threat to society. For example, individuals may have been convicted of a sexual offense that has since been decriminalized, such as

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(2003); MASS. GEN. LAWS ANN. ch. 6, §§ 178C-178O (West 2003); MICH. STAT. ANN. § 4.475 (Michie 1997); MINN. STAT. ANN. § 243.166 (West 2003); MISS. CODE ANN. §§ 45-33-21 (2003); MO. ANN. STAT. §§ 589.400-.425 (West 2003); MONT. CODE ANN. §§ 46-23- 501 to -511 (2003); NEB. REV. STAT. §§ 29-4001 to -4013 (2003); NEV. REV. STAT. §§ 179D.450-.490 (2003); N.H. REV. STAT. ANN. § 651-B:2 (2003); N.J. STAT. ANN. §§ 2C:7-1 to -11 (West 2003); N.M. STAT. ANN. §§ 29-11A-1 to -8 (Michie 2003); N.Y. CORRECT. LAW § 168 (McKinney 2003); N.C. GEN. STAT. §§ 14-208.5 to -208.32 (2003); N.D. CENT. CODE § 12.1-32-15 (2003); OHIO REV. CODE ANN. §§ 2950.01-.99 (West 2002); OKLA. STAT. ANN. tit. 57, §§ 581-587 (West Supp. 2003); OR. REV. STAT. §§ 181.585-.606 (Supp. 2002); 42 PA. CONS. STAT. ANN. §§ 9791 (West 2003); R.I. GEN. LAWS §§ 11-37.1-1 to .1-19 (Supp. 2002); S.C. CODE ANN. §§ 23-3-400 to 3-520 (Law. Co-op. 2002); S.D. CODIFIED LAWS §§ 22-22-30 to -22-41 (Michie 2003); TENN. CODE ANN. §§ 40-39-101 to -39-110 (2003); TEX. GOV'T. CODE ANN. § 508.186 (Vernon 2001); UTAH CODE ANN. § 77-27-21.5 (2003); VT. STAT. ANN. tit. 13, §§ 5401-5413 (2003); VA. CODE ANN. § 19.2- 390.1 (Michie 2003); WASH. REV. CODE ANN. §§ 9A.44.130-.44.140, 4.24.550 (West 2003); W. VA. CODE § 15-12-2 (2003); WIS. STAT. ANN. § 301.45 (West 2002); WYO. STAT. ANN. §§ 7-19-301 to -19-306 (Michie 2003).

[75] Kerri L. Arnone, *Megan's Law and Habeas Corpus Review: Lifetime Duty with No Possibility of Relief?* 42 ARIZ. L. REV. 157, 159 (2000).

[76] Trivits & Reppucci, *supra* note 32, at 691.

[77] The officials charged with making the assessment also varies from state to state. A judge makes the decision in Montana, in New Jersey the prosecutor or a clinician makes the determination, and in Washington the responsibility typically rests with a law enforcement agency. *See id.*

[78] Jane A. Small, *Who are the People in Your Neighborhood? Due Process, Public Protection, and Sex Offender Notification Laws,* 74 N.Y.U. L. REV. 1451, 1462-65 (1999).

[79] Trivits & Reppucci, *supra* note 32, at 691.

[80] Small, *supra* note 78, at 1461.

[81] Trivits & Reppucci, *supra* note 32, at 692.

[82] Swearingen, *supra* note 3, at 526.

[83] Nicole Marie Nigrelli, *The Sex Offender Registry: Is it Attacking People That Were Not Meant to Be Part of the Law?* 4 SUFFOLK J. TRIAL & APP. ADVOC. 343, 352-54 (1999).

[84] *Id.*

consensual sodomy.[85] In some instances, although consensual sodomy poses no risk to the public, individuals convicted of this previously criminal activity have been ordered to register as sex offenders.[86] In addition, a majority of the statutes do not differentiate by the severity of the crime.[87] Thus, individuals convicted of multiple rapes may appear no different on the registry than individuals convicted of a less serious offense.[88] The possibility also exists that a person never convicted of a sexual offense will be included on the list due to human error.[89]

Conversely, critics argue these statutes are under-inclusive because offenders who do not comply with the registration requirements remain unknown to the community.[90] Less than complete compliance has been reported, with few agencies responsible for enforcement having the resources to ensure full compliance.[91]

Critics also fear sex offender registration statutes will create a false sense of security.[92] They do not prevent further offenses from occurring but the public may believe that the knowledge they provide is sufficient for protection.[93] In addition, critics claim that because many of the victims actually know their attacker the registration and notification laws do little in the way of providing additional protection.[94]

Another significant risk associated with the registration and notification statutes is their potential to lead to acts of vigilantism.[95] This can manifest itself as harassment,[96] ostracism, and "outright acts of violence."[97] Some instances of vigilantism that have taken place include a car bombing after the sex offender had been listed on the registry for only four days,[98] a sex offender's house being fired upon after it was discovered that he was living in the community,[99] and a sex offender's house being burned down when it was learned that he was going to move into the community.[100]

Although it has been estimated that there have actually been few major incidents of vigilantism, the threat of violence and the sex offender's concern regarding his or her safety adversely impacts the transition back into the community.[101] It may affect the ability to obtain employment and housing, as well as destroy the capacity to develop and maintain personal relationships.[102] Mental health professionals have expressed concern that the stress created by the inability to assimilate back into society may lead sex offenders to re-offend.[103]

### E. *Constitutional Challenges*

Considering the controversial nature of the registration and notification statutes, it is not surprising that these laws have been attacked on numerous occasions as being unconstitutional.[104] They have been challenged as violating the Ex Post Facto Clause, the Fifth Amendment's Double Jeopardy Clause, and the Eighth Amendment's Cruel and Unusual Punishment Clause.[105] It has also been argued that they

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[85] *See* Doe v. Poritz, 662 A.2d 367 (N.J. Sup. Ct. 1995) (plaintiff was a first time offender who had successfully completed treatment, successfully reintegrated into the community, and was no longer a threat to the public).
[86] Sedaghati, *supra* note 69, at 34; Small, *supra* note 78, at 1465.
[87] Trivits & Reppucci, *supra* note 32, at 692.
[88] *Id.*
[89] Small, *supra* note 78, at 1465.
[90] Trivits & Reppucci, *supra* note 32, at 692.
[91] *Id.*
[92] Lee, *supra* note 13, at 514.
[93] Trivits & Reppucci, *supra* note 32, at 692.
[94] Lee, *supra* note 13, at 514.
[95] Small, *supra* note 78, at 1467.
[96] Trivits & Reppucci, *supra* note 32, at 692.
[97] Small, *supra* note 78, at 1467.
[98] Trivits & Reppucci, *supra* note 32, at 692.
[99] *Id.*
[100] Sedaghati, *supra* note 69, at 36.
[101] Trivits & Reppucci, *supra* note 32, at 693.
[102] *Id.*
[103] *Id.*
[104] Swearingen, *supra* note 3, at 532.
[105] Trivits & Reppucci, *supra* note 32, at 693.

violate the right to privacy, equal protection, and due process.[106]

1. Ex Post Facto, Double Jeopardy, and Cruel and Unusual Punishment

The constitutional protections of the Ex Post Facto Clause, the Double Jeopardy Clause, and the Cruel and Unusual Punishment Clause only apply in the criminal context.[107] In an effort to have these protections apply, offenders have argued, usually unsuccessfully, that the registration and notification statutes constitute punishment if any facet of the law was aimed primarily at deterrence or retribution.[108] However, courts have consistently held that these laws are remedial in purpose, making the Ex Post Facto, the Double Jeopardy, and the Cruel and Unusual Punishment Clauses inapplicable.[109] As the New Jersey Supreme Court in *Doe v. Poritz* stated, "they were designed simply and solely to enable the public to protect itself from the danger posed by sex offenders"[110] and any punitive effect is merely "the inevitable consequence of these remedial provisions."[111]

2. Right to Privacy and Due Process

The Due Process Clause of the Fifth and Fourteenth Amendments may grant individuals a right to privacy that allows them to protect certain information from reaching the general public.[112] Offenders have claimed that the registration statutes impede their right to privacy because they are forced to disclose their name, address, and place of employment. To assert such a claim, however, one must show a reasonable expectation of privacy.[113]

Courts have held that sex offenders are not entitled to the same level of privacy because they are felons and thus the community's right to protect itself has prevailed over the right to privacy of sex offenders.[114] In addition, it has been determined that there is a diminished expectation of privacy in this information because it is a matter of public record.[115] It has also been found that the state's interest in protecting the members of society from sex offenders is significant and may outweigh the offender's privacy rights.[116] Some courts, as a result, have engaged in a balancing of the two interests and permit disclosure only to the extent needed to protect society, which in turn requires an assessment of the risk posed by the offender.[117]

3. Equal Protection

Sex offenders have argued that classifying those that have completed treatment or that no longer pose any danger to society with more violent repeat offenders is an Equal Protection violation.[118] Courts have found this argument lacking since "equal protection does not preclude the use of classifications, but requires only that those classifications not be arbitrary."[119] Moreover, they have asserted there is a strong state interest present, thereby justifying the use of such classification in the various registration and notification laws.[120] As stated in *Poritz*, "the state interest in protecting the safety of members of the public from sex offenders is clear and compelling."[121]

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[106] Small, *supra* note 78, at 1473; Swearingen, *supra* note 3, at 536-40.
[107] Swearingen, *supra* note 3, at 534.
[108] Sedaghati, *supra* note 69, at 37.
[109] *Id.*
[110] Poritz, 662 A.2d at 404.
[111] *Id.*
[112] Trivits & Reppucci, *supra* note 32, at 693.
[113] *Id.*
[114] *Id.*
[115] Poritz, 662 A.2d at 407-08; Sedaghati, *supra* note 69, at 38.
[116] Poritz, 662 A.2d at 412; Sedaghati, *supra* note 69, at 38.
[117] Poritz, 662 A.2d at 412; Trivits & Reppucci, *supra* note 32, at 693.
[118] Swearingen, *supra* note 3, at 535.
[119] *Id.* at 538.
[120] Lee, *supra* note 13, at 491.
[121] Poritz, 662 A.2d at 412.

4. The Supreme Court's Opinions

During 2003, the United States Supreme Court handed down decisions regarding challenges to the sex offender registration and notification provisions of Alaska and Connecticut, respectively. The Supreme Court rejected both challenges.

In *Smith v. Doe I*, it was argued that Alaska's placement of a sex offender's name on an Internet registry constituted a form of punishment and because this requirement was imposed after the offender was convicted and sentenced it was a violation of the Ex Post Facto Clause.[122] The Court found that although registration as required by the Alaska Sex Offender Registration Act could result in public humiliation,[123] the statute was intended as a "civil, non-punitive" means of identifying sexual offenders for the protection of the public.[124] Thus, the Court held that the publication of the offender's name did not constitute retroactive punishment in violation of the Ex Post Facto Clause.[125] Moreover, the Court stated that the widespread public access, a consequence of posting the information on the Internet, was necessary to ensure the effectiveness of Alaska's regulatory scheme.[126] The Court further reasoned that because the information was largely a matter of public record, the dissemination of the offender's registration information did not amount to a significant "affirmative disability or restraint."[127]

In a second case, *Connecticut Department of Public Safety v. Doe*, the offender alleged that the lack of a hearing to assess an offender's risk of recidivism before information was posted on the Internet was a violation of the Fourteenth Amendment's Due Process Clause.[128] The Court held that due process did not entitle the offender to a hearing to prove a fact—his or her current level of dangerousness—that was not "material to the State's statutory scheme."[129] The Court determined that all that was being asserted by placement of the offender's information on the Internet was that the offender had previously been convicted of a sexual crime,[130] "a fact that an offender had already had a procedurally safeguarded opportunity to contest."[131]

## V. Applying Megan's Law to Juveniles

Because of the public's alarm at the acts of violence committed by juveniles and the fear that juvenile sex offenders will recidivate, more and more states include juveniles among those sex offenders ordered to register.[132] In subjecting juveniles to the same registration and notification provisions as adult sex offenders, many legislatures relied on the few studies that have followed juvenile offenders into adulthood and that found that "sex offenders that began committing sexual crimes in their adolescence had a higher rate of recidivism for sexual offenses than other juvenile offenses."[133] Little attention has been given to whether these registration and notification requirements may cause harm to the juvenile.[134]

At least nineteen states explicitly require registration by juvenile sex offenders adjudicated delinquent.[135] Only New Mexico

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[122] 123 S. Ct. 1140, 1146-47 (2003).
[123] *Id.* at 1150.
[124] *Id.* at 1149.
[125] *Id.* at 1155.
[126] *Id.* at 1150.
[127] *Id.* at 1151.
[128] 123 S. Ct. 1160, 1163-64 (2003).
[129] *Id.* at 1162.
[130] *Id.* at 1163-64.
[131] *Id.* at 1164. Because the respondent did not raise a substantive due process challenge, the Court expressed no opinion as to whether Connecticut's "Megan's Law" violated these principles. *Id.* at 1165.
[132] Rothchild, *supra* note 12, at 735-36.
[133] Thakur, *supra* note 4, at 101.
[134] Rothchild, *supra* note 12, at 735-36.
[135] *See* ALA. CODE § 15-20-21 (2003); ARIZ. REV. STAT. § 13-3821 (2003); ARK. CODE ANN. § 12-12-905 (Michie 2003); COLO. REV. STAT. 16-22-103 (2003); Del. Code Ann., tit. 11, § 4121 (2003); IDAHO CODE §§ 18-8401, 18-8404, 18-8407 (Michie 2003); 730 ILL. COMP. STAT. 150/2 (2003); IND.

has specifically opted to exclude juveniles from the provisions of registration and notification statutes.[136] Other states' statutory language is ambiguous on whether juveniles need to comply with the registration and notification provisions as required of adult sex offenders.[137]

Among those states applying the registration and notification requirements to juveniles, a number have determined that juvenile offenders are not similarly situated to adult sex offenders and impose on juveniles shorter periods of registration or make available special waiver mechanisms.[138] In contrast, New Jersey treats juveniles no differently than adult sex offenders, mandating that their information be disclosed to the community.[139] California and Texas both release the juvenile's information but only after a specific request.[140] Although Indiana forbids the disclosure of a juvenile's address, it does notify the juvenile offender's school and other agencies deemed to have a right to know.[141] Colorado, however, will only disclose the information upon a showing of "demonstrated need to know."[142]

Not surprisingly, the legality of juvenile sex offender registration statutes has been challenged.[143] In February 2003, the Supreme Court of Illinois specifically addressed the issue in *In re* J.W.[144] A twelve-year-old juvenile, J.W., had been adjudicated delinquent of aggravated criminal assault against two seven-year-old boys and placed on probation. As a condition of his probation, he was required to comply with the Illinois Sex Offender Registration Act and thus register as a sex offender for the rest of his life.[145] The crux of his argument was that requiring him to register for the remainder of his natural life was a violation of his substantive due process rights.[146] He contended that juveniles "traditionally have been viewed as less culpable than adults and as more amenable to rehabilitation and treatment," "imposing a lifetime registration requirement on a 12-year-old child is at odds with the purpose and policy of the Juvenile Court Act," and that such an imposition was unreasonable.[147]

The court did not find that the registration statute infringed a fundamental right. The Illinois Supreme Court therefore applied the less stringent rational basis test which required that the statute be upheld if it "'bears a reasonable relationship to a public interest

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CODE ANN. § 5-2-12-4 (West 2003); KAN. STAT. ANN. § 22-4904 (2002); MASS. GEN. LAWS ANN. ch. 6, § 178C (West 2003); MONT. CODE ANN. § 41-5-1513 (2003); N.J. STAT. ANN. § 2C:7-2 (West 2003); N.C. GEN. STAT. § 14-208.26 (2003); OR. REV. STAT. § 181.594 (Supp. 2002); R.I. GEN. LAWS § 11-37.1-12 (2003); S.C. CODE ANN. § 23-3-490 (Law. Co-op. 2002); S.D. CODIFIED LAWS § 22-22-31 (Michie 2003); WASH. REV. CODE § 9A.44.130 (2003); WIS. STAT. § 301.45 (2002).

[136] *See* N.M. Stat. Ann. § 29-11A-3 (Michie 2003).

[137] *See* ALASKA STAT. §§ 12.63.010 to .100 (Michie 2003); D.C. CODE ANN. § 22-4001 (2003); FLA. STAT. ANN. § 775.21 (West 2003); GA. CODE ANN. §42-1-12 (2003); MD. CODE ANN., Crim. Proc. § 11-708 (2003); MO. ANN. STAT. §§ 589.400 to .425 (West 2002); NEB. REV. STAT. §§ 29-4001 to 4013 (2003); N.Y. CORRECT. LAW §§ 168-a to -v (McKinney 2003); OKLA. STAT. ANN. tit. 57, §§581-588 (West Supp. 2003); 42 PA. CONS. STAT. ANN. §§ 9791-9799.6 (West 2003); TENN. CODE ANN. §§40-39-101 to -110 (2003); UTAH CODE ANN. § 77-27-21.5 (2003); VT. STAT. ANN. tit. 13, §§ 5401-5413 (2003); W. VA. CODE ANN. § 15-12-1 (2003); WYO. STAT. ANN. §§ 7-19-301 to -306 (Michie 2003).

[138] Swearingen, *supra* note 3, at 569. ("[I]n Minnesota, Oregon, and Texas, the period of registration lasts only ten years. In Mississippi, juveniles are required to register only after they have been adjudicated of a sex offense. . . . In Indiana, juveniles are only required to register if it is proven by clear and convincing evidence that they are likely to re-offend. Similarly, in South Carolina only juveniles who were convicted in adult criminal proceedings are required to register.").

[139] *Id.* at 573.

[140] *Id.*

[141] *Id.*

[142] *Id.*

[143] *Id.* at 545-55.

[144] *In re* J.W., 787 N.E.2d 747 (Ill. 2003), *cert. denied* 124 S. Ct. 222 (U.S. 2003).

[145] *Id.* at 753-54.

[146] *Id.* at 755.

[147] *Id.* at 758.

to be served, and the means adopted are a reasonable method of accomplishing the desired objective.'"[148] The court found the statute to be constitutionally valid because it bore a reasonable relationship to the public interest in protecting children from sexual assault.[149] The court concluded the statute was non-punitive in nature[150] and emphasized that access to a juvenile offender's information was restricted, only being disseminated upon a showing that a public member's safety "might be compromised."[151]

The Appellate Division of the New Jersey Superior Court was faced with a similar challenge in *In re* B.G.[152] A twelve-year-old juvenile was adjudicated delinquent for conduct that would have constituted a second degree sexual assault if committed by an adult after he committed a sexual act with his eight-year-old stepbrother.[153] He was subsequently ordered to register in accordance with New Jersey's Megan's Law.[154] B.G. objected to the registration requirement arguing that it was contrary to New Jersey's juvenile code.[155] The court disagreed, holding that the registration requirements apply to "'all juveniles, no matter what their age, found delinquent'" of the requisite sexual offense.[156] The court also ruled that the requirement did not terminate when the juvenile reached the age of eighteen, even though "dispositions" issued by the juvenile court ended at that point.[157]

[148] *Id.* at 757 (quoting People v. Adams, 581 N.E.2d 637 (1991)).
[149] *Id.* at 757-59.
[150] *Id.* at 761-62.
[151] *Id.* at 760.
[152] *In re* B.G., 674 A.2d 178 (N.J. Super. Ct. App. Div. 1996). *See also In re* K.B., 701 A.2d 760 (N.J. Super. Ct. App. Div. 1997).
[153] *In re* B.G., 674 A.2d at 182. *See also* Hiller, *supra* note 9, at 279-80; Lee, *supra* note 13, at 505-08.
[154] *In re* B.G., 674 A.2d at 182.
[155] *Id.* at 181.
[156] *Id.* at 184 (quoting Doe v. Portiz, 662 A.2d 367, 392 (N.J. Sup. Ct. 1995)).
[157] *Id.* at 185.

Despite these rulings, the controversy continues. Mental health professionals are among the most vocal opponents to the application of sex offender and notification statutes to juveniles, fearing its detrimental effect on juveniles' assimilation back into society.[158] Critics contend that the application of such laws to juveniles is in direct conflict with the guiding philosophy of *parens patriae* and that, rather than protect, they actually harm juvenile offenders by subjecting them to anger, isolation, and retribution.[159]

A. *Conflict with Parens Patriae Philosophy*

> Alan Groome, a juvenile sex offender who spent three years in a Washington prison for raping two boys, moved into an Olympia, Washington, apartment with his mother. The local police department knocked on seven hundred doors in the neighborhood, handing out fliers containing Groome's photo and address. The landlord eventually evicted Groome and his mother.[160]

If *parens patriae* principles are applied, the juvenile justice system should serve as a protector of children. As the above example illustrates, the application of the registration and notification statutes can result in considerable harm to the young offender.[161] The disclosure associated with such statutes "may inspire vigilantism, public shame, social ostracism, and various types of adverse legal action, including loss of employment and eviction."[162]

Confidentiality, a hallmark of juvenile proceedings, may also be difficult to maintain when Megan's Law is applied to juvenile offenders.[163] One goal of the juvenile justice system has been to prevent the labeling or

[158] Trivits & Reppucci, *supra* note 32, at 694-95.
[159] Hiller, *supra* note 9, at 282-83.
[160] *Id.* at 287.
[161] Trivits & Reppucci, *supra* note 32, at 694.
[162] Hiller, *supra* note 9, at 287.
[163] Trivits & Reppucci, *supra* note 32, at 694.

stigmatization of juveniles, thereby enabling juveniles to re-integrate into society without being burdened by their past mistakes.[164] When Megan's Law is applied to juveniles, this fundamental tenet is destroyed. The registration requirements permanently brand juveniles as sex offenders, serve as a constant reminder of their transgression, and prevent their re-assimilation into society.[165] Allowing juveniles to be subjected to this shame and ridicule, it has been contended, constitutes neglect by the state.[166]

Because of their impact, the application of these laws to juveniles has been asserted to constitute punishment, placing them at variance with the juvenile justice system's articulated purpose of rehabilitation.[167] Although the legislators' intent may have been remedial, in practice, these laws have had a punitive effect on offenders.[168] Although the U.S. Supreme Court has refused to classify registration and notification requirements as punitive when applied to adult sexual offenders,[169] because juvenile offenders do not possess the same due process and procedural rights as adults, these laws may be more punitive when applied to juveniles.[170] Concern has been raised as to how juveniles can be subjected to the same registration and notification provisions as adult sex offenders, while concomitantly only being afforded limited due process rights.[171]

B. *Impact on Rehabilitative Efforts*

Mental health professionals posit that public disclosure hinders rehabilitative efforts by stigmatizing the juvenile as a sex offender,[172] which may result in increased isolation from peers, social ostracism, an inability to form meaningful relationships, and a failure to experience normal child-adolescent development.[173] This may manifest itself in heightened feelings of anger, fear, low self-worth, and aggression.[174]

Furthermore, the registration and notification provisions send a message to juvenile offenders that rehabilitation is futile.[175] Even if a juvenile successfully completes treatment, he or she will always be identified as a sex offender,[176] hampering his or her ability to re-integrate and to mature into a productive member of society.[177] Psychologists fear that this will only "increase the risk of recidivism among sexually abusive youth whose impaired social and interpersonal skills were a contributing factor in turning to younger children for sexual gratification and social interaction."[178] The irony is that in applying Megan's Law to juveniles, the legislatures are countering efforts at treatment and rehabilitation and undermining their purported goal of deterring offenders from recidivating.[179] Rather, the application of these laws to juvenile offenders only increases their alienation and the likelihood that they will re-offend.[180] Moreover, critics posit that "until research has demonstrated the protective efficacy of notification with juveniles and explored the impact of notification on the youth, their families and the community, notification – if imposed at all for juveniles – should be done conscientiously, cautiously, and selectively.[181]

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[164] *Id.*
[165] *Id.*
[166] Hiller, *supra* note 9, at 288.
[167] Trivits & Reppucci, *supra* note 32, at 694.
[168] *Id.*
[169] *See* Conn. Dep't of Pub. Safety v. Doe, 123 S. Ct. 1160 (2003); Smith v. Doe I, 123 S. Ct. 1140 (2003).
[170] Trivits & Reppucci, *supra* note 32, at 694.
[171] *Id.*
[172] Rothchild, *supra* note 12, at 745; Swearingen, *supra* note 3, at 560.
[173] Trivits & Reppucci, *supra* note 32, at 694.
[174] Leversee & Pearson, *supra* note 8, at 51; Swearingen, *supra* note 3, at 561.
[175] R. Jeffrey Lowe, *School Notification of Students' Sexual Offense Convictions: Does it Protect our Children or Impede Quality Education?* J.L. & EDUC. 169, 174 (1997).
[176] *Id.*
[177] Swearingen, *supra* note 3, at 562.
[178] Leversee & Pearson, *supra* note 8, at 51.
[179] Lowe, *supra* note 175, at 174.
[180] Hiller, *supra* note 9, at 293.
[181] Leversee & Pearson, *supra* note 8, at 52.

C. *The Recidivism Myth*

As previously discussed, one of the primary motivations behind extending Megan's Law to juveniles was the public's perception that sexual offenders, including juveniles, resisted change, thereby making them untreatable.[182] The widespread media attention paid to the sex crimes perpetrated by juveniles only served to perpetuate the overbroad generalization of "once a sex offender, always a sex offender."[183] To the contrary, research studies suggest that the recidivism rate of juveniles who successfully complete a treatment program is only ten to twenty percent.[184] Similarly, the Office of Juvenile Justice and Delinquency Prevention's 1999 National Report found that, contrary to the widespread belief that juvenile sexual crimes are on the rise, the arrest rate for forcible rapes committed by juveniles did not show "substantial growth" between 1987 and 1994 and on average has remained relatively constant since the 1980s.[185]

Mental health professionals have long argued that children are more amenable to treatment than adults.[186] It was this very concept of children's deviant behavior being less ingrained that served as a basis for the rehabilitation ideal of the juvenile justice system.[187] Because children's deviant behavior is less established, treatment modalities such as cognitive-behavioral therapies, relapse conditioning, pharmacological therapies, and intensive family based interventions can prove effective in enabling the juvenile sex offender to control his or her sexually deviant behavior.[188]

Some researchers have hypothesized that children may perpetrate these types of offenses as they explore and grow into their own sexualities.[189] Attaching consequences such as treatment, counseling, or probation to the juvenile's deviant behavior, it is believed, makes it unlikely the behavior will be repeated.[190] Furthermore, it has been asserted that legislatures may lack a "clear understanding of what constitutes normative sexual development."[191] As a result, a juvenile engaging in normal age-appropriate sexual behavior could be charged with a felony sexual offense, be required to register as a sexual offender, and be identified to the community as a sexual offender.[192]

Mental health professionals have also voiced concern that by focusing on the offense, instead of the offender, juvenile sex offenders suffering from a mental disease or defect may fail to be diagnosed and properly treated.[193] The National Task Force on Juvenile Sexual Offending has recommended that treatment, not punishment, be pursued.[194] It focused on the importance of the juvenile's acceptance of responsibility for his or her behavior, the identification of any cognitive disorders that may be related to the deviant behavior, and the development of the juvenile sex offender's empathy towards others.[195] Most importantly, adopting treatment as the default with respect to juvenile sex offenders, instead of the more punitive measure of the registration and notification statutes, comports with the juvenile justice system's tradition of *parens patriae*.[196]

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[182] Richard Hamill, *Recidivism of Sex Offenders: What You Need to Know,* 15 WTR CRIM. JUST. 24 (2001).
[183] *Id.*
[184] *Id.* at 31.
[185] *See* Office of Juvenile Justice and Delinquency Prevention, *Law Enforcement and Juvenile Crime* (in 1999 National Report) (visited Jan. 7, 2004) <http://www.ncjrs.org/html/ojjdp/nationalreport99/chapter5.pdf>.
[186] Trivits & Reppucci, *supra* note 32, at 697.
[187] *Id.*
[188] Rothchild, *supra* note 12, at 747.
[189] Trivits & Reppucci, *supra* note 32, at 696.
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] *Id.* at 701.
[194] Ryan et al., *supra* note 14, at 24-25.
[195] *Id.*
[196] Rothchild, *supra* note 12, at 758.

## VI. Conclusion

In the wake of Megan Kanka's brutal death at the hands of her neighbor, a convicted sex offender, Congress and legislatures nationwide began passing sex offender registration and notification statutes.[197] As the public grew increasingly concerned with what it perceived to be the inability of juvenile sex offenders to reform, legislatures began modifying their registration and sex offender statutes to encompass the very people these laws had been drafted to protect.[198]

By extending the registration and notification provisions of Megan's Law to juveniles, we call into question the philosophy of the juvenile justice system, we sacrifice rehabilitation for the sake of punishment, and we permanently and unfairly brand juveniles as sex offenders. In effect, we are denying them the opportunity for a successful future free from the burden of their previous mistakes. Without this hope, few options remain open for juvenile sex offenders, enhancing the likelihood that they will become entangled in the vicious cycle of re-offense. Instead, we should adhere to the premise of the system that was established with the juvenile's best interests at heart, the juvenile justice system, and offer juveniles a second chance at a life without the scarlet letter label of "sex offender."

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[197] Small, *supra* note 78, at 1451-52.
[198] Rothchild, *supra* note 12, at 735-36.

**Death Penalty Reversed Because Counsel Did Not Conduct "Reasonable" Investigation of Defendant's Childhood History**

Under the Sixth Amendment, a criminal defendant is entitled to the "effective assistance" of an attorney. In a Maryland case, the Supreme Court ruled a capital defendant received ineffective assistance of counsel when his lawyers failed to conduct a "reasonable" investigation of the defendant's childhood history before deciding not to present related mitigation evidence at sentencing. According to the Court, the attorneys should have pursued childhood privation and abuse leads brought to their attention by the records they reviewed.

The defendant was convicted of murdering an elderly woman. During the sentencing hearing, counsel focused on perceived weaknesses in the state's case but presented no evidence of his life history. The Fourth Circuit had concluded counsel were sufficiently aware of defendant's background to make an informed strategic choice on how to use this information. Reversing this ruling, the Supreme Court said the primary concern was not whether counsel should have presented a mitigation case but whether they undertook a reasonable investigation of the mitigating facts before making their decision.

The attorneys had a pre-sentence investigation report with a one-page personal history noting defendant's "disgusting" and miserable youth. They also had records of defendant's placements in the state's foster care system. This information revealed defendant's mother was a chronic alcoholic; he was shuttled from foster home to foster home where he displayed some emotional difficulties; he had frequent, lengthy absences from school; and, on at least one occasion, his mother left him and his siblings alone for days without food. The attorneys' failure to expand their investigation beyond these records, the Court found, fell short of prevailing professional standards. Standard practice in capital cases, the Court determined, included preparation of a forensic social history report. Despite their knowledge of this practice and the availability of public funds to pay for it, the Court noted counsel failed to obtain such a report. The Court concluded that the abuse the defendant suffered at the hands of his mother and in numerous foster homes, as well as the years he spent homeless, was "the kind of troubled history we have declared relevant to assessing a defendant's moral culpability." This ruling may indicate that an attorney's failure in a capital case to investigate a defendant's history of mental illness when the attorney has at least some notice of that history may serve as grounds for overturning a death penalty. Wiggins v. Smith, 123 S. Ct. 2527 (2003); 71(50) U.S. Law Week 1798-99 (July 1, 2003).

**"Treating Physician Rule" for Making Disability Benefit Determinations Under Employee Benefit Plans Rejected**

The Supreme Court unanimously held that although special weight is given to a claimant's treating physician (the "treating physician rule") in determining whether a claimant is entitled to Social Security disability benefits, an administrator of an employee benefit plan is not required to similarly give preferential weight to the opinion of an employees' treating physician. Such benefit plans are governed by the federal Employee Retirement Income Security Act (ERISA). The Ninth Circuit had ruled that ERISA, like the Social Security Act, imposed the "treating physician rule." The Supreme Court rejected this position and determined a plan administrator was free to give greater weight to the conclusions of a physician who conducted an independent assessment at the behest of the plan administrator than to the employee's treating physician. The Court concluded employee benefit plans were best served by preserving for them the greatest flexibility possible in their processing of

employee health benefit claims. Black & Decker Disability Plan v. Nord, 123 S. Ct. 1965 (2003); 71(45) U.S. Law Week 1720 (May 27, 2003).

**Two-Year Ban on Visits to Inmates with Two Substance-Abuse Violations Upheld**

The Supreme Court upheld a Michigan prison regulation that prisoners with two substance-abuse violations could not receive any visitors except attorneys and members of the clergy for two years. In a unanimous decision, the Court noted drug smuggling and drug use in prison are intractable problems and asserted withdrawing visitation privileges is a proper and even necessary management technique to induce compliance with the rules governing inmate behavior. The Court did add it might reach a different conclusion if the ban was for a much longer period of time, treated as a *de facto* permanent ban, or applied in an arbitrary manner to a particular inmate. Overton v. Bazzetta, 123 S. Ct. 2162 (2003).

**Ruling Ordering Evidentiary Hearing on Whether Defendant's Confession to a Prison Psychiatrist Following a Group Therapy Session Was Involuntary Because He Reasonably Believed Statements Were Protected by a Confidentiality Agreement Not Disturbed**

The Supreme Court declined to review a decision by the Ninth Circuit that permitted a criminal defendant to obtain a new hearing on whether his confession had been involuntary under the Fifth Amendment. The defendant had been convicted of murder partly on the strength of a prison psychiatrist's testimony regarding a confession the defendant made to him after a group therapy session. The Ninth Circuit held the defendant was entitled to a hearing on whether he reasonably believed his statements to the psychiatrist were protected by a confidentiality agreement he had signed that promised that "all group communication" would be kept confidential. Beaty v. Stewart, 303 F.3d 975 (9th Cir. 2002), *cert. denied*, Stewart v. Beaty, 123 S. Ct. 2073 (2003); 71(44) U.S. Law Week 3715 (May 20, 2003).

**Ruling that Dangerous Student May Be Suspended Pending Psychiatric Evaluation Not Disturbed**

The Supreme Court declined to review a decision by a New York appellate court that upheld the suspension of a public school student from school and his placement in homebound instruction pending the completion of a psychiatric evaluation of the student and review by the school district's committee on special education. Under New York law, a school district may not unilaterally change a student's placement from regular instruction to homebound instruction while proceedings to determine whether the student is disabled are pending, even when a student poses a danger to himself or others. However, the New York appellate court determined a school district is entitled to seek a judicial ruling to extend a student's suspension upon a showing that maintaining the student in his current placement is substantially likely to result in injury to the student or to others. The New York court found that such a showing had been made when it was undisputed that the student had without permission run out of classrooms and school buildings dangerously close to the Long Island Expressway, chased other students in the classroom, hit teachers and students with either a folder or crumpled paper, and chewed on sharp objects while leaning back in his chair. Roslyn Union Free Sch. Dist. v. Geffrey W., 293 A.2d 662 (N.Y. App. Div. 2002), *cert. denied*, Waxman v. Roslyn Union Free Sch. Dist., 123 S. Ct. 2077 (2003); 71(44) U.S. Law Week 3719 (May 20, 2003).

**Ruling that Officials Can Force Convicted Murderer to Take Medication to Make Sane Enough to Be Executed Not Disturbed**

The Supreme Court declined to review a ruling by the Eighth Circuit that allowed Arkansas officials to force a convicted murderer to take medication intended to make him sane enough to be executed. In 1986 the

Supreme Court held that executing an insane individual violates the Eighth Amendment's cruel and unusual punishment clause. However, the Supreme Court has not ruled on whether an individual can be forcibly medicated to be made sane enough to qualify for an execution.

In the first decision by a federal court of appeals, the Eighth Circuit ruled six-to-five that the cruel and unusual punishment clause is not violated when authorities forcibly administer antipsychotic medication to an individual for this purpose. The defendant was convicted of killing a grocery clerk in Arkansas in 1979 and was sentenced to death that year. His mental health began to deteriorate in 1987 and he reportedly believes his prison cell is possessed by demons, authorities planted a device in his ear, and his victim is still alive. The dissent in the Eighth Circuit argued that the majority opinion will force the medical community to practice its profession in a manner contrary to its ethical standards, leaving it with an impossible ethical choice: treat the individual to afford him short-term relief that ultimately results in his execution or leave him untreated but condemned to a world filled with disturbing delusions and hallucinations. Singleton v. Norris, 319 F.3d 1018 (8th Cir. 2003), *cert. denied*, 124 S. Ct. 74 (2003).

**Reversal of Capital Conviction Because Counsel Failed to Request Diminished Capacity Jury Instruction to Reflect Defendant's "Explosive Dyscontrol" from Chronic Drug Use Not Disturbed**

Perhaps presaging its decision in *Wiggins* (described above), the Supreme Court declined to review a ruling of the Ninth Circuit that overturned a first-degree murder conviction for ineffective assistance of counsel in violation of the Sixth Amendment because defendant's attorney failed to request a diminished capacity jury instruction. At trial, the defendant testified he ingested methamphetamines, cocaine, and marijuana the night before the murder but was "coming down" three hours before the murder. Despite this evidence the drugs he used were wearing off three hours before the murder, defense counsel requested an intoxication instruction.

The Ninth Circuit asserted counsel should have recognized the weakness of this defense and instead have requested a diminished capacity instruction. The court asserted this defense, long recognized under Washington law, could have been used to reflect evidence the defendant suffered from a right temporal lobe seizure, or "explosive dyscontrol," from chronic drug use. This, the court concluded, would have allowed the jury to consider whether the defendant's mental condition affected his ability to premeditate and might have avoided the capital conviction and subsequent death penalty. Without it, the jury "had no legal framework" in which to place the expert testimony they heard about the defendant's mental state. The State of Washington was given 180 days to begin new proceedings. Pirtle v. Morgan, 313 F.3d 1160 (9th Cir. 2002), *cert. denied*, Morgan v. Pirtle, 123 S. Ct. 2286 (2003); 71(47) U.S. Law Week 3756 (June 10, 2003).

**Reversal of Capital Conviction and Death Sentence Because Counsel Failed to Investigate Defendant's Mental Health and Drug Abuse Problems Not Disturbed**

Perhaps reflecting its decision in *Wiggins* (described above), the Supreme Court declined to review a Ninth Circuit ruling that overturned a capital conviction and imposition of the death penalty for ineffective assistance of counsel because defendant's attorney failed to discover and present easily available evidence of the defendant's mental health and drug abuse problems despite knowing that the defendant had such problems. The defendant was a habitual, heavy methamphetamine user, had attempted suicide, was described by a psychiatrist as schizophrenic, had a long history of injuring himself and pouring liquids in the resulting wounds causing gangrene, and had been involuntarily committed for psychiatric evaluation because he appeared catatonic. In addition, a number of individuals told the attorney they thought something was

"seriously wrong" with the defendant.

The Ninth Circuit concluded counsel was obliged to investigate these problems to determine whether reliance on mental status defenses would have been a better strategy than relying on the alibi asserted by the defendant. The court asserted that introducing the evidence of defendant's psychological and family history would almost certainly have raised reasonable doubt with respect to the mental elements of the offense and likely would have led the jury to return a conviction on lesser charges than capital murder. Although attorneys are entitled to considerable latitude in conducting their cases, the Ninth Circuit ruled they must "have gathered sufficient evidence upon which to base their tactical choices." The court determined counsel had not concluded after a reasonable investigation that mental status defenses were not viable. Jennings v. Woodford, 290 F.3d 1006 (9th Cir. 2002), *cert. denied*, Woodford v. Jennings, 123 S. Ct. 2638 (2003); 71(50) U.S. Law Week 3795 (July 1, 2003).

**Reversal of Death Sentence Because Counsel Failed to Investigate and Present Defendant's Childhood Abuse as Mitigating Evidence Not Disturbed**

Perhaps reflecting its decision in *Wiggins* (described above), the Supreme Court declined to review the ruling of the Ninth Circuit that overturned the imposition of the death penalty for ineffective assistance of counsel in violation of the Sixth Amendment because defendant's attorney failed to thoroughly investigate and present during the sentencing phase substantial mitigating evidence concerning the defendant's childhood history. This evidence included abuse inflicted upon the defendant and his mother by his father and stepfather. Notwithstanding the family's denial of and reluctance to discuss this abuse, the Ninth Circuit said counsel should have investigated and presented this evidence in view of the extremely probative and wrenching nature of the evidence, the sparseness of the mitigating evidence actually offered, the prosecution's focus on the defense's failure to provide substantial mitigating evidence, and the fact the jury took three days to reach a verdict in favor of death. The court stressed such evidence was vital for informing the jury about the background and character of the defendant in a capital case so that the defendant is treated as a uniquely individual human being and a reliable determination is made that death is the appropriate sentence.

At the same time, the Ninth Circuit upheld a lower court ruling that rejected defendant's claim that he had received ineffective assistance of counsel because of a failure to examine the defendant's family history of mental illness. The court determined that in 1982, when the trial occurred, counsel was not constitutionally compelled to research this issue. Karis v. Calderon, 283 F.3d 1117 (9th Cir. 2002), *cert. denied*, Woodford v. Karis, 123 S. Ct. 2637 (2003); 71(50) U.S. Law Week 3795 (July 1, 2003).

**Reversal of Death Sentence Because Counsel Failed to Adequately Investigate Defendant's Social History and Mental Health, Even Though Defendant Was Not Forthcoming and Was Opposed to an Investigation of His Mental Health, Not Disturbed**

Perhaps reflecting its decision in *Wiggins* (described above), the Supreme Court declined to review a Ninth Circuit ruling that a capital defendant received ineffective assistance of counsel in violation of his Sixth Amendment rights when counsel failed to adequately investigate defendant's social history and mental health for information that could have been used as mitigating evidence at sentencing. The defendant thus was entitled to have his death sentence vacated even though he had not been forthcoming with information about his social history and was opposed to an investigation of his mental health. The Ninth Circuit ruled trial counsel had a duty to investigate a defendant's mental state if there was evidence to suggest, as was the case here, that the defendant was

impaired and this duty was not absolved by the defendant's refusal to cooperate when there was a significant and readily discoverable alternative source of information available. Woodford v. Douglas, 316 F.3d 1079 (3d Cir. 2003), *cert. denied*, 124 S. Ct. 49 (2003).

**Ruling that Alcoholism and Intoxication Do Not Require Special Capital Sentencing Jury Instruction Identifying Them as Mitigating Factors Not Disturbed**

The Supreme Court declined to review a Fifth Circuit ruling that upheld the capital sentence of a Texas man. The defendant argued in part that the trial court was required to identify alcoholism or evidence of intoxication at the time of the offense as mitigating factors during the sentencing hearing. The Fifth Circuit concluded that neither constituted a "uniquely severe permanent handicap[ ] with which the defendant was burdened through no fault of his own," which would have required a special jury instruction under the Supreme Court's opinion in *Penry v. Lynaugh* (1989). The Fifth Circuit also determined the jury was able to give mitigating effect to evidence of the defendant's alcoholism under jury instructions pertaining to deliberateness and future dangerousness and to evidence of the defendant's intoxication through the instruction on deliberateness.

The Fifth Circuit also rejected the defendant's assertion he had received ineffective assistance of counsel when evidence was not introduced of his troubled childhood and family background, drug and alcohol problems, and prior prison record. The court characterized proposed evidence that would have shown the defendant's IQ score in the seventh grade was 88 as "weak". The court similarly found evidence of an abusive childhood as "less than compelling" when the defendant proposed to show that, although he was raised in a stable family environment, his father played favorites among his children and blamed the defendant for the death of his brother. The Fifth Circuit asserted this omitted evidence could be viewed by a jury as either mitigating or aggravating and a "failure to present such double-edged evidence is not prejudicial." The court also noted the overwhelming evidence of violence in the defendant's background, which undercut the argument that the omitted evidence would have resulted in a different outcome. Harris v. Cockrell, 313 F.3d 238 (5th Cir. 2002), *cert. denied,* 123 S. Ct. 1576 (2003).

**Ruling that Defendant Found Incompetent to Stand Trial Must Initially Be Hospitalized, Even if Unlikely to Be Restored to Competence, Not Disturbed**

The Supreme Court declined to review a ruling of the Eighth Circuit that joined the First, Seventh, and Eleventh Circuits in holding that an initial period of hospitalization is mandatory for a criminal defendant in the federal system who has been found incompetent to stand trial, even when the evidence shows he is unlikely to be restored to competence. The Eighth Circuit ruled the trial court did not have the discretion, prior to a reasonable period of hospitalization, to determine whether the defendant will likely attain the capacity to stand trial. The court determined hospitalization permitted a more careful and accurate diagnosis; the limited length of the hospitalization, a maximum of four months, minimized the potential harm to the defendant; and the "miracles of science suggest that few conditions are truly without the possibility of improvement." United States v. Ferro, 321 F.3d 756 (8th Cir. 2003), *cert. denied*, Ferro v. United States, 124 S. Ct. 296 (2003).

**Ruling that Woman Can Be Convicted of "Homicide by Child Abuse" for Causing Stillbirth of Viable Fetus by Using Cocaine Not Disturbed**

The Supreme Court declined to review a ruling by the South Carolina Supreme Court that a woman could be convicted of the crime of homicide by child abuse and sentenced to 20 years in prison for causing the stillbirth of her viable fetus by using cocaine. The South Carolina court held that the statute defining the crime of homicide by child abuse could be

applied to stillbirths based on prior holdings that the legislature's use of the word "child" encompassed a viable fetus. In light of common knowledge that cocaine use during pregnancy can harm a fetus, the court determined the statute provided sufficient notice that it could be applied to a woman whose fetus is stillborn. The court also found that the application of the statute here did not violate constitutional rights of privacy and autonomy, that the sentence was not grossly disproportionate to the offense, and that taking a urine sample from the defendant in the hospital did not violate her Fourth Amendment rights. State v. McKnight, 576 S.E.2d 168 (S.C. 2003), *cert. denied,* McKnight v. South Carolina, 124 S. Ct. 101 (2003).

**Ruling that 12-Year-Old Boy Could Be Subject to Life-Long Sex Offender Registration and Be Required to Move from His Home Town Not Disturbed**

The Supreme Court declined to review a ruling of the Supreme Court of Illinois that a juvenile adjudicated delinquent for aggravated criminal sexual assault could be required to register and report for the rest of his life as a sex offender and could be prohibited from residing in his home town. The juvenile was a 12-year-old boy who had been sentenced to a term of five years' probation following his admission of having sexual contact with two 7-year-old boys a number of times. He was required to reside with his aunt and would be allowed to reside with his parents only if they moved to another town. The juvenile had argued in part that subjecting him to the registration requirement was inconsistent with the purposes and policies underlying the Illinois Juvenile Court Act.

The Illinois Supreme Court rejected this argument, noting the serious problems presented by juvenile sex offenders and adding that the purpose and policy of the Juvenile Court Act had shifted to include the protection of the public from juvenile crime and holding juveniles accountable. The court also noted that the dissemination of information about juvenile sex offenders under Illinois law was more limited than for adults and thus registration was a reasonable means of protecting the public. *In re* J.W., 787 N.E.2d 747 (Ill. 2003), *cert. denied*, 124 S. Ct. 222 (2003).

**Ruling that Civil Rights Claim Can Be Pursued Against Police Officer for Failure to Inform Jail Officials Inmate on Verge of Attempting Suicide Not Disturbed**

The Supreme Court declined to review a ruling of the Seventh Circuit that the mother of a jail inmate was entitled to pursue a civil rights claim against a police officer for his alleged failure to inform jail officials that her son was on the verge of trying to commit suicide. The Seventh Circuit rejected the officer's argument that his duty to inform ended when the pretrial detainee was transferred from municipal to county custody.

The court held the officer had an ongoing duty despite surrendering custody of the individual to jail officials in a different police agency and indicated he had a duty to inform any state-affiliated entity that next held custody over the detainee. The court emphasized the officer did not have a duty to sit by the telephone all day communicating with the county facility about transferred prisoners but noted there may have been some immediate measures that would have been quite easy for him to undertake. The court also stated that "strange behavior' alone was insufficient to impute knowledge of a high suicide risk but found that here there was evidence that the officer had been told about this specific risk. Cavalieri v. Shepard, 321 F.3d 616 (7th Cir. 2003), *cert. denied*, Shepard v. Cavalieri, 124 S. Ct. 531 (2003).

**Ruling that State Settlement of Tobacco Litigation Satisfies Liens Against Medicaid Recipient's Estate for Health Care Costs Related to Smoking Not Disturbed**

The Supreme Court declined to review a ruling that New Hampshire's tobacco litigation settlement with major tobacco companies

barred it from also recovering Medicaid expenditures from the estate of a woman who died from smoking-related causes. The New Hampshire Supreme Court determined the settlement, in which a number of states agreed to release tobacco companies from further claims in exchange for a stream of payments, satisfied New Hampshire's $169,765.16 lien against the Medicaid recipient's estate. The New Hampshire Supreme Court was not swayed by a series of rulings that have rejected attempts by individual smokers to obtain access to the tobacco settlement fund. The New Hampshire Supreme Court concluded the payments made pursuant to the tobacco settlement were made, in part, to reimburse the state for the health care costs it paid through the Medicaid program on behalf of individuals such as this woman and to allow the state to also collect for these expenses from the woman's estate would unjustly enable the state to collect the money to which it is entitled twice. *In re* Raduazo, 814 A.2d 147 (N.H. 2002), *cert. denied*, New Hampshire Dep't of Health and Human Services v. Estate of Raduazo, 123 S. Ct. 2610 (2003); 12(26) BNA's Health Law Reporter 1020 (June 26, 2003).

**Refusal to Grant "Parental Immunity" to Residential Child Care Facility Not Disturbed**

The Supreme Court declined to review a ruling by the Illinois Supreme Court that refused to grant immunity from liability to a residential child care facility and its employees. The facility and seven of its employees were sued when a 12-year-old boy who had been placed in their care for a 90-day diagnostic assessment died. After being placed in restraint for more than four hours, the boy died from positional asphyxia.

In Illinois, a limited form of parental immunity has been extended to foster parents but the Illinois Supreme Court refused to extend this immunity to the residential child care facility and its employees. The Illinois court ruled that foster parent immunity was justified because the acts of foster parents mirror the care, supervision, and discipline of children exercised by parents. The court, however, concluded residential child care facilities are not entitled to this immunity because their actions involve the exercise of professional duties. Wallace v. Smyth, 786 N.E.2d 980 (Ill. 2002), *cert. denied*, Maryville Academy v. Wallace, 124 S. Ct. 43 (2003).

**Suspension of Medical Student Not Disturbed**

The Supreme Court declined to review a ruling of the Sixth Circuit that upheld the suspension of a medical student at a state university for what the student claimed was a suspected behavioral or psychological disorder. The Sixth Circuit held that due process was satisfied when the student was fully informed of the faculty's dissatisfaction with the student's academic progress and when the decision to suspend had been careful and deliberate. Ku v. Tennessee, 322 F.3d 431 (6th Cir. 2003), *cert. denied*, 124 S. Ct. 325 (2003).

**Ruling Striking Down Federal Policy to Revoke Prescription Privileges for Recommending Medical Marijuana Not Disturbed**

The Supreme Court declined to review of ruling of the Ninth Circuit that held that a federal policy that threatened to revoke a physician's authority to prescribe controlled substances if the physician recommended the use of medical marijuana to a patient violated the First Amendment. Conant v. Walters, 309 F.3d 629 (9th Cir. 2002), *cert. denied*, Walters v. Conant, 124 S. Ct. 387 (2003).

**Ruling that Physician Can Be Excluded from Federal Health Programs for Factors Not in Place at Time of Misconduct Not Disturbed**

The Supreme Court declined to review a ruling by the Eleventh Circuit that upheld a decision by the Department of Health and Human Services (HHS) to exclude for ten years from all federal health programs a

physician who pleaded *nolo contendere* to a charge of sexual battery of a patient. The Eleventh Circuit ruled HHS could rely on two aggravating factors in excluding the physician beyond the five-year period provided by statute, even though those factors were added after the occurrence of the physician's conduct. HHS was permitted to consider that the doctor engaged in a non-consensual sexual act and that his medical license was revoked as a result of the conduct because the regulations adding these factors were intended to protect federal medical program recipients. Thus, their retroactive application was permissible because they were remedial rather than punitive. Patel v. Thompson, 319 F.3d 1317 (11th Cir. 2003), *cert. denied*, 123 S. Ct. 2652 (2003).

**Ruling Upholding HIPAA Not Disturbed**

The Supreme Court declined to review a ruling by the Fourth Circuit that upheld the constitutionality of the Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated pursuant to it. The South Carolina Medical Association had challenged the statute and its regulations as transferring too much legislative authority in the medical privacy arena to the Department of Health and Human Services. South Carolina Med. Ass'n v. Thompson, 327 F.3d 346 (4th Cir. 2003), *cert. denied*, 124 S. Ct. 464 (2003).

**Ruling that Fired Employee Entitled to FMLA Leave if Change in Behavior Sufficient to Notify Reasonable Employer that Mentally Unable to Work Not Disturbed**

The Supreme Court declined to review a ruling by the Seventh Circuit that an employee should have been given leave under the Family and Medical Leave Act (FMLA) rather than being fired if a change in the employee's behavior was sufficient to notify a reasonable employer that the employee (1) had a serious health condition or (2) was mentally unable to work or give notice of his or her need for FMLA leave. Under FMLA, advance notice of the need for leave is required unless it is not "feasible." In this case an employee was fired for sleeping on the job during the two weeks preceding a period of hospitalization for depression. The Seventh Circuit concluded the employee could take to a jury his claim that his firing violated FMLA.

At the same time, the Seventh Circuit ruled the employee was not entitled to indefinite leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) after he was diagnosed with major depression. The court determined that the employee's inability to work for a multi-month period removed him from the class of individuals protected by the ADA. Byrne v. Avon Products Inc., 328 F.3d 379 (7th Cir. 2003), *cert. denied*, Avon Products Inc. v. Byrne, 124 S. Ct. 327 (2003).

**Ruling that School System's Response to Student's Behavioral Difficulties Was Adequate Under IDEA Not Disturbed**

The Supreme Court declined to review a ruling of the Eighth Circuit that a school district provided an eleven-year-old boy with a long history of mental illness the free appropriate public education required by the Individuals with Disabilities Education Act (IDEA). As a result, the Eighth Circuit rejected his mother's effort to obtain reimbursement for the tuition of a private school in which she placed him after the use of physical restraint and "time-outs" increased during the preceding year.

In reaching its conclusion, the court identified academic progress as an "important factor" in ascertaining whether a disabled student's individualized education plan (IEP) was reasonably calculated to provide educational benefit. The Eighth Circuit stressed the child had progressed academically at an average rate despite his consistent behavioral difficulties and this progress indicated his behavioral problems were being managed in a way that allowed him to learn. The Eighth Circuit also cited the continuous efforts by the school district to tailor his IEP to his behavioral challenges. The court concluded that even if more positive behavior

interventions could have been used, that fact was largely irrelevant when the school district made good faith efforts to assist the student achieve his educational goals. Although unfortunate that physical restraints and time-outs had been used more of late, the Eighth Circuit asserted that the appropriate use of restraint may help prevent bad behavior from escalating to a point where suspension is required. Thus, it refused to adopt a rule prohibiting its use, even if its frequency is increasing.

A dissenting judge asserted that the child's self-destructive behavior was the result of the school district's structured and inflexible approach, the IDEA required the school district to respond to a child's "unique needs," and that academic progress did not establish a sufficient response to a student's behavioral disability. CJN v. Minneapolis Public Schools, 323 F.3d 630 (8th Cir. 2003), *cert. denied sub nom.,* Nygren v. Minneapolis Public Schools, 124 S. Ct. 478 (2003).

## *Cases in Other Federal Courts*

**Law Struck Down that Established Means to Override Advance Directives and Involuntarily Medicate Individuals Civilly Committed or Imprisoned**

The Second Circuit struck down a Vermont law that allowed the state to involuntarily medicate individuals who had been civilly committed or judged mentally ill while imprisoned, notwithstanding a pre-existing durable power of attorney (DPOA) for health care to the contrary. The Second Circuit ruled that such a law discriminated against individuals with a mental disability in violation of the Americans with Disabilities Act.

The law allowed a health care professional to petition a court for authority to involuntarily medicate an individual civilly committed or judged mentally ill while in prison. When the proposed medication contravened the individual's DPOA, the directions in the DPOA were to be honored for 45 days. After 45 days, if the individual had not experienced a significant clinical improvement and remained incompetent, the court could order treatment without regard to the DPOA.

The Second Circuit determined that this law violated the ADA because only individuals with a mental illness could have their DPOAs revoked, while equally incompetent individuals who are physically ill or injured could not. The court rejected as immaterial the state's argument that the statute only applied to a subset of the mentally ill, namely, those who are mentally ill, dangerous, committed to state custody, and incompetent to make treatment decisions. The court responded that anti-discrimination provisions become applicable when a program treats an individual with a mental illness in a particular set of circumstances differently than it treats individuals who are not mentally ill in the same circumstances. Hargrave v. Vermont, 340 F.3d 27 (2d Cir. 2003).

**ADA Suit Against Government for Failure to Reasonably Accommodate Disabled Persons Does Not Require Showing that Persons Without Disability Treated Better**

The Second Circuit held that individuals with a disability who claim the government has failed to reasonably accommodate their disability as required under Title II of the Americans with Disabilities Act (ADA) do not have to show that the government treated individuals who are not disabled better (i.e., that there was a "disparate impact"). The case was filed by HIV-infected individuals who allege New York City violated the ADA by not providing them with adequate access to public social service benefits such as food stamps, welfare benefits, and Medicaid coverage. The city responded there was no ADA violation because the plaintiffs received the same—albeit difficult to obtain—access to services as persons without disabilities.

The Second Circuit rejected this defense and ruled it was sufficient for the plaintiffs to show their disability was making it difficult for them to access these benefits, even though access was also difficult for individuals without a disability. The court concluded the ADA and the Supreme Court's interpretation of the ADA in *Olmstead v. L.C.* (1999) do not require disabled plaintiffs to identify a comparison class of similarly situated individuals given preferential treatment. Instead, it is sufficient for them to show they are being denied access to public benefits to which they are legally entitled and it does not matter that this lawsuit will have the effect of providing plaintiffs with benefits beyond those made available to eligible individuals in general. Henrietta D. v. Bloomberg, 331 F.3d 261 (2d Cir. 2003); 71(49) U.S. Law Week 1780-81 (June 24, 2003).

**Fallacious Forensic Expert Testimony Basis for Vacating Conviction**

The Second Circuit vacated a murder conviction that relied heavily on expert testimony when the expert's qualifications were "largely perjured" and the testimony described a syndrome "referenced nowhere but in a true-crime paperback." The crime involved the shooting of a young couple in a parked car in an isolated area near a junk-yard. Because there was no apparent motive for the shooting, the prosecutor called at the last minute a putative expert who testified about a sexual dysfunction syndrome—"picquerism"—that could explain these events. The Second Circuit ruled the defendant should be given an opportunity to show the prosecution was aware or should have been aware that the witness' testimony was perjured. The court noted the prosecutor made no independent inquiry into the witness' background, relied entirely on the recommendation of a dentist in exploring whether to call the witness as an expert on aberrant psychology, intended the testimony to bolster what it thought to be a significant weakness in its case, and opposed defendant's request for a continuance when defense counsel protested he could find no psychologist who had so much as heard of picquerism. Drake v. Portuondo, 321 F.3d 338 (2d Cir. 2003).

**Juvenile Curfew Ordinance Found Unconstitutional**

The Second Circuit struck down the juvenile curfew ordinance of a town in Connecticut. The ordinance made it unlawful for any person under 18 to be in any public place between 11 p.m. and 5 a.m. Sunday through Thursday, or between midnight and 5 a.m. on Friday and Saturday nights. Allowed exceptions included juveniles accompanied by an adult or juveniles engaged in employment. The curfew had three stated goals: protecting minors from harm at night, protecting the general population from nighttime juvenile crime, and promoting responsible parenting. The court determined the ordinance infringed "a minor's right to move about freely when not prohibited from doing so by his or her parents" and that it should receive "intermediate scrutiny" under the 14th Amendment's equal protection clause. This in turn required that the town show a "direct, substantial relationship" between the factual premises of the curfew and its restrictions. The Second Circuit concluded there was insufficient evidence juveniles commit or are victims of nocturnal street crimes to justify the ordinance. Ramos v. Town of Vernon, 331 F.3d 315 (2d Cir. 2003); 71(48) U.S. Law Week 1772-73 (June 17, 2003).

**Mandatory Public School Health Education Classes Upheld**

The Second Circuit ruled parents do not have a fundamental right to object to a requirement that their children attend health education classes at their public school. A father objected to his child's required attendance at a Connecticut seventh grade health education class covering alcohol, drugs, tobacco, family life, and AIDS education. The father asserted he was exercising his rights and those of his son in pursuing home schooling concerning "health, morals, ethical and personal behavior." The child was excused from the family life and AIDS education portions of the

class but not the rest of the curriculum. The father filed suit claiming that this requirement violated his due process and free exercise of religion rights. The Second Circuit determined a parent does not have a fundamental right to tell a public school what his or her child will and will not be taught. As a result, the state need only establish a rational basis for its mandatory curriculum. Because the father did not dispute that mandatory attendance at health classes is reasonably related to the legitimate state interest in promoting child health and welfare, the court rejected the father's objection. Leebaert v. Harrington, 332 F.3d 134 (2d Cir. 2003); 71(50) U.S. Law Week 1805-06 (July 1, 2003).

**Health Insurer Not Entitled to Recover Subrogation Claims for Deceptive Tobacco Industry Marketing Activities but May Be Able to Recover on Direct Claim**

The Second Circuit ruled a health insurer was not entitled to recover over $11.8 million on subrogation claims associated with treating the tobacco-related illnesses of the individuals it insured. The insurer argued the tobacco companies engaged in a scheme to distort public knowledge of the risks of smoking and this behavior resulted in the insurer paying increased costs for medical services provided to subscribers with smoking-related medical conditions. The court determined the insurer failed to adequately define the identities and claims of those individuals whose rights it was asserting and thus this claim must be dismissed.

The Second Circuit, however, also rejected many of the arguments tobacco companies had asserted to overturn a $17.8 million jury award the insurer had received based on its direct claim for damages stemming from the tobacco companies' deceptive tobacco marketing activities. The court found the insurer had standing to pursue its own claims despite the fact that it was not a consumer per se. Nevertheless, two related questions were determined to be issues of state law and were certified to the New York Court of Appeals for resolution, including whether the insurer was entitled to use aggregate and statistical, as opposed to individualized, proof of causation and damages to establish its damages. Blue Cross and Blue Shield of New Jersey, Inc. v. Philip Morris USA Inc., 344 F.3d 211 (2d Cir., 2003); 12(38) BNA's Health Law Reporter 1473-74 (Sept. 25, 2003).

**HMOs Not Required to Disclose Financial Incentives Used to Encourage Health Care Providers to Ration Care Except Under Limited Circumstances**

Disagreeing with the Eighth Circuit, the Third Circuit held that a health maintenance organization (HMO) does not breach its fiduciary duties under the Employee Retirement Income Security Act (ERISA) when it fails to disclose the financial incentives it provides to health care providers to ration care unless (1) a member of the HMO requests such information, (2) circumstances have put the HMO on notice that its members require such information to avoid making bad decisions regarding their health care coverage, or (3) an HMO patient was harmed as a result of not having such information disclosed to them. Horvath v. Keystone Health Plan, 333 F.3d 450 (3d Cir. 2003); 72(4) U.S. Law Week 2063 (Aug. 5, 2003).

**Internet Sites Can Include Home Addresses of Sex Offenders**

The Third Circuit ruled a sex offender's constitutional privacy rights were not violated by an amendment to New Jersey's Megan's Law that makes convicted sex offenders' home addresses available to the public on the Internet. Prior to the amendment, home addresses were only available to residents of the counties where the offenders lived.

The court determined the enhanced scope of notification was justified by the need to protect a mobile society and outweighed the offenders' constitutionally protected privacy interest in their home addresses. The court rejected the argument that this expansion made the information available to persons that had no particularized need for it and

concluded this argument ignores the "need to access information in a mobile society." As examples justifying the ruling, the court cited parents with young children who want to purchase a new home or who are planning a vacation in New Jersey.

The court also ruled that the inclusion of other information such as the offenders' names, ages, race, birth dates, height, weight, and hair color was similarly permissible. A.A. v. State, 341 F.3d 206 (3d Cir. 2003); 72(8) U.S. Law Week 1120-21 (Sept. 9, 2003).

**Juvenile Adjudications Can Count as "Prior Conviction" and Enhance Sentencing Under Federal Law**

The Third Circuit ruled a juvenile adjudication can count as a "prior conviction" for purposes of enhancing sentencing under federal law if the adjudication was based on a proceeding that included the privilege against self-incrimination and rights to notice, counsel, confrontation, and proof beyond a reasonable doubt. The court determined the absence of a right to a jury trial in the juvenile proceeding was not dispositive because a bench trial provided sufficient reliability to the outcome. In so ruling, the court agreed with the Eighth Circuit but disagreed with the Ninth. United States v. Jones, 332 F.3d 688 (3d Cir. 2003); 72(1) U.S. Law Week 1003-04 (July 8, 2003).

**Fourth Circuit Rejects Argument Capital Defendant Received Ineffective Assistance of Counsel on Voluntary Intoxication and Insanity Defenses and *Alford* Plea**

The Fourth Circuit rejected a Virginia capital defendant's argument he received ineffective assistance of counsel because counsel allegedly failed to adequately investigate and advise the defendant on a voluntary intoxication defense, an insanity defense, and entering an *Alford* plea. The defendant, who claimed to have no memory of the crime, was convicted pursuant to his *Alford* plea of murdering an 80-year-old woman. Under an *Alford* plea, a defendant pleads guilty even though he is unwilling or unable to admit his participation in the crime.

In addressing the voluntary intoxication defense claim, the Fourth Circuit noted that under Virginia law voluntary intoxication does not excuse a crime but can be used to establish the defendant could not commit a class of murder that requires proof of a deliberate and premeditated killing. The Fourth Circuit found that Virginia courts, in evaluating a voluntary intoxication defense, look to the defendant's behavior before and after the offense. Relevant behaviors include whether the defendant attempted to conceal the crime, the lapse of time between ingestion of the intoxicants and the crime, whether the conduct of the defendant was planned and purposeful, and whether the defendant was able to engage in complex behaviors such as driving a car. While acknowledging that this defendant's consumption of alcohol was contemporaneous with the crime, no attempt was made to conceal the crime, and expert opinion supported his defense, the Fourth Circuit determined there was strong evidence the defendant was capable of planned and purposeful conduct because he located and used three different weapons in the course of the murder and wrote "I've gotta kill you" on a card while in the house. Furthermore, the court noted several strategic considerations that played into trial counsel's decision not to pursue this defense, including their experience that defendant would do better having a judge decide his case and the prosecutor had indicated he would refuse to waive a jury trial if the defendant pled not guilty. The Fourth Circuit concluded counsel were not ineffective for advising against a defense of voluntary intoxication.

With regard to counsel's purported failure to adequately investigate and advise the defendant regarding the insanity defense, the Fourth Circuit noted that under Virginia law the defendant bears the burden of proving he was insane at the time of the offense. The court determined that neither doctor that evaluated the defendant concluded an insanity defense was supported. Although they determined his ability to control his

actions was impaired, that constituted a possible mitigating factor for sentencing but not the basis for an insanity defense.

Finally, the court rejected defendant's assertion that counsel were constitutionally ineffective for failing to ensure he understood the nature of an *Alford* plea and, in particular, dismissed his claim that he was not told he might receive the death penalty under such a plea. The court found the evidence indicated the nature of an *Alford* plea was explained to the defendant and family members, citing a letter written by one of his attorneys and signed by the defendant before his plea and the recorded plea colloquy before the trial judge. Reid v. True, 349 F.3d 788 (4th Cir., 2003).

**_Ake_ Independent Mental Health Expert Requirement Not Met by Appointment of a Mental Health Professional from Court's Psychiatric Center**

The Sixth Circuit ruled a defendant convicted of murder and sentenced to death had been denied his right to psychological assistance and effective assistance of counsel during the sentencing phase of his trial and remanded the case for a new penalty proceeding. Prior to trial the judge ordered an evaluation of the defendant by a clinical psychologist from the court's psychiatric center. Defendant's counsel requested that a mental health expert be appointed to assist counsel in understanding the reports generated. This request was rejected. The defendant was subsequently found guilty by a jury. Counsel then moved to hire a neuropsychiatrist to assist counsel at the mitigation phase. In response the court engaged the psychologist who had conducted a pretrial competency evaluation but refused to grant a continuance of the sentencing hearing to allow for additional testing even though the psychologist admitted she was not equipped to conduct the necessary testing for this phase of the case. At the sentencing hearing, the psychologist stated she was not given sufficient time to conduct an appropriate investigation and tests and was not "equipped" to conduct the necessary neuropsychological testing for this phase of the case.

Disagreeing with the Fifth Circuit, but agreeing with the Eighth, Ninth, Tenth, and D.C. Circuits, the Sixth Circuit interpreted the U.S. Supreme Court's opinion in *Ake v. Oklahoma* (1985) to mean that due process is not satisfied unless the defendant is provided an independent mental health expert to aid in his defense and that the appointment of a neutral court-affiliated mental health expert, as here, did not satisfy due process. The Sixth Circuit concluded that after the defendant made the requisite preliminary showing that his sanity at the time of the offense was to be a "significant factor at trial," the trial court erred in failing to grant the defendant's motion for an independent mental health expert. The Sixth Circuit noted the defendant had supported his request with specific facts justifying the request.

Although the court concluded this error was harmless at the guilt phase because there was sufficient evidence the defendant was capable of performing purposeful acts and committed the acts, the error was not considered harmless at the penalty phase because here the jury was required to consider whether because of a mental disease or defect the defendant lacked substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. The expert used was not, by her own admission, equipped to conduct the appropriate examination to provide all of the relevant information the jury should have considered at this phase. The court concluded the testimony of an independent mental health expert—particularly one who was qualified to conduct the appropriate test—might have led to a different sentencing recommendation and this required reversal of the death penalty.

The court added a reversal was also required because the trial court should have granted a continuance to allow an additional psychiatric examination to be obtained for presentation at

the mitigation hearing. The court also found the defendant had received ineffective assistance of counsel at the penalty phase because counsel waited until after the conclusion of the guilt phase to begin preparing for the penalty phase of the trial and presented no testimony other than that of the self-admitted "unequipped" psychologist. Powell v. Collins, 332 F.3d 376 (6th Cir. 2003).

**Employee of State Mental Health Care Hospital Can Pursue Lawsuit Claiming She Was Fired in Violation of Her First Amendment Rights for Complaining About Quality of Care in Hospital**

The Sixth Circuit ruled the director of quality management at a state mental health care hospital who was fired after lodging complaints about the quality of care in the hospital could bring a federal lawsuit alleging she was terminated in violation of her First Amendment right to free speech. She had complained that the placement of a psychiatrist's office in a patients' unit compromised the patients' privacy, that there was a lack of concern over quality standards, and that restrooms were not adequately kept clean. The Sixth Circuit determined the focus of these complaints was on patient care, a matter of public concern, and as a result it was necessary to balance the interests of a public employee as a citizen commenting on matters of public concern against the interests of a public employer attempting to efficiently provide public services. The court found no evidence the complaints either disrupted or threatened to disrupt the efficient functioning of the hospital and management had not established a state interest that outweighed the employee's First Amendment right to call her supervisor's attention to the quality of patient care in the hospital. Rodgers v. Banks, 344 F.3d 587 (6th Cir. 2003); 12(39) BNA's Health Law Reporter 1500-01 (Oct. 2, 2003).

**Developmentally Disabled Adults Not Entitled to ICFs Near Their Parents' Homes**

In Illinois, several developmentally disabled adults lived at home with their parents in the Chicago metropolitan area. Their parents preferred that their children live in Intermediate Care Facilities (ICFs). Most of these facilities, however, are located in southern Illinois, far from Chicago. The parents did not want to use these facilities because of the time and expenses that would be entailed in traveling to visit their children but there were few vacancies in the Chicago area. These parents wanted state officials to adopt a plan for expanding the number of ICFs in the northern part of the state. To accomplish this goal, a suit was brought alleging violations of the federal Medicaid statute, section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA).

The Seventh Circuit rejected the Medicaid claims, asserting Medicaid does not assure identical convenience of service everywhere in a state or require the creation of new facilities. The court, however, noted that both the Rehabilitation Act and the ADA entitle disabled persons to care in the least restrictive possible environment. Furthermore, the court determined that ICFs can be considered to provide a less restrictive alternative than living at home with parents because parents by reason of age or incapacity may not be capable of taking good care of their adult disabled children. Because the trial court did not consider the merits of these claims, the Seventh Circuit remanded the case for consideration of these claims.

At the same time, the Seventh Circuit also directed the lower court to consider the U.S. Supreme Court's opinion in *Olmstead v. L.C.* (1999) and its guidance that a state would be in compliance "if . . . the State . . . had a comprehensive, effectively working plan for placing qualified persons . . . in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated." Bruggeman v. Blagojevich, 324 F.3d 906 (7th Cir. 2003).

**Fired Employee Entitled to FMLA Leave if Change in Behavior Sufficient to Notify Reasonable Employer that Employee Mentally Unable to Work or Give Notice of Need for FMLA Leave**

The Seventh Circuit ruled an employee should have been given leave under the Family and Medical Leave Act (FMLA) rather than being fired if a change in the employee's behavior was sufficient to notify a reasonable employer that the employee (1) had a serious health condition or (2) was mentally unable to work or give notice of his or her need for FMLA leave. Under FMLA, advance notice of the need for leave is required unless it is not "feasible." In this case an employee was fired for sleeping on the job during the two weeks preceding a period of hospitalization for depression. After two months of treatment the employee was ready to return to work but the employer refused to take him back.

The Seventh Circuit concluded the employee could take to a jury his claim that his firing violated FMLA. The court noted the employee had worked for the employer for four years and had been a "model employee" up to this point. The court determined a dramatic change in behavior can provide an employer sufficient notice of a medical problem and the employee was not required to give the employer verbal or written notice of the need for leave. The court did note that unproductive time preceding the discharge could be reclassified as unpaid leave (with restitution of wages received) or taken as vacation or medical leave if any was available.

At the same time, the Seventh Circuit ruled the employee was not entitled to indefinite leave as a reasonable accommodation under the Americans with Disabilities Act (ADA) after he was diagnosed with major depression. The court determined that the employee's inability to work for a multi-month period removed him from the class of individuals protected by the ADA. Byrne v. Avon Products Inc., 328 F.3d 379 (7th Cir. 2003); 71(44) U.S. Law Week 1708-09 (May 20, 2003).

**Ban on Selling "Graphically Violent" Videos to Minors Unconstitutional**

The Eighth Circuit ruled that a county ordinance that banned making "graphically violent" video games available to minors violates the First Amendment. The county had argued that the ban was necessary to prevent psychological harm to youth and to aid parents in protecting their children's well being. The court determined that video games are speech entitled to full First Amendment protection and therefore the restrictions on this speech had to satisfy "strict scrutiny." The court concluded the first rationale offered by the county for this restriction was insufficiently documented and the second rationale was inadequate. Interactive Digital Software Ass'n v. St. Louis County, 329 F.3d 954 (8th Cir. 2003); 71(48) U.S. Law Week 1771 (June 17, 2003).

**HMOs Cannot Recover from Tobacco Industry Costs of Treating Members' Smoking-Related Illnesses**

The Eighth Circuit ruled health maintenance organizations (HMOs) cannot recover from tobacco companies the costs of treating its subscribers' tobacco-related illnesses. Four Minnesota HMOs had sued several tobacco manufacturers and associated groups, alleging the tobacco industry conspired to mislead the public and the health care industry regarding the addictive effects of tobacco use and that the HMOs suffered indirect injury because they were required to assume the medical costs their members sustained as a result of their tobacco use. The court determined the HMOs failed to provide adequate evidence of the damage they suffered in paying for smoking-related illnesses because their expert witness presented only a "speculative" calculation of the costs they incurred. Group Health Plan, Inc. v. Philip Morris USA, Inc., 344 F.3d 753 (8th Cir. 2003); 12(38) BNA's Health Law Reporter 1472-73 (Sept. 25, 2003).

**Ninth Circuit Refuses to Recognize "Dangerous Patient" Exception to Federal Psychotherapist-Patient Privilege**

The Ninth Circuit of the U.S. Court of Appeals ruled that although therapists have a duty to warn authorities about patients' threats to inflict serious harm on others, this does not mean therapists may testify in subsequent federal court proceedings about these statements. In this case, the defendant suggested during therapy sessions that he might injure FBI agents and other individuals. The psychotherapist alerted law enforcement personnel and, after the psychotherapist testified at trial about the defendant's threats, the defendant was convicted of threatening to murder federal agents.

The Ninth Circuit held the psychotherapist's testimony should not have been admitted because the defendant's conversations with her were protected by the federal psychotherapist-patient testimonial privilege and refused to recognize a "dangerous patient" exception to the privilege. The court determined that just because therapists have a duty to warn authorities about patients' threats does not mean they may testify in court proceedings about confidential statements made during therapy sessions. The court reasoned that the urgency to act that creates a duty to warn will normally have subsided by the time the case is brought to trial. The court concluded the protection of society would increase only slightly by allowing this testimony and would not outweigh the harm done to the psychotherapist-patient relationship.

A dissenting opinion argued "the social interest in assuring that the judge and jury know the whole truth greatly exceeds the value of preserving any remaining shreds of the confidential therapeutic relationship." The Ninth Circuit ruling is consistent with that of the Sixth Circuit but is contrary to that of the Tenth Circuit. United States v. Chase, 340 F.3d 978 (9th Cir. 2003); 72(9) U.S. Law Week 1145-46 (Sept. 16, 2003).

**Psychiatrist as HMO Team Leader May Be "Treating Source" Whose Opinion Is Entitled to Greater Weight in Social Security Disability Determination Even Though Psychiatrist Has Minimal Patient Contact**

The Ninth Circuit held that the lead psychiatrist on a patient's managed care treatment team may be considered a "treating" source whose opinions are entitled to greater weight in Social Security disability proceedings even though the psychiatrist has minimal contact with the patient and most of the direct patient contact is provided by others on the managed care treatment team.

The individual seeking Social Security disability benefits had quit working because of asserted chronic pain stemming from a knee injury incurred 25 years earlier that persisted despite seven subsequent surgeries. She was a member of a health maintenance organization (HMO) and had consulted an HMO psychiatrist. The psychiatrist diagnosed her with major depression, an unspecified personality disorder, and chronic pain. The psychiatrist prescribed medications, first Elavil and then Paxil, consulted regularly with her treating therapists, and concluded on the claimant's social security disability application that her prognosis was very poor.

The agency processing the application asked for an independent psychiatric evaluation. An agency psychiatrist who examined the claimant concluded the claimant did not have a severe mental impairment. A vocational expert testified that the absence or presence of a mental disability was the difference between the claimant being able to perform her past relevant work or not. An Administrative Law Judge (ALJ) hearing the matter did not credit the opinion of the HMO psychiatrist, asserting that there was no evidence that he was the claimant's treating physician and gave greater weight to the reviewing psychiatrist.

The Ninth Circuit reversed. Under Social Security regulations, a "treating source" is to

be given greater weight than those of examining but non-treating physicians or physicians who only review the record. However, to be a "treating source" requires an "ongoing relationship." The court noted that although the definition of "treating source" has remained consistent since 1991, the provision of medical treatment, particularly for psychological dysfunction and particularly within HMOs, has not. The court determined that current practice is often to have a psychiatrist manage the medications, receive reports from other sources providing "hands-on" treatment, and not see the patient with any regularity.

The Ninth Circuit concluded the Social Security regulations did not preclude a supervising physician from being considered a treating source, even when as here the psychiatrist had seen the claimant on only a single occasion. The court noted limited contact with a claimant might result in such a physician's opinion being placed relatively low on a continuum of treating physician opinions, but that physician's opinion was still entitled to greater weight than that of an examining or reviewing physician.

Moreover, the court added, this opinion was entitled to enhanced consideration when the physician transmitted both his own knowledge and opinion and that of the treatment team under his supervision, provided the treatment team kept the psychiatrist adequately informed. The ALJ was directed to explore whether the psychiatrist's treatment relationship with the claimant, individually and as a representative of a treatment team, was consistent with accepted medical practice for the type of treatment required for the claimant's medical condition.

The Ninth Circuit concluded that if the ALJ found the psychiatrist warranted "treating source" status and his opinion was not out-weighed by that of the reviewing psychiatrist, the ALJ should authorize payment of the claimant's disability benefits. Benton v. Barnhart, 331 F.3d 1030 (9th Cir. 2003); 71(49) U.S. Law Week 1790 (June 24, 2003).

**ADA Expands Range of Individuals that May Be Entitled to Medicaid Funded Home and Community Based Health Care**

The Ninth Circuit joins many other courts that have grappled with the scope of the Americans with Disabilities Act (ADA) and its impact on Medicaid waiver programs. The state of Washington participates in the federal Medicaid program that provides federal financial assistance to states that choose to reimburse certain costs of medical treatment for needy persons. Participation by states in this program generally is optional but a state receiving Medicaid funds must comply with the requirements of the Medicaid Act. An exception to this rule is the Medicaid waiver program under which certain Medicaid requirements can be waived for innovative or experimental state health care programs. The programs encouraged by the waiver program include increased provision of home and community based health care to Medicaid recipients who would otherwise only qualify for nursing home care.

The Medicaid Act groups needy persons into two categories, usually distinguished by income level: the "categorically needy" and the "medically needy." A participating state must provide certain types of services to categorically needy persons. In Washington, persons whose income is below 300% of the Social Security Income Federal Benefit Rate are deemed categorically needy. For medically needy persons, the state is only obligated to establish "reasonable standards" for determining the extent of assistance it will offer. Washington provides through the Medicaid program long-term medical care and living assistance in nursing home settings to both the categorically and the medically needy. However, categorically needy persons have the additional option of receiving long-term living assistance and medical care in their own homes or in adult family homes in the community through a Medicaid waiver program. A lawsuit was filed that claimed that the denial of community-based long term care to some disabled Medicaid recipients but not others (i.e., to categorically rather than

medically needy disabled persons) violates the ADA because it contravenes the ADA requirement that public entities administer services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

The Ninth Circuit agreed in principle with this claim, noting that the ADA was intended to eliminate the unjustified segregation and isolation of disabled persons. However, the court remanded the case to the lower court to determine whether extending eligibility for in-home nursing services to all the state's disabled Medicaid recipients would fundamentally alter the state's Medicaid program, which the U.S. Supreme Court in *Olmstead v. L.C.* (1999) had said was not required. As part of this review, the lower court was directed to consider the financial impact on the state of this proposal and whether the extra costs associated with it would compel cutbacks in services to other Medicaid recipients. Such cutbacks, the Ninth Circuit said, were not required under *Olmstead*. Townsend v. Quasim, 328 F.3d 511 (9th Cir. 2003).

**Compulsory Arbitration Agreement Negated by Mental Incapacity**

An investor filed a lawsuit against his brokerage firm and alleged the firm was negligent in allowing the broker with whom he dealt to handle his account because she was "legendary" in the brokerage community for convincing elderly men to loan her money in exchange for sex. The brokerage firm responded that the investor's investment account agreement contained an arbitration clause covering all related disputes and asserted that as a result the claim must be resolved by an arbitrator and not a court. In reply, the investor alleged that he was incapable of managing his financial affairs because he has dementia and Alzheimer's disease and thus the account agreement and its arbitration clause were unenforceable.

The Tenth Circuit agreed, concluding that the investor's mental incapacity defense goes to both the entire contract and the arbitration clause within the contract and thus the dispute was for a court to resolve. Spahr v. Secco, 330 F.3d 1266 (10th Cir. 2003); 71(48) U.S. Law Week 1763-64 (June 17, 2003).

**Oklahoma May Violate the ADA by Imposing a Five-Prescription Per Month Cap on Medicaid Recipients Receiving Services at Home**

Oklahoma may be violating the Americans with Disabilities Act (ADA) by imposing a five-prescription per month cap on Medicaid recipients who receive their state-funded services at home rather than in a nursing facility. Oklahoma, as part of an optional federal Medicaid waiver program in which it participates, allows individuals who meet the level of care required for institutionalization in a nursing facility to live at home and receive state-funded medical care. Until September 2002, participants were entitled to an unlimited number of state-paid medically necessary prescriptions. At that point, responding to a budgetary shortfall, the cap was put into operation, although patients in nursing facilities continued to receive unlimited prescriptions. The state anticipated that capping the number of prescriptions available would save the state $3.2 million.

In their complaint, the plaintiffs, Medicaid recipients receiving services at home, alleged that because of the state's action they would have to enter nursing homes to get medically necessary care because their income would not reasonably cover all their required medication and that this violated the ADA. The trial court dismissed the complaint and asserted the integration mandate of the ADA, as stated in *Olmstead v. L.C.* (U.S. 1999), only protected persons who are institutionalized.

The Tenth Circuit responded that the community integration protections provided by *Olmstead* are not limited to individuals who are institutionalized. The court concluded genuine issues of material fact existed as to whether the state's termination of its unlimited

prescription benefits would place participants at high risk of premature entry into nursing homes. At the same time, the court ruled the state was entitled to attempt to establish that the continuation of this benefit would result in a fundamental alteration of the program, which could defeat the plaintiffs' claim. Fisher v. Oklahoma Health Care Auth., 335 F.3d 1175 (10th Cir. 2003); 72(4) U.S. Law Week 1056 (Aug. 5, 2003).

**California Tax on Cigarettes to Fund Anti-Tobacco Ads Upheld**

A California law that directed a state agency to develop a media program to discourage tobacco use with funding provided by a surtax on wholesale cigarette sales was upheld by the U.S. District Court for the Eastern District of California. California voters in 1988 enacted a 25¢ per pack surtax with the revenue placed in a limited-use fund, a portion of which is used for the media campaign. Various tobacco companies challenged the law, asserting that the state annually spends $25 million on anti-smoking ads and the surtax compels them to fund speech with which they disagree.

The court rejected this challenge, concluding the program did not violate the tobacco companies' First Amendment rights because this was a permissible government speech program rather than illicit compelled private speech. Although the court acknowledged that the line between the two can be difficult to discern, it based its determination on the fact that the speech at issue was controlled by and attributable to state officials. R. J. Reynolds Tobacco Co. v. Bonta, 272 F. Supp. 2d 1085 (E.D. Cal. 2003); 72(4) U.S. Law Week 1060-61 (Aug. 5, 2003).

**Residents of Community Program Entitled to Written Notice but Not Formal Hearing Prior to Discharge if They Pose Imminent Threat to Other Residents**

Two residents of a supportive residence that provides a transitional living program for people with HIV/AIDS were asked to leave because of "inappropriate behavior" but without a written explanation of the reason they were asked to leave. The residence received federal funds through the Housing Opportunities for People with AIDS Act (HOPWA). Both residents had threatened fellow residents.

Noting such residents are likely to become homeless when discharged from such a program and may experience psychological stress that exacerbates their illness, a federal court in Illinois ruled that under HOPWA they were entitled to a written pre-termination notice. At the same time, the court recognized there may be a legitimate need to move quickly to remove residents if they pose an imminent threat to other residents and if such exigent circumstances exist it is not necessary to provide a formal pre-termination hearing. Cotton v. Alexian Bros. Bonaventure House, No. 02 C 7969, 02 C 8437, 2003 WL 22110501 (N.D. Ill. Sept. 9, 2003).

**Mental Health Facility that Closes May Have to Give Employees 60-Days Notice**

The federal Worker Adjustment and Retraining Notification Act (WARN) has been applied to the rapid closure of a mental health care facility near Detroit. WARN requires that workers be given 60 days notice of a mass layoff unless closure followed "unforeseeable circumstances," which includes the "unexpected termination of a major contract." The facility provided inpatient, outpatient, and partial hospitalization care for individuals with mental illnesses. The majority of its patient load came from referrals from the Community Mental Health Agency of the county in which it was located. On Dec. 19, 2001, the agency announced it would no longer refer patients to the facility, it would not renew its contract with the facility effective Dec. 31, 2001, and the facility should make arrangements to transfer all of its referral patients to other medical providers by Jan. 31, 2002. Faced with the loss of this business, virtually the entire facility workforce, which consisted of several hundred employees, was laid off. Layoffs began in late December 2001.

A Michigan federal district court ruled WARN's 60-day notice may have been required because the loss of the contract was not "sudden and unexpected." While acknowledging that the contract was crucial to the financial survival of the facility, the court noted executives had been put on notice in the fall of 2001 that its contract was in jeopardy because the facility was not in compliance with the agency's policies and practices. The court determined this provided "at least some advance warning" that the contract might not be renewed even though the letter the facility received at that time did not expressly state the contract was in immediate danger of termination. Michigan AFSCME Council 25 v. Aurora Healthcare, Inc., 256 F. Supp. 2d 713 (E.D. Mich. 2003); 12(19) BNA's Health Law Reporter 737 (May 8, 2003).

**Virginia Capital Defendant Not Provided Ineffective Assistance of Counsel Just Because Defendant's Mental Health Expert Misdiagnosed Defendant**

The U.S. District Court for the Eastern District of Virginia refused to overturn the capital conviction of a defendant because of the purported ineffective assistance of counsel in presenting mental health evidence as a mitigating factor in the penalty phase of the trial. The defendant's claim was characterized as being that his mental health expert had misdiagnosed him as having a personality disorder when he should have been diagnosed as having a bipolar disorder.

The court determined, however, that defendant's trial counsel had properly secured the assistance of a competent, court-appointed mental health expert who assisted the defense by testifying during the penalty phase about mitigating circumstances concerning defendant's mental state. The court stressed counsel was cognizant of the importance of mental health issues in determining culpability and mitigation in capital cases, successfully filed a motion for the appointment of a mental health expert and secured an expert's assistance, and obtained pertinent records.

The court concluded counsel's performance was not outside the range of professionally competent assistance and the defendant could not demonstrate any prejudice from this performance. The court noted the Sixth Amendment is not implicated by a claim that defendant's mental health expert misdiagnosed the defendant's mental condition. Bailey v. True, No. CR02-511 (E.D. Va. Apr. 15, 2003); 17(51) Virginia Lawyers Weekly 1288 (May 26, 2003).

**Federal Suit by Virginia Physician Fired by State Mental Health Facility Dismissed**

A lawsuit filed by a physician who was fired by a Virginia state mental health facility was dismissed by the Western District of the U.S. District Court in Virginia. The physician, who was an internist at Western State Hospital from 1995 until May 2001, claimed he was fired because of his criticisms of the patient care provided at the facility. In response, the physician initiated a grievance procedure under Virginia state law, *see* DMHL, v. 22, n. 2, p. 29, and also filed a lawsuit in federal court. The federal district court concluded it was without jurisdiction to hear this case because the physician's claims were "inextricably intertwined" with the retaliation claims set forth in his grievance and his federal claim did not differ in any substantial part from the essential facts presented in the state proceedings. While noting his grievance was subject to state appellate review and, ultimately, to review by the United States Supreme Court, the court concluded lower federal courts were not authorized to review it. Horner v. Dep't of Mental Health, No. Civ.A. 5:02CV00099, 2003 WL 21391678 (W.D. Va. May 1, 2003); 18(13) Virginia Lawyers Weekly 306 (Sept. 1, 2003).

**Parental Rights Terminated When Mother Refused to Acknowledge Parental Deficiencies and Thwarted Counseling Efforts to Remedy Deficiencies**

The Virginia Court of Appeals held that a mother's parental rights were appropriately terminated when evidence was presented the mother refused to acknowledge that any deficiencies in her parental abilities existed and she appeared to thwart attempts to provide her with mental health and counseling services designed to remediate her lack of parenting and supervisory skills. A clinical psychologist who evaluated the mother's emotional and cognitive functioning testified (1) that her cognitive functioning fell in the "borderline range," (2) that although persons functioning within this range can learn new skills, their inability to apply this learning to new situations was unlikely to change, (3) that the mother tended to be emotionally reactive, hostile, and oppositional, particularly when under stress and this accounted for her difficulty in making use of the assistance other people might provider her, and (4) that her tendency to deny problems and externalize blame, among other things, made it unlikely she would be able to adequately identify and respond to her children's needs. Hansberry v. Charlottesville Dep't of Soc. Servs., No. 0117-03-2, 2003 WL 21391022 (Va. Ct. App. June 17, 2003); 18(6) Virginia Lawyers Weekly 136 (July 14, 2003).

**Conviction of Mentally Retarded Defendant of Malicious Wounding for Injuries Suffered by Infant from "Shaken Baby Syndrome" Upheld**

Although the defendant was mentally retarded with an IQ of 65 and his lawyer argued he did not understand the fragility of his six-week-old son, the Virginia Court of Appeals ruled the defendant was properly convicted of malicious wounding for the permanent injuries suffered by the child from "shaken baby syndrome." The court noted these injuries left the child severely retarded, the child was under the sole care of the defendant, and he eventually admitted he shook the victim three times and may have been too rough. The court determined the jury could reasonably infer from the violence necessary to cause such severe and extensive injury that the defendant intended that which resulted.

The court also upheld the trial court's exclusion of an evaluation report by a licensed clinical psychologist that would have shown that the injuries were "likely due to a lack of understanding of the fragility of infants, rather than to any intentional or grossly careless act." The court ruled the report was properly excluded because under Virginia law a trial court cannot consider an expert opinion of a defendant's mental state absent an insanity defense. Funk v. Commonwealth, No. 1821-02-4, 2003 WL 21524686 (Va. Ct. App. July 8, 2003); 18(8) Virginia Lawyers Weekly 185-86 (July 28, 2003).

**Sanctions for Alleged Sexual Harassment of Medical Students and Social Worker by Psychiatrist Set Aside**

The Virginia Court of Appeals reversed the sanctions imposed and set aside a finding by the Board of Medicine that a psychiatrist was guilty of unprofessional conduct because of purported sexual harassment by the psychiatrist.

The court first found there was an insufficient showing of the standards of ethics by which the psychiatrist's behavior was to be judged. Although related sections of the ethical codes of the American Medical Association and the American Psychiatric Association were considered, the court noted the Board had not promulgated a regulation adopting them as the applicable "standards of ethics."

Second, the court found insufficient evidence the psychiatrist's interactions with three female medical students and a staff social

worker interfered with or were likely to interfere with his ability to provide care to his patients. Similarly, the court found insufficient evidence these interactions interfered with the ability of these four women to perform their duties at work or school or otherwise prevented them from providing suitable care to patients and other members of the public.

As a result, the court concluded there was not substantial evidence in the record upon which the Board could reasonably find that the psychiatrist performed any act likely to deceive, defraud, or harm the public in violation of Virginia law. Goad v. Virginia Bd. of Med., 580 S.E.2d 494 (Va. Ct. App. 2003); 17(51) Virginia Lawyers Weekly 1291 (May 26, 2003).

**Sexual Assault Conviction Reversed Because Prosecutor Told Jury that Commonly Known Children Don't Report Sexual Assaults Right Away**

The Virginia Court of Appeals overturned a sexual assault conviction because the trial court failed to specifically direct the jury to disregard a statement made by the prosecutor during jury selection that "it's commonly known that children don't report sexual assaults right away, if at all." The court noted in this case the credibility of the victims was vital to the Commonwealth's case because only the victims' testimony proved defendant was the perpetrator of these assaults. Furthermore, a major factor affecting their credibility was their delay in reporting the assaults to an adult.

Thus, the prosecutor's comment was characterized as a central, if not the central, issue in the case and increased the likelihood of prejudice. In addition, the prosecutor presented this comment as a "commonly known" fact but presented no evidence to substantiate it. The court concluded the prosecutor's attempt to testify to the jury regarding the typical behavior of juvenile abuse victims was improper and so impressive as to remain with the jury and influence their verdict. Smith v. Commonwealth, 580 S.E.2d 481 (Va. Ct. App. 2003); 17(51) Virginia Lawyers Weekly 1291 (May 26, 2003).

**Child Testimony Via Closed-Circuit Testimony Upheld**

The Virginia Court of Appeal upheld a Virginia statute that allows victims of child sexual abuse to offer trial testimony via closed-circuit television. In rejecting the defendant's Sixth Amendment challenge, the court noted the statute appropriately required a "case-specific" showing of necessity and that it met the requirements established by the U.S. Supreme Court in *Maryland v. Craig* (1990) when it required the trial court to find that the child is unavailable to testify in open court in the presence of the defendant because the child refuses to testify, the child is unable to communicate, or there is a substantial likelihood that the child will suffer severe emotional trauma if the child testifies. The court added the statute actually went beyond the requirements in *Craig* because it provided for two-way closed-circuit television as opposed to the one-way closed-circuit testimony upheld in *Craig.*

Also, the court noted the trial court took the additional step of having the Commonwealth provide an independent psychological examination of the child prior to the court making its decision. The psychologist stated that "it would be very traumatic" for the child to testify in open court in front of the defendant after the child said she would run away if forced to so testify. Finally, the court concluded the "other elements" of the defendant's confrontation rights were met when the trial court found the child competent to testify, the child testified under oath, the defendant retained a full opportunity for contemporaneous cross-examination, and the fact finder was able to view the child's demeanor. The court rejected the defendant's argument that there had to be a finding that the child's testimony would be "distorted" if given in open court in front of the defendant. Johnson v. Commonwealth, 580 S.E.2d 486 (Va. Ct. App. 2003); 17(51) Virginia Lawyers

Weekly 1290 (May 26, 2003).

**Malpractice Action for Sexual Relationship that Developed Subsequent to Treatment Provided by Psychologist Settled for $225,000**

A lawsuit in which a woman filed a medical malpractice action against a psychologist from whom she sought treatment for major depression was settled for $225,000 in the Circuit Court of Fairfax County. The woman alleged she was harmed by an inappropriate romantic and sexual relationship that developed between them. Reportedly, as part of the settlement the defendant acknowledged an inappropriate relationship developed between them subsequent to treatment, that such relationships are forbidden by the regulations governing the practice of clinical psychology in Virginia and the ethical principles of the American Psychological Association, and that such relations are defined as unethical because of the high likelihood of harm to the patient. 18(16) Virginia Lawyers Weekly 389 (Sept. 22, 2003).

## *Cases in Other State Courts*

**Statutory Immunity for Mental Health Detention Decisions Does Not Extend to Accidents Occurring During Detention**

In California, an individual can be detained for 72 hours ("72-hour hold") in a designated facility for treatment and evaluation if the person is determined to be, as a result of mental disorder, a danger to self or others or gravely disabled. California has also established that individuals authorized to detain a person for a 72-hour hold cannot be held liable for exercising this authority. The California Court of Appeals, Fourth District, has held that this immunity from liability is limited to the decision to detain and does not extend to accidents that may occur in the course of the detention.

In this case, an individual, who was lawfully detained under the 72-hour hold by the medical staff of a hospital emergency room, slipped, fell, and fractured her leg while assisted by a nurse as she was walking in a hospital corridor. The individual sued the hospital for negligently failing to supervise and monitor her and for careless maintenance of the property.

The court rejected the hospital's argument that the statutory immunity provision extended to all acts pertaining to treatment during this period and gave the individual the opportunity to show the hospital breached the applicable standard of care. Jacobs v. Grossmont Hosp., 133 Cal. Rptr. 2d 9 (Cal. Ct. App. 2003).

**Psychotherapist-Patient Privilege in California Protects Psychotherapy Records from Disclosure Even When Therapy Only Commenced Because It Was a Condition of Probation**

A California Court of Appeal held that California's psychotherapist-patient privilege may be asserted to block the release of a criminal defendant's psychotherapy records even though those records pertain to therapy into which the defendant entered only because it was made a condition of probation. After the defendant was charged with murder during the course of a rape and burglary, the state sought a court order to release the defendant's psychotherapy records. In a case of first impression in California, the court ruled the defendant was a "patient" for purposes of this privilege regardless of why he entered treatment and was therefore entitled to raise this privilege in blocking the state's request for records.

The state had sought evidence of the defendant's commission of a previous sexual offense, his mental state during the prior assault, including his "urges to force himself sexually upon non-consenting females by means of violence," and his intent and motive

in committing the murder. The state argued the privilege did not apply because the defendant's motivation in attending psychotherapy was to obtain probation, not to obtain treatment of his mental or emotional condition.

The court rejected this argument and determined that an individual's motive for participating in psychotherapy is immaterial to determining whether the psychotherapist-patient privilege attaches. The court did indicate that the records of probation-conditioned psychotherapy can be disclosed to the extent necessary for a court to monitor the defendant's participation in the psychotherapy. In reaching its position, the court distinguished an exception that permits the release of institutional psychotherapy records of a committed sexually violent predator. Story v. Superior Court, 135 Cal. Rptr. 2d 532 (2003); 72(2) U.S. Law Week 1032 (July 15, 2003).

**Connecticut Supreme Court Applies *Sell* to Determination of Whether Defendant Can Be Forcibly Treated to Restore Competence**

The Supreme Court of Connecticut has issued one of the first appellate opinions applying the U.S. Supreme Court's decision in *Sell v. United States* (2003) to a determination of whether involuntary medication can be authorized to render a defendant competent to stand trial. The defendant was charged with breach of the peace, simple trespass, assault of a peace officer, carrying a dangerous weapon, and interference with an officer, which carried a combined maximum punishment of 14 years. Subsequent to the defendant being found incompetent to stand trial, the trial court ordered treatment with psychotropic medication to restore the defendant's competence to stand trial. The defendant appealed, claiming forced medication would violate his constitutional rights under the first amendment (i.e., his right to free speech or the right to free thought and communication), sixth amendment (i.e., his right to a fair trial), and fourteenth amendment (i.e., his interest in privacy or liberty). The state argued this question was limited to whether the defendant's fourteenth amendment rights were infringed.

The Connecticut Supreme Court ruled *Sell* established that the trial court must also consider whether the defendant's sixth amendment fair trial rights are compromised by the proposed medication. Because the trial court failed to consider this impact, the Connecticut Supreme Court remanded the case for a new hearing. The court added in a footnote that *Sell* implicitly rejected the claim that an incompetent defendant has a first amendment right to avoid involuntary medication in such cases. State v. Jacobs, 828 A.2d 587 (Conn. 2003).

**Expert Testimony Based on Grisso Protocol Excluded Under *Daubert* and Confession of Fourteen-Year-Old Defendant Admitted**

The Appellate Court of Connecticut ruled a trial court properly excluded expert testimony regarding the nature of a juvenile's confession and concluded the juvenile had knowingly, intelligently, and voluntarily waived his privilege against self-incrimination. The defendant, convicted of manslaughter, had been fourteen years of age at the time of the crime. He attempted to suppress his confession at trial based on the testimony of a clinical psychologist.

The psychologist testified she had evaluated the defendant to determine whether he was competent to understand his *Miranda* rights. As part of her evaluation, she tested the defendant with a set of questions addressing the specific tasks associated with waiving *Miranda rights.* She explained these questions were part of a protocol developed by Thomas Grisso, a forensic psychologist whose work has focused on juvenile competency. Based on this test, she concluded the defendant did not understand his right to remain silent nor the role of an attorney during the interrogation process.

The appellate court ruled the trial court had properly subjected the expert testimony to a *Daubert* analysis because the Grisso test constituted an "innovative scientific technique." Under that analysis, the court determined the defendant bore the burden of proving its reliability and concluded the defendant had failed to meet this burden. The court found the expert's testimony about the peer review of the Grisso test to be limited and noted she did not cite evidence showing that the test had gained widespread acceptance in the relevant scientific community.

In addition, the court ruled the defendant's confession occurred after he knowingly, intelligently, and voluntarily waived his *Miranda* rights. The court noted the defendant was not questioned until he was accompanied by his legal guardian, the defendant's *Miranda* rights were fully explained to both of them, the tone of conversation was quiet and no effort was made to coerce or threaten the defendant, the defendant had prior experience with the *Miranda* process, and he showed no sign of "psychotic illness," demonstrated only a mild to moderate delay in intellectual development, and was not intoxicated or under the influence of drugs at the time of his confession. The court concluded the "totality of the circumstances" established the defendant understood his rights and voluntarily waived them. State v. Griffin, 823 A.2d 419 (Conn. Ct. App. 2003).

The Supreme Court of Connecticut has agreed to review this ruling. State v. Griffin, 831 A.2d 252 (2003).

**Prison Sentences Issued for Illegally Selling Prescription Drugs Over the Internet**

A South Florida woman and her son were sentenced to federal prison for selling prescription pain killers over the Internet without a physician's review or a prescription. The woman received a prison term of thirty-seven months, while her son received a term of twenty-four months. Operating out of their home, the pair purportedly earned more than $1.2 million in gross revenues in slightly more than one year. United States v. Gorman, No. 01-CR-1632 (S.D. Fla. *sentencing* Sept. 04, 2003); 12(37) BNA's Health Law Reporter 1418-19 (Sept. 18, 2003).

**Florida Medicaid Recipients Entitled to Notification of Reasons for Denial of Prescription Drug Coverage and Steps They Can Take to Appeal Denial**

Under a settlement agreement approved by a federal judge, Florida Medicaid recipients who are denied prescription drug coverage will be notified in writing of the reason for the rejection and what steps they can take to appeal the decision. In addition, the Florida agency responsible for these determinations, the Agency for Health Care Administration (AHCA), agreed to provide the services of an ombudsman office to assist in resolving claim reimbursement problems. The agreement also provides for emergency coverage if a pharmacist believes failure to receive a drug could result in a serious health threatening situation. In addition, the AHCA agreed to pay for brand name drugs if a physician asserts they are medically necessary. Hernandez v. Medows, No. 02-20964-Civ-Gold/Simonton (S.D. Fla. *order* 5/21/03); 12(24) BNA's Health Law Reporter 925-26 (June 12, 2003).

**De Facto Therapist-Patient Relationship Necessary for Medical Malpractice Claim May Have Existed When Psychologist Gave Employee Advice on Family Problems**

An Indiana appeals court ruled a therapist-patient relationship may have existed between a psychologist and a woman who worked as an employee in the clinic of which the psychologist was half-owner. During her employment, the woman sought advice about problems she was having with her marriage and her children from the psychologist and from her co-workers. After a number of years at the clinic, the woman and the psychologist began a sexual relationship, which continued for approximately one year. At that time, both

the employment and sexual relationships were ended. The woman and her husband sued the psychologist for malpractice, claiming in part that the psychologist had mishandled the transference phenomenon that had arisen. The trial court dismissed the lawsuit after determining that no therapist-patient relationship existed between the woman and the psychologist because the psychologist had merely counseled the woman as his employee and friend.

The Indiana Appeals Court ruled there was sufficient evidence a therapist-patient relationship may have existed to allow a jury to make this determination and reversed the dismissal. Under Indiana law, the court held, the key inquiry is whether the physician performed an affirmative act for a patient's benefit. The court listed three relevant factors: (1) whether the individual met with the therapist for the purpose of receiving treatment, (2) whether the therapist made a recommendation to the individual regarding his or her condition or any course of treatment, and (3) whether the therapist performed some affirmative act that indicated the therapist consented to the establishment of a therapist-patient relationship.

The court noted the psychologist told the woman she should discontinue the anti-depressant drugs prescribed for her headaches and depression by a psychiatrist and recommended herbal treatments, which he provided her, in their place. However, the court also noted the absence of scheduled appointments, that the woman was never billed, that the psychologist stated he only gave her advice as a friend, and that the woman had sought advice from other members of the clinic. Thus, it was up to a jury to decide if this was merely friendly advice or constituted treatment. Thayer v. OrRico, 792 N.E.2d 919 (Ind. Ct. App. 2003).

**Iowa Grandparent Visitation Statute Struck Down**

The Iowa Supreme Court ruled that an Iowa law that allowed grandparents to seek visitation with their divorced children's children violated that state's constitution. Under the law, visitation could be ordered if visitation was in the best interests of the child and the grandparent had established a substantial relationship with the child prior to the filing of the divorce petition. The court ruled that there must be a presumption that a fit parent acts in the child's best interest, a presumption that is not diminished by the fact that the marriage is no longer intact. Furthermore, there must be a showing that the absence of this visitation harms the child, not merely that such visitation is in the child's best interest. *In re* Howard, No. 07/02-0211 (Iowa May 7, 2003); 71(44) U.S. Law Week 1712 (May 20, 2003).

**Missouri Supreme Court Bans Execution of Juvenile Offenders**

The Missouri Supreme Court ruled that the execution of defendants who were juveniles when they committed their offense is barred by the Eighth Amendment's prohibition of cruel and unusual punishment. Applying the analysis used by the U.S. Supreme Court in *Atkins v. Virginia* (2002), the court concluded that evolving standards of decency have similarly led to a national consensus opposing juvenile executions. The court asserted that if the U.S. Supreme Court were to review its decision from 14 years ago in *Stanford v. Kentucky* (1989), it would rule that "evolving standards of decency" mandate that the execution of 16- and 17-year-old offenders be found unconstitutional.

As evidence, the court noted that five additional states have banned the execution of juvenile offenders despite the popularity of "law and order" legislation, no state has lowered the minimum age for execution, 16 states now require a minimum age of 18 for the death penalty, and, although 22 states permit the death penalty for juveniles, only six have executed a juvenile in the past 14 years. The court also cited increased opposition to the juvenile death penalty by professional, social, and religious groups and found no retributive or deterrent value in these executions because of the lesser culpability of

juveniles and the evolving nature of the adolescent mind. The court also determined that the risk of wrongful execution was greater with juveniles because they had less time to develop ties to the community, compile a stable work history, and perform good works, which might be viewed as mitigating factors, and were more likely to waive their rights and give false confessions.

A dissenting opinion argued the Missouri court was bound by the U.S. Supreme Court determination in *Stanford* that no national consensus against juvenile executions existed. State ex rel. Simmons v. Roper, 112 S.W.3d 397 (Mo. 2003); 72(9) U.S. Law Week 1143-44 (Sept. 16, 2003).

**Missouri Woman Confined as Sexual Predator Ordered Released**

The only woman ever confined in Missouri under that state's violent sexual predator law, and one of the few in the nation, has been released. The 27-year-old woman, Angela Coffel, was sentenced in 1995 to a five-year term after being convicted of two counts of sodomy for placing the penises of two brothers, ages 11 and 14, in her mouth during a game of "Truth or Dare." Coffel, 18-years-old and HIV-positive at the time of the crime, has a family history that includes significant physical and emotional abuse, has a below-normal IQ, and contracted HIV at the age of 17. At the completion of her sentence, she was committed indefinitely to the Missouri Sexual Offender Treatment Center after a judge ruled she was likely to assault someone again. No one committed under the Missouri sexual predator law (enacted in 1998) to this center has ever been judged safe for release. The center currently houses 75 individuals, roughly half of which have been committed under this law and the other half are awaiting court determinations.

However, the Missouri Court of Appeals freed Coffel because there was insufficient evidence to support a finding that Coffel was more likely than not to reoffend sexually. The court noted the lack of scientific research into the risk of female sex offenders acting again and found that what does exist indicates it is extremely rare. The court added that the testimony of a clinical psychologist that recommended commitment could not be considered because the factors on which she relied were solely a product of her clinical expertise and were not based, as required, on any scientific research or principles generally accepted in the psychological community.

Reportedly, at least 1,300 men are being held as sexual predators nationwide but Coffel is one of only four women being held as such. *In re* Cofel, 117 S.W.3d 116 (Mo. Ct. App. 2003); Todd C. Frankel, *State's Only Woman Sexual Predator Heads Home*, ST. LOUIS POST-DISPATCH, Nov. 5, 2003.

**Missouri Jury Finds Two Psychologists Breached Duty to Warn of Danger of Child Abuse and Awards $5 Million in Damages**

A jury found two Missouri psychologists failed to meet their common law duty to warn when there was a danger of child abuse to a readily identifiable victim and awarded $5 million in damages. The suit was brought by a 27-year-old woman who claimed her father sexually abused her from the ages of 4 to 13. During this time, the plaintiff's mother discovered sexually explicit photos of the daughter that had been taken by the father and contacted the psychologists for assistance. After meeting with the psychologists, the mother confronted the father, who admitted to inappropriate behavior and agreed to seek counseling. When counseling sessions began, the mother and father told the psychologists they did not want the police or other authorities informed, a condition to which the psychologists agreed. The father attended four sessions with the psychologists but broke them off without telling his wife.

The abuse of the child continued for two more years and only came to light when the mother sought counseling from a social worker for the daughter because of the daughter's growing behavioral problems. The daughter told the social worker about the abuse and the

daughter was quickly removed from her parents' home and placed in foster care. The father was subsequently convicted and imprisoned for the offense.

The Missouri Court of Appeals subsequently established that the common law recognizes a duty on the part of professionals to warn appropriate authorities of specific risks of serious future harm to readily identifiable victims of child abuse. *Bradley v. Ray*, 904 S.W.2d 302 (Mo. Ct. App. 1995). The daughter at trial asserted she was harmed both physically and psychologically, including contracting a venereal disease; experiencing recurring bouts of depression, suicidal tendencies, nightmares, and sleep disorders; and suffering from personality and behavioral disorders and antisocial and aggressive emotional outbursts, making it difficult for her to form relationships. Christopher Brown, *Psychologists Ordered to Pay $5 Million for Not Reporting Patient's Abuse of Child,* 12(40) BNA's Health Law Reporter 1565-66 (Oct. 9, 2003).

**Attorneys' Fees Available When Executor or Trustee Engages in Undue Influence**

In New Jersey, a wealthy unmarried woman placed her assets in three trusts. She named as beneficiaries a foundation and her brother, who was two years younger than his sister. A long-time friend was named as trustee. However, the woman, who had dementia and other medical problems, subsequently replaced the trustee with the son of her brother's recent much younger bride. The son was also named executor of the woman's will. The trusts and the will were then modified to confer substantial benefits on the sister-in-law, her son, and her son's children. The sister-in-law and her son also used the woman's assets to buy luxury items. The former trustee and the foundation filed suit claiming that the sister-in-law and her son had unduly influenced the woman to change her will and trusts.

The trial court removed the son as trustee, finding that he had embezzled and misused assets and exercised undue influence. In addition, the trusts and will modifications were annulled and the former trustee was reinstated. The former trustee and the foundation then sought to recover $2.2 million in attorneys' fees incurred by the estate in the litigation.

The New Jersey Supreme Court ruled that although the "American Rule," which rejects fee-shifting and makes all parties responsible for their own attorneys' fees, is ordinarily applied in litigation, an exception should be made for the "pernicious tort" of undue influence. The court concluded that the breach of the fiduciary relationship owed by an executor or trustee entitled the estate to be made whole by an assessment of all reasonable counsel fees against the fiduciary that exercised undue influence. Thus, the sister-in-law and her son were held jointly and severally liable for the fees incurred by the former trustee and the foundation. *In re* Trust Created March 31, 1992 (Niles Trust), No. A-7/8 (N.J. 2003); 71(47) U.S. Law Week 1748-49 (June 10, 2003).

**Hospital Not Liable for Disappearance of Mentally Ill Daughter Even Though Mother Only Left Her Alone for 45-Minute Meeting with Counselor Because Nurse Promised to Look After Daughter**

A Washington Court of Appeals ruled that a hospital could not be held liable for the promise made to a mother by a nurse to look after her mentally ill 15-year-old daughter while the mother conferred with a counselor. The family's physician had arranged for the daughter to be evaluated at the hospital after he concluded the daughter showed symptoms similar to the manic phase of a manic-depressive disorder. The mother took her daughter to the hospital's emergency room where the hospital's notes indicated the daughter was acting "manic and paranoid," had a six-month history of depression and mania, and her status was "urgent." The hospital's crisis services counselor asked to meet privately with the mother. When the mother said she did not want to leave her

daughter alone in an examination room, the counselor asked a nurse from the nurses' station across the hallway to watch the daughter. The nurse explained she could watch the room from a video monitor. Finding this acceptable, the mother left to meet with the counselor in another room. When they returned 45 minutes later, the daughter was gone. The nurse said she had left her station to administer an I.V. to another patient. The parents have not seen their daughter since then.

The parents sued the hospital for negligently allowing their daughter to escape and for breaching its promise to keep her safe. Their lawsuit was dismissed. The court determined that in Washington a youth who is at least 13 years of age has a general right to seek or to decline mental health services without parental consent and thus, when the daughter decided she did not want services, the hospital had no legal authority to detain her. As for the hospital's broken promise, the court held that under Washington law only the patient, and not her parents, could recover for the injury suffered as the result of a broken health-care-related promise. Nash v. Sisters of Providence, No. 28295-0-II, 2003 WL 21791593 (Wash. Ct. App. Aug. 5, 2003); 12(33) BNA's Health Law Reporter 1278 (Aug. 14, 2003).

**Subtle Interrogation Tactics Unconstitutional When Used to Question Suspect Suffering from Alcohol Withdrawal and Mental Health Problems**

The Wisconsin Supreme Court ruled that subtle interrogation tactics that would be acceptable during the questioning of an ordinary suspect are unconstitutionally coercive when used to question a suspect suffering from alcohol withdrawal and mental health problems. The court noted an interrogation tactic violates the 14th Amendment's due process clause when it is coercive and that coerciveness must be determined with the particular suspect's characteristics in mind. The court asserted that as interrogators have turned to more subtle forms of psychological persuasion, courts have found the mental condition of the defendant to be a more significant factor. Furthermore, the police conduct involved does not need to be egregious or outrageous to be coercive.

Instead, the court determined, subtle pressures are considered to be coercive if they exceed the defendant's ability to resist, which varies with the defendant's condition. The court concluded that the police officer's tactics in this murder case, which included invoking emotional topics and asking leading questions, were coercive in light of the "significant mental and physical difficulties" that the suspect was having at the time of the interviews. State v. Hoppe, 661 N.W.2d 407 (Wis. 2003); 71(48) U.S. Law Week 1776 (June 17, 2003).

## *Other Legal Developments*

**Virginia Commits Its First Sexually Violent Predator**

William Glen Martin, 61, scheduled to be released from prison in July, became the first individual committed under Virginia's newly effective sexually violent predator law. He was convicted in 1989 of forcing two young children to perform sex acts on each other and in 1998 for showing pornography to three girls between the ages of five and eight and exposing himself to them. He was taken into custody by the Department of Mental Health, Mental Retardation and Substance Abuse Services after a Hanover County Circuit Judge ruled he was a sexually violent predator.

Under Virginia law, a sexually violent predator "because of a mental abnormality or personality disorder, finds it difficult to control his predatory behavior which makes him likely to engage in sexually violent acts." Under the

law, a seven-member Commitment Review Committee evaluates and makes recommendations for sex offenders within ten months of their prison release dates. The Virginia Attorney General may then seek a court order mandating commitment for an indefinite period. As of October, the Virginia Attorney General's Office had reportedly sought the commitment of 11 convicted sex offenders. One case was dismissed after the offender was convicted of new crimes, while the other nine cases are pending. A court hearing to determine whether the basis for commitment continues is held every year for the first five years and every other year after that. 18(19) Virginia Lawyers Weekly 473 (Oct. 13, 2003).

**Virginia Claim that State Mental Health Facility Responsible for Beating Death of 18-Year-Old Patient Settled Out-of-Court**

A lawsuit that claimed that a Virginia state mental health facility was responsible for the beating death of an 18-year-old patient was settled out-of-court. The young man died in 1996, 14 months after suffering severe internal injuries at Western State Hospital in Staunton, Virginia. A medical examiner ruled the death a homicide but no arrests were made. The patient's family claimed the hospital and its director were to blame because the patient was beaten either by an employee or by a patient who was not properly supervised. The amount of the settlement was not disclosed although the lawsuit sought $10 million. The state denied any liability in the dismissal order filed in conjunction with the settlement. 18(6) Virginia Lawyers Weekly 128 (July 14, 2003).

**Arizona Limits Civil Liability of Health Care Providers Under Elder Abuse Laws**

Arizona has enacted legislation that removes most physicians and certain licensed health care providers from civil liability under elder abuse laws. These professionals can still be sued under the Arizona Medical Malpractice Act. Under elder abuse laws, however, victims of alleged elder abuse had seven years rather than two years to file their suit. The rationale given for the enactment is that it will curb increases in the costs of medical malpractice premiums among doctors. Medical professionals holding positions of medical director or house physician at an assisted living facility, residential care facility, or nursing home, however, are not entitled to this exemption. 12(20) BNA's Health Law Reporter 769 (May 15, 2003).

**Florida Enacts Law Requiring State Agency to Post on the Internet the Average Price of Drugs Prescribed for the Elderly**

In response to concerns that Medicare beneficiaries had no way to verify they were receiving the 9% discount on drug prices to which they are entitled under Florida law, Florida passed a law that requires the state's Agency for Health Care Administration to post on the Internet the most recent average wholesale price for the 200 drugs most frequently dispensed to the elderly. The web site will also provide a mechanism that permits consumers to calculate the retail price that should be paid. According to a legislative analysis, Florida has 2.6 million elderly Medicare beneficiaries, over 90% of them take prescription drugs, and Medicare recipients on average take seven different medications. 12(24) BNA's Health Law Reporter 927 (June 12, 2003).

**Maine Requires Drug Manufacturers to Report How Much They Spend on Marketing Their Prescription Drugs**

Maine has enacted what are characterized as strict new reporting requirements for drug manufacturers. The legislation, which becomes effective July 1, 2004, requires drug manufacturers to report annually how much they spend on advertising, marketing, and promoting their products. Promotion expenses to be reported include spending on seminars, travel, food, entertainment, gifts over $25, items provided at less than market value, and product samples (but not samples distributed free of charge to patients). Information from individual companies will be

confidential but aggregate data will be available to the public. Reports are to be submitted to the Maine Department of Human Services. ME. REV. STAT. tit. 22, § 2698-A (2003); 12(24) BNA's Health Law Reporter 926 (June 12, 2003).

**Maryland Law Makes It Easier to Establish Physician Wrongdoing in Some Cases**

Under legislation enacted in Maryland, a less stringent evidentiary standard will be used in some physician disciplinary hearings to determine whether doctors have engaged in wrongdoing. The standard for establishing wrongdoing has been changed from a "clear and convincing evidence" standard to a "preponderance of the evidence" standard in all cases except those involving standards of care. The new standard will apply to violations such as fraudulently obtaining a license, providing services while intoxicated, or selling drugs for illegal purposes. It will not apply to charges that there has been a failure to deliver quality medical or surgical care. 12(20) BNA's Health Law Reporter 768 (May 15, 2003).

**Michigan Establishes First Mental Health Commission and Directs It to Make Recommendations to Improve State's Mental Health Network**

The Governor of Michigan, Jennifer Granholm, announced the creation of Michigan's first Mental Health Commission on December 15, 2003, and charged it to make broad recommendations to turn the state's mental health network into a national model. The executive order (No. 2003-24) establishing the Commission asserted that the "[t]he publicly-supported mental health system is currently at a crossroads" and "requir[es] the input of interested parties working together to address the challenges confronting the system." The Commission will consist of 29 members and include state legislators from both parties, representatives from mental health organizations, educators, parents, judges, social workers, and community mental health workers. The Commission is expected to finish its report by September.

The Commission's assigned duties include identifying methods to simplify access to care, promote effective service and support practices, improve care outcomes, and enhance consumer and family satisfaction. It is also directed to identify financing options for expanding prevention and early intervention efforts. 13(1) BNA's Health Law Reporter 34 (Jan. 1, 2004).

**Minnesota Mandates Reporting of 27 "Never" Events by Hospitals**

Minnesota enacted legislation that requires hospitals in the state to report to the state health department 27 "never" events, i.e., adverse events including medical errors that should never occur. The legislation made Minnesota the first state to fully adopt the National Quality Forum standards for mandatory reporting of medical errors. Events that must be reported include death or serious disability associated with medication error, patient death or disability due to the use of contaminated drugs or devices, abductions and assaults of patients, and suicides or attempted suicides that result in a serious disability. Reports must be filed within 15 working days of the discovery of an event but are not to include the names of anyone involved.

Hospitals must conduct a root cause analysis of the event and either implement a corrective action plan or determine that corrective action is not required. The health department is to analyze the information provided to uncover systemic flaws in the health care system and to identify successful methods for correcting flaws. The system is claimed to have the advantage of seeking information without assigning blame. Annual reports are to be published detailing the reported events by facility. MINN. STAT. § 144.7065 (2003); 12(25) BNA's Health Law Reporter 986 (June 19, 2003).

**Credentials, Experience, Disciplinary and Malpractice Histories of Physicians in New Jersey to Be Made Available to Public via Internet and Toll-Free Number**

New Jersey has passed a law that will make available to the public via the Internet and a toll-free telephone number profiles of all the state's licensed physicians, including their credentials, experience, and disciplinary and malpractice histories. Doctors are to be provided with advance copies of their respective profiles before they are made available for public release and given 30 days to correct inaccuracies.

The profiles will report all medical malpractice court judgments, settlements, and arbitration awards in which a payment has been awarded during the last five years, although pending malpractice claims and awards on appeal will not be included. Each doctor's number of judgments, arbitration awards, and settlements will be categorized as either average, above average, or below average based on a comparison to the number of claims among doctors within specialty pools. 2003 N.J. Sess. Law Serv. Ch. 96 (West); 12(27) BNA's Health Law Reporter 1059 (July 3, 2003).

**North Carolina Broadens Confidentiality Statute to Reflect Privatization of Mental Health Care Network**

In response to efforts to privatize its delivery of mental health care with a network of community providers, North Carolina amended its mental health confidentiality provisions to permit the sharing of information between the private entities and local and state authorities. Previous legislation had established that information could be shared between state authorities and local mental health authorities providing direct services to clients without the patient's consent when necessary to facilitate the coordination of care.

Under the new law, this sharing of information is expanded to include private entities when needed to coordinate care, conduct payment and claims activities, determine patient eligibility, and develop, manage, monitor, or evaluate the provider network. In enacting the law, special care was reportedly taken to ensure compliance with the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191). 2003 N.C. Sess. Laws 313; 12(30) BNA's Health Law Reporter 1172-73 (July 24, 2003).

**Ohio Enacts Law That Specifically Authorizes Advanced Directives for Mental Health Treatment**

Ohio joined at least 14 other states when it enacted a law that specifically authorizes advanced directives for mental health treatment. Although Ohio already had in place a law that authorizes the use of durable powers of attorney for health care for physical or mental conditions, advocates of the new law asserted that fewer than a thousand individuals in the state had used this option to address future mental health treatment.

Supporters of the new stand-alone statute for mental health care assert it will increase the likelihood that a person's wishes regarding mental health care will be honored, will prevent disputes over related treatment, and will reduce the number of people who are involuntarily sent to a mental health care facility. The law authorizes declarations for mental health treatment and the designation of proxies to make mental health treatment decisions. The law emphasizes that it does not supersede a valid declaration governing the use of life-sustaining treatment. 2003 Ohio Legis. Serv. 27 (West); 12(32) BNA's Health Law Reporter 1246 (Aug. 7, 2003).

**Texas Law Requires Psychiatric Hospitals to Report Certain Medical Errors; Annual Reports Summarizing Errors Will Be Made Available to Public**

A new Texas law requires psychiatric hospitals, as well as hospitals and ambulatory surgical centers, to report certain medical

errors to the state Department of Health. These facilities will also be required to implement risk-reduction strategies and share the steps that are effective in improving patient safety. Medical errors must be summarized in an annual report that will be available to the public, although the report will contain only the error and the number of occurrences.

Medical errors that must be reported include errors resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or the underlying condition of the patient; the suicide of a patient in a setting where he or she received care 24 hours a day; and the sexual assault of a patient. Within 45 days after becoming aware of the error, the facility must analyze its cause and develop an action plan that identifies strategies to reduce the risk of similar future events. Information in the submitted reports may not be admitted into evidence or disclosed in any court or administrative proceeding. 12(31) BNA's Health Law Reporter 1210-11 (July 31, 2003).

**Texas Enacts Medical Malpractice Legislation but Does Not Encompass Mental Health Workers**

Texas, as have a number of states, enacted legislation designed to address a reported medical malpractice crisis in the state. The legislation placed a cap of $250,000 on non-economic damages that can be awarded against health care providers and expanded the definition of health care providers encompassed within the state's medical malpractice statute to include chiropractors and optometrists. However, mental health workers, psychologists, and social workers remain uncovered by the statute. 12(26) BNA's Health Law Reporter 1017-18 (June 26, 2003).

**Texas Regulates Use of Internet by Out-of-State Physicians to Provide Treatment**

Under a new regulation in Texas, out-of-state physicians using the Internet to treat Texas patients must obtain written, informed consent before communicating with the patients by e-mail. Obtained informed consent must contain an acknowledgement by the patient that electronic transmission may compromise the confidentiality of patient information. The state's telemedicine regulations also address the use of the Internet in the areas of evaluation, treatment, communications, medical records, state licensure, disclosure, accountability, and advertising. Physicians who treat patients using the Internet must have the appropriate licensure in all jurisdictions where the patients reside. The rules are available at http://www.tsbme.state.tx.us./rules/rules/174.htm. 12(19) BNA's Health Law Reporter 749 (May 8, 2003).

**AMA Adopts Guidelines on Use of Internet to Prescribe Medications**

The House of Delegates of the American Medical Association (AMA) in June adopted new guidelines on Internet prescribing. Purportedly, the guidelines are intended to protect patients from substandard medical care and to help physicians avoid disciplinary actions by state medical boards and other regulatory agencies. It has been reported that since 1998 27 of the nation's 70 medical boards have disciplined doctors for improperly prescribing medications online.

AMA policy supports Internet prescribing. However, this report asserted that many of the companies prescribing medications to patients electronically via Web sites dispense drugs based solely on online questionnaires and consultations.

The AMA guidelines direct physicians to not prescribe medications online without first obtaining a medical history from the patient and performing a physical examination. The report also advised that physicians who prescribe medication via the Internet should be licensed in the states where their patients live or meet the regulatory requirements of individual state medical boards. To protect

patient privacy, it was recommended that physicians use a secure network with password requirements and prescription encryption.

The AMA guidelines can be found at www.ama-assn.org/ama/pub/category/10292.html. Christine Lehmann, *AMA Steers MDs Around Internet Prescribing Pitfalls*, 38(14) Psychiatric News 9 (2003); 12(26) BNA's Health Law Reporter 1010 (June 26, 2003).

**APA Issues Guidelines for Assessment and Treatment of Suicidal Patients**

The American Psychiatric Association approved guidelines for the assessment and treatment of suicidal patients. The guidelines were published in November and provide information about prevalence rates, risk factors, protective factors, and psychotherapeutic and pharmacologic treatments for at-risk patients. They also address how best to manage the risk of suicide in patients from a legal standpoint and under what conditions it may be necessary to reveal confidential information about the patient to significant others. In addition, they advise against reliance on suicide-prevention contracts in which a patient agrees to contact his or her psychiatrist or other treatment team members before harming himself or herself. The guidelines can be found at http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf. Eve Bender, *APA's Newest Practice Guideline Addresses Suicide-Risk Issues*, 38(14) Psychiatric News 15 (2003).

**Partners and Supervisors of a Lawyer Who Has Become Mentally Impaired Have Affirmative Obligations to Respond According to ABA Opinion**

The American Bar Association's Committee on Ethics and Professional Responsibility has issued an advisory opinion that asserts that the partners and supervisors of a lawyer who becomes mentally impaired have an affirmative obligation to protect the interests of the lawyer's clients. Qualifying impairments include those stemming from alcoholism and substance abuse—problems that afflict lawyers at an especially high rate—as well as conditions such as Alzheimer's disease or other age-related problems. Once a law firm realizes a lawyer in the firm has developed a mental impairment, this advisory opinion states the firm must take steps to prevent ethics violations by the lawyer. The committee suggested steps such as confronting the impaired lawyer, pressing the lawyer to get help, and restricting or even preventing the lawyer from handling matters or dealing with clients.

Furthermore, the opinion concludes that if breaches of ethics rules by the lawyer do occur, the firm may have to report the lawyer to the appropriate authority unless the lawyer's impairment has ended or the firm's supervision and support eliminate the risk of future violations. If the lawyer has left the firm, the firm may have disclosure obligations to its clients who are considering being represented by the impaired lawyer.

The committee noted the ABA Model Rules of Professional Conduct specifically prohibit a lawyer from providing representation if the lawyer's mental condition materially impairs the ability to represent the client. The committee observed, however, that a mentally impaired lawyer may deny or ignore the impairment and its consequences, necessitating that partners and supervisors of such lawyers interject themselves. 72(1) U.S. Law Week 2003-04 (July 8, 2003).

**Survey Finds Employees Unlikely to Prevail on ADA Claims**

An American Bar Association survey found employers prevailed in 94.5% of federal court decisions issued in 2002 under Title I of the Americans with Disabilities Act (ADA). The employee prevailed in only two out of 73 mental illness cases and in none of 14 substance abuse cases. Employees had a better overall chance of prevailing on their ADA claims at the Equal Employment

Opportunity Commission, although even there the employer prevailed in 78.1% of the cases. 71(49) U.S. Law Week 2805 (June 24, 2003).

**Report Finds Medicaid Paying 29% More for Mental Health Drugs Than Other Federal Purchasers and Mental Health Drugs Constitute 20% of All Medicaid Drug Expenditures**

The Office of Inspector General of the Department of Health and Human Services issued a report that reviewed expenditures for prescribed mental health drugs by ten state Medicaid agencies. Information was obtained on twenty-five mental health drugs from those state agencies with the largest reimbursement for prescription drugs. The study found that these ten agencies paid 29% more than the "Big 4" of federal purchasers of these drugs, which included the Department of Defense, the Department of Veterans Affairs, the Public Health Service, and the Coast Guard.

The report concluded that Medicaid would have saved $126 million if it had paid prices equal to the Big 4 prices. The report also determined that a subgroup of nine antipsychotic drugs accounted for over half of the difference. The report also noted that of the $20 billion the Medicaid program spends on prescription drugs, mental health drugs represented an estimated 20% or $4 billion and are among the fastest-rising costs for Medicaid. The report recommended that the Centers for Medicare and Medicaid Services work with states to pursue more efficient means of purchasing pharmaceuticals and initiate a review of the Medicaid rebate program. The OIG report, "Medicaid's Mental Health Drug Expenditures" (OEI-05-02-00080; August 2003) can be found at http://oig.hhs.gov/oei/reports/oei-05-02-00080.pdf.

**Medicaid Expenses Driving Up State Budget Costs**

A survey by the National Governors Association and the National Association of State Budget Officers found that Medicaid expenditures are continuing to drive up state budget costs. The report found the state share of Medicaid grew by 13% in fiscal year 2002 and an estimated 8% in fiscal year 2003, and this surge in Medicaid costs combined with a reduction in state revenues contributed to state budget shortfalls. It was noted Medicaid spending accounts for 20% of all state expenditures. 12(27) BNA's Health Law Reporter 1055-56 (July 3, 2003).

**All States Impose Medicaid Cost Containment Measures**

A survey of state Medicaid directors by the Kaiser Commission on Medicaid and the Uninsured found all fifty states implemented Medicaid cost containment measures in fiscal year 2003, with all states either freezing or reducing provider payments and forty-six states putting new mechanisms in place to reduce the growth of their spending on prescription drugs. Each state also planned to put in additional spending constraints in fiscal year 2004. According to the report, federal legislation (Pub. L. No. 108-27) that provided $10 billion for a temporary increase in federal Medicaid matching rates helped forestall greater cuts to state Medication programs but, with this temporary increase set to expire near the end of fiscal year 2004, states are expected to again face "significant gaps" in their budgets. 12(38) BNA's Health Law Reporter 1480 (Sept. 25, 2003).

**Six States Cap Monthly Prescriptions Allowed Medicaid Beneficiaries**

Six states—Alaska, Kansas, Louisiana, Maryland, Oklahoma, and Texas—limit the number of prescriptions allowed Medicaid beneficiaries per month according to a survey released July 24 by the National Conference of State Legislatures. 12(31) BNA's Health Law Reporter 1205 (July 31, 2003).

**Congress Approves Extension of Mental Health Parity Bill**

The U.S. Senate on Nov. 21 approved by unanimous consent legislation (s. 1929) to

reauthorize the 1996 Mental Health Parity Act. The bill was passed by the House of Representatives the previous week. The Mental Health Parity Act requires employer sponsored health benefit plans to provide similar coverage for mental health benefits as for other medical benefits. The new legislation extends the effective date of this Act through December 31, 2004. Mental Health Parity Reauthorization Act of 2003, Pub. L. No. 108-197, 117 Stat. 2998; 12(47) BNA's Health Law Reporter 1812 (Dec. 4, 2003).

**Medicare Bill Includes Provision to Establish Better Means of Checking Criminal and Abuse Histories of Prospective Long-Term Care Facility Employees**

Included within the mammoth Medicare drug and reform bill (H.R. 1) recently approved by Congress is a requirement that the Department of Health and Human Services establish a pilot program to identify better means "for long-term care facilities or providers to conduct background checks on prospective direct patient access employees." The bill calls for demonstration projects in up to ten states to test procedures for conducting background checks.

Under these procedures, prospective employees must provide a written statement disclosing any prior criminal convictions or findings of patient or resident abuse, authorize the facility to request federal and state criminal history background checks, and provide the facility with fingerprints. States that already have such systems in place are not precluded from participating in the project. HHS, working with the U.S. attorney general, will evaluate the results of the pilot project and recommend procedures necessary to implement a national criminal background check program. Sen. Charles E. Grassley expressed concern that under the current system abusive workers can move readily from nursing home to nursing home. 12(47) BNA's Health Law Reporter 1826 (Dec. 4, 2003).

*Developments in Mental Health Law*
Institute of Law, Psychiatry & Public Policy
University of Virginia Law School
UVA Health System Box 800660
Charlottesville, VA 22908-0660

# DEVELOPMENTS IN MENTAL HEALTH LAW

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## Mandated Treatment in the Community for People with Mental Disorders*

Treating people without their consent has always been the defining human rights issue in mental health law.

By John Monahan,† Marvin Swartz,‡ and Richard J. Bonnie§

**Abstract.** Commitment to community-based mental health treatment bears limited resemblance to commitment to treatment in a closed institution. It can be better understood in the context of a broad movement to apply leverage to induce treatment engagement, a movement that includes the use of the social welfare and justice systems and psychiatric advance directives. Understanding "mandated community treatment" in all of its forms can be advanced by viewing it within the framework of health care quality as recently outlined by the Institute of Medicine, particularly along the dimension of patient centeredness.

**Prologue.** The process of deinstitutionalizing people with mental illness in the United States–now a half-century in the making–has manifested itself in a dramatic decline in the populations of state and county mental hospitals: from more than half a million in 1950 to about 50,000 today. At the same



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† Henry and Grace Doherty Professor of Law, University of Virginia School of Law.
‡ Professor of Social and Community Psychiatry, Duke University Medical Center.
§ John S. Battle Professor of Law, University of Virginia School of Law; Director, Institute of Law, Psychiatry and Public Policy, University of Virginia.

time, the ranks of jails and prisons are swelling with a rising number of inmates with a serious mental illness, to the point where a person with a serious mental illness is about five times more likely to find himself incarcerated rather than admitted.

The juxtaposition of declining treatment and increasing incarceration rates among people with mental illness has led to considerable criticism of the deinstitutionalization movement for failing to follow through on promised community-based treatment. But the tide could be turning. Backed up by research that confirms that treatment can reduce violence in people with major psychiatric disorders and fueled by several high-profile cases of violent crimes committed by people with severe mental illness, mandated community-based treatment has now taken center stage in this drama. But the issue remains controversial, as it pits public safety concerns against the rights of individuals.

The following paper explores the context within which coerced community treatment has arisen and seeks to break the impasse between advocates and opponents by placing mandated treatment within the larger conceptual framework of health care quality. The authors are all part of the Research Network on Mandated Community treatment, a MacArthur Foundation-funded project designed to evaluate programs in which mentally ill patients are instructed by the courts to get community-based treatment.

### Introduction

Requiring adherence to community-based mental health treatment is now the single most contested human rights issue in mental health law and policy. Although forty United States jurisdictions have statutes nominally authorizing outpatient commitment (a legal order to adhere to prescribed community treatment), until recently few states made substantial use of these laws. With the 1999 enactment in New York State of "Kendra's Law" and the 2003 enactment in California of "Laura's Law," both statutes named after young women killed by people with untreated mental illness, national interest in outpatient commitment has soared. Many states are now experiencing a take-no-prisoners battle between advocates for "assisted treatment" (the more benign term preferred by the proponents of outpatient commitment) and advocates against "leash laws" (the less benign term used by its opponents).


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In this paper we first describe the mental health policy context within which coerced community treatment has arisen. Second, we provide an account of the current uses of outpatient commitment and other forms of "mandated community treatment" and how these practices came to be. Finally, we place mandated treatment within the larger conceptual framework of health care quality recently proposed by the Institute of Medicine (IOM), a framework more conducive to reasoned policy deliberation than that often reflected in the current polarized debate.

## The Context of Coercion in the Community

Almost every U.S. community has a subpopulation of mentally ill people who manifest complex problems in multiple areas of life and who come into contact with a variety of public agencies and institutions–including community mental health centers, public hospitals, substance abuse treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The growth of this population, often termed "revolving door patients," is attributable to increasingly restrictive criteria for involuntary inpatient commitment, limited availability of effective inpatient care, a paucity of effective community-based services, and a lack of other needed community supports. Many of these patients derive little benefit from available treatment programs because they often do not adhere to medication regimens or keep scheduled appointments, may abuse substances, and tend to live in impoverished, dangerous environments with inadequate social supports.

Much of the debate on treatment mandates, or the use of coercion in treatment, assumes that treatment mandates represent a coordinated policy to tighten social controls on people with serious mental illness. It is more useful to understand these mandates as a set of convergent responses to the common challenges facing the diverse agencies and institutions serving this population. While many critics cogently argue that the scarcity of appropriate treatment and rehabilitation/ habilitation resources is the fundamental cause of poor treatment outcomes, poor adherence to even scarce treatment programs is equally problematic. It is not surprising that diverse agencies and institutions have developed similar strategies to address the common problem of treatment non-adherence. However, it is also important to recognize that treatment mandates arise from quite different contexts.

## The Varieties of Mandated Community Treatment

Treating people with mental disorders without their consent has always been the defining human rights issue in mental health law. (This same historical debate has been largely absent in substance abuse treatment, however, and the ubiquitous use of coercion in substance abuse treatment is largely uncontested.) For centuries, unwanted treatment for mental disorder took place in a closed institution–a mental hospital. What has changed is that now the locus of involuntary treatment has shifted to the open community.

Much of the strident policy debate on outpatient commitment treats it as simply an extension of inpatient commitment and views it within the same conceptual and legal framework as commitment to a mental hospital. We believe that outpatient commitment should be seen in the context of a growing array of legal tools now being used to improve treatment adherence in the community. In this way, outpatient commitment can be adequately understood, and informed policy decisions on whether to promote or oppose its adoption can be reached.[1]

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[1] J. Monahan et al., "Mandated Community Treatment: Beyond Outpatient Commitment," *Psychiatric Services* 52, no. 9 (2001): 1198-1205; G. Szmukler and P. Appelbaum, "Treatment Pressures, Coercion, and Compulsion," in *Textbook of Community Psychiatry*, ed. G. Thornicroft and G. Szmukler (Oxford, UK: Oxford University Press, 2001), 529-543.

**Conditional release.** Of course, many states in the past have explicitly or implicitly permitted "conditional release" from inpatient commitment as a way to move committed patients into the community while assuring appropriate follow-up and treatment adherence. Sometimes, conditional release was treated as a form of "leave"–the patient remained on the census and could be returned to the hospital at any time during the period of conditional release. In addition, some states allowed so-called split commitments, reserving some of the commitment time for an outpatient period of observation after hospital discharge. In either instance, these forms of conditional release were reserved exclusively for patients who met inpatient commitment criteria.

**Preventive commitment.** Beginning in the 1990s, commitment laws permitted outpatient commitment as an alternative to inpatient commitment. More recently, states have used outpatient commitment as a preventative procedure, allowing a court order before a psychiatric crisis that would be needed to meet inpatient commitment criteria. These latter uses of commitment law represent a departure from the historical use of inpatient commitment.

As noted, the preventative use of outpatient commitment is one of several forms of mandated community treatment. People with severe and persistent mental disorders are often dependent upon goods and services provided by social welfare agencies, including disability benefits and housing. Their access to these goods and services may be tied to treatment participation. Similarly, many people with severe and persistent mental disorders often find themselves arrested for criminal offenses. Lenient disposition of their cases may be tied to treatment participation. In each of these contexts, the targeted patients face loss of liberty, property, or other valued interests if they fail to comply with prescribed treatment. Facing such pervasive constraints on "free choice," patients may attempt to maximize their own control over the treatment they receive in the event of later deterioration by executing advance directives; paradoxically, they may choose to authorize treatment even over their subsequent resistance. Each of these forms of leverage is described in more detail below.

## Mandated Treatment in the Social Welfare System

People with disabilities, such as those associated with a serious mental disorder, may qualify under current federal or state laws to receive certain social welfare benefits, such as income supports and subsidized housing.

**Money as leverage.** Because people with mental disorder sometimes have cognitive deficits that impair their ability to manage money, the Social Security Administration (SSA) may appoint a representative payee to manage clients' disability benefits. A representative payee can be either an agency or person who is paid directly by the SSA and through whom a recipient can gain access to his or her disability payments. Some estimates indicate that about half of those receiving disability benefits for mental disorders use representative payees.[2]

The system of representative payees arose out of concern that vulnerable people might be victimized or might not use public funds appropriately. Thus, the system was designed to protect such people while serving the fiduciary interests of the government. Informally, some representative payees have construed the payee role as more broadly supervisory and have made access to some funds contingent on treatment adherence. One survey in Chicago indicated that the majority of patients who have a representative payee believe that there is a relationship between their adherence to treatment and whether they receive funds, and a large minority believes that this relationship

[2] L. Dixon et al., "Case Managers' and Clients' Perspectives on a Representative Payee Program," *Psychiatric Services* 50, no. 6 (1999): 781-786.

approaches quid pro quo.[3] Other studies have correlated the presence of representative payees with decreased homelessness, victimization, and days spent in psychiatric hospitals and increased participation in treatment.[4] Clearly, representative payeeship is an informal tool of mandated treatment–to apparent benefit–but it arose because of government's concern about the appropriate use of public funds.

**Housing as leverage.** A survey conducted in 2001 found that in not a single U.S. city or county could a person with a mental disorder living solely on disability benefits afford the fair market rent for a "modest" efficiency apartment.[5] The only alternative to subsidizing housing for many people with severe and persistent mental illness, therefore, is homelessness. To avoid this outcome, the government provides a number of housing options in the community for people with mental disorders that it does not provide to other citizens. Of the 600,000 Americans with disabilities who in 2001 resided in housing subsidized by the federal Department of Housing and Urban Development (HUD), approximately one-third qualified for this subsidy because of a mental disorder.[6]

No one doubts that landlords can impose generally applicable requirements on their tenants. The issue is whether landlords legally can and in fact do impose additional requirements on tenants with mental disorders and whether any such requirements can pertain to treatment. The slim literature on this topic finds that subsidized housing sometimes is used formally and much more often may be used informally as leverage to assure adherence to mental health treatment in the community.

Many agencies that manage housing programs for people with mental disorders appear to consider the programs to be primarily "residential treatment" and only incidentally lodging.[7] For example, the standard lease used by one group providing supported housing reads: "Refusing to continue with mental health treatment means that I do not believe I need mental health services . . . I understand that since I am no longer a consumer of mental health services, it is expected that I will find alternate housing. I understand that if I do not, I may face eviction."[8] While it appears that the intent is to leverage treatment adherence through the offer of housing, the more general rationale offered by providers is that given the limited housing resources available, existing housing slots must be reserved for persons participating in treatment and likely to benefit from treatment-affiliated housing. They also argue that allowing residence by non-adherent people disrupts the treatment of other clients. One recent randomized study, however, found that a program that allowed the tenants of subsidized housing to control whether or not they receive services–compared with a program that linked housing to treatment adherence–reduced homelessness without increasing psychiatric symptoms or substance abuse.[9]

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[3] P. Hanrahan et al., "Representative Payee Programs for Persons with Mental Illness in Illinois," *Psychiatric Services* 53, no. 2 (2002): 190-194.

[4] D. Luchins et al., "An Agency-Based Representative Payee Program and Improved Community Tenure of Persons with Mental Illness," *Psychiatric Services* 49, no. 9 (1998): 1218-1222; E. Elbogen, J. Swanson, and M. Swartz, "Third-Party Money Management for Persons with Psychiatric Disabilities: Prevalence, Type of Payee, and Client Characteristics," *Psychiatric Services* (forthcoming).

[5] E. Edgar et al., *Priced Out in 1998: The Housing Crisis for People with Disabilities* (Boston: Technical Assistance Collaborative, 1999).

[6] Ann O'Hara, Technical Assistance Collaborative, personal communication, May 2002.

[7] H. Korman, D. Engster, and B. Milstein, "Housing as a Tool of Coercion," in *Coercion and Aggressive Community Treatment*, ed. D. Dennis and J. Monahan (New York: Plenum Press, 1996), 95-113.

[8] M. Allen, "Separate and Unequal: The Struggle of Tenants with Mental Illness to Maintain Housing," *Clearinghouse Review* (November 1996): 720-739.

[9] M. Shinn et al., "Effects of Housing First and Continuum of Care Programs for Homeless

## Mandated Treatment in the Judicial System

People with severe mental disorders can be ordered to comply with treatment by judges or by other officials acting in the shadow of judicial authority (such as probation officers). Even in the absence of a judicial order, patients might agree to adhere to treatment requirements to avoid an unfavorable judicial order such as a sentence of incarceration.

**Avoidance of jail as leverage.** Making the acceptance of mental health treatment in the community a condition of sentencing a defendant to probation rather than to jail has long been an accepted judicial practice, and one that can affect many defendants. Of the 3.8 million U.S. defendants who were convicted and sentenced to probation in 2002, 8-12% (300,000-450,000 people) were estimated to have a serious mental disorder. In addition, a new type of criminal court–called, appropriately, a "mental health court"–makes even more explicit the link between sanctioning and treatment in the community.

Mental health courts focus on the nonviolent mentally ill offender who has had repeated contact with the criminal justice system. Adapted from the drug-court model, a mental health court differs from a regular court in several respects: cases are heard on their own court calendar, separate from other cases, and are handled by their own specialized team of legal and mental health professionals; emphasis is put on implementing new working relationships between the criminal justice system and the mental health and social welfare systems; and defendants appearing before mental health courts generally receive intensive supervision in the community. Mental health courts appear to be spreading rapidly across the country. There was but one operating mental health court in 1997, a dozen in 2002, and close to a hundred by 2004.[10]

Mental health courts arguably use avoidance of incarceration to mandate treatment. However, closer examination reveals great variability in their operations. For some courts, the key motivation appears to be to reduce jail crowding, and they give relatively less attention to assuring treatment participation. Other courts, by use of frequent status hearings, follow the subject's treatment participation and apply sanctions for non-adherence. These latter courts more directly use the court to mandate treatment.

**Avoidance of hospitalization as leverage.** Outpatient commitment, as described above, refers to a court order directing a person with a serious mental disorder to comply with a community treatment plan, under pain of being hospitalized for failure to do so, if the person meets the criteria for involuntary hospitalization.

Outpatient commitment was conceived as a less restrictive alternative to involuntary hospitalization for people at risk of being dangerous or gravely disabled without treatment. It arose as a recognition by the courts that noncompliance with treatment was a common cause of repeated involuntary hospitalizations and thereby a barrier to accessing less restrictive treatment alternatives. By using the moral authority of the court, outpatient commitment was envisioned as a means to reduce relapse, reduce involuntary hospitalizations, and

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Individuals with Psychiatric Diagnoses" (Unpublished paper, New York University, January 2003).

[10] J. Monahan, P. Griffin, H. Steadman, and J. Petrila, "The Use of Criminal Charges and Sanctions in Mental Health Courts," *Psychiatric Services* 53, no. 10 (2002): 1285-1289; N. Poythress et al., "Perceived Coercion and Procedural Justice in the Broward County Mental Health Court," *International Journal of Law and Psychiatry* 25, no. 5 (2002): 517-533; "Survey of Mental Health Courts" (2004), *available at* http://www.mentalhealthcourtsurvey.com.

improve the effectiveness of outpatient care by improving treatment adherence.[11]

In New York State, Kendra's Law mandates adherence to mental health treatment in the community for those who meet a number of statutory qualifications, including that the person is suffering from mental illness and "because of mental illness is unlikely to participate voluntarily in recommended treatment and . . . needs assisted outpatient treatment to prevent a relapse or deterioration which would likely result in serious harm to the person or others." From the time it was enacted in December 1999 through June 2003, 7,983 people in New York State have been evaluated for outpatient commitment under Kendra's Law, of whom 2,602 were committed and another 1,913 "voluntarily" agreed to adhere to treatment in the community before a judgment was rendered.[12]

**Advance directives.** One way to establish a person's preferences regarding future treatment, should the person become unable to make those decisions or to communicate those preferences in the future, is for the person to "mandate" his or her preferred treatment in an advance directive. Usually, advance directives pertain to wanted or unwanted medical care at the end of life. But a 1991 federal law has given impetus to mental health advocates to promote the creation of psychiatric or mental health advance directives to promote self-determination during periods of incapacitation because of mental disorder. All fifty states permit psychiatric advance directives, and fifteen have enacted specific statutes to promote them.

Psychiatric advance directives can also be applied as leverage in the form of "self-mandated" treatment.[13] However, the origin of these advanced directives is more clearly associated with the patient self-determination and empowerment movements than with treatment mandates. In fact, much of the enthusiasm for these legal tools is based on their ability to help the person avoid coerced treatment.

## Mandated Treatment and Health Care Quality

Recent health policy literature abounds with reports of efforts to define and measure health care quality. Yet the developing concepts and frameworks typically omit any consideration of coercion or therapeutic leverage. In fact, use of coercion–a core problem in mental health care and also in other health contexts, including infectious disease control and geriatric care–seems to be viewed as extrinsic to any health care quality assessment.

Mental health practitioners and policymakers uniformly assume that coercion and therapeutic pressure are sometimes needed to help people recover or avoid deterioration; presumably, some practices are likely to work better than others do–because they are more

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[11] S. Compton et al., "Effects of Involuntary Outpatient Commitment on Homelessness in Persons with Severe Mental Illness," *Mental Health Services Research* 5, no. 1 (2003): 27-38; V. Hiday et al., "Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness," *American Journal of Psychiatry* 159, no. 8 (2002): 1403-1411; M. Swartz et al., "A Randomized Controlled Trial of Outpatient Commitment in North Carolina," *Psychiatric Services* 52, no. 3 (2001): 325-329; H. Steadman et al., "Assessing the New York City Involuntary Outpatient Commitment Pilot Program," *Psychiatric Services* 52, no. 3 (2001): 330-336; M. Swartz, J. Swanson, and J. Monahan, "Endorsement of Personal Benefit of Outpatient Commitment among Persons with Severe Mental Illness," *Psychology, Public Policy, and Law*, no. 9 (2003): 70-93.

[12] New York State Office of Mental Health, "Statewide AOT Report as of June 1, 2003," www.omh.state.ny.us/omhweb/Kendra_web/kstatus_rpts/statewide.htm (21 July 2003).

[13] J. Swanson et al., "Psychiatric Advance Directives: An Alternative to Coercive Treatment?" *Psychiatry* 63, no. 2 (2000): 160-172; P. Backlar et al., "Consumer, Provider, and Informal Caregiver Opinions on Psychiatric Advance Directives," *Administration and Policy in Mental Health* 28, no. 6 (2001): 427-441.

effective or because they are more respectful of patients' values and wishes, or both. Where do these questions fit into a quality framework? In our view, mandated treatment should be brought, to the greatest extent possible, within standard paradigms of health care quality.

**IOM framework.** We illustrate these points by commenting on the IOM framework for assessing health care quality outlined in a recent series of reports.[14] The IOM framework has two major dimensions. One dimension concerns consumer's perspectives on health care needs. The most directly relevant consumer perspectives on health care are getting better (recovering from an illness) and living with illness and disability ("getting help with managing an ongoing, chronic condition or dealing with a disability that affects function"). In the mental health context, the first perspective might simply be termed "recovery," and the second, "support."

The other dimension of the IOM framework consists of four components of health care quality: patient-centeredness (health care that establishes a partnership among practitioners, patients, and their families), safety, effectiveness of care, and timeliness of care. Consumers are morally entitled to care that satisfies all of these components and, depending on the legal basis for their care, may be legally entitled to such care as well. Inadequate investment in mental health services by government bodies and restrictively "managed" private systems can prolong suffering and disability or even endanger the patient or others, by closing the door to timely and effective treatment. Even when services are adequately funded, however, quality of care could be compromised by inadequate respect for the patient. A key conclusion of the IOM report is that patient-centeredness is an independent, freestanding component of health care quality. That is, it is a crucial aspect of high-quality care in its own right, even if it affected no other aspect of health care.

**Patient-centeredness.** Patient-centeredness is the component of quality to which treatment mandates are most relevant. Yet, because the criteria for this component emphasize respect for patients' preferences and other indicators of patient autonomy, any use of coercion or leverage would seem to signify "poor" care on this component of quality. But surely such a characterization is misleading and incomplete. Under some circumstances, typically involving patients with impaired decision-making capacity, respect for the patient's express wishes is ethically and legally unthinkable. In such cases, overriding the patient's wishes could be regarded as "patient-centered" care in the most fundamental sense.

Two solutions to this puzzle are possible. Recognizing that trade-offs among the four quality components are sometimes necessary, one possibility is to say that effectiveness or timeliness of mandated interventions can sometime trump patient-centeredness. This formulation would be consistent with the standard ethical and legal accounts of mandatory treatment by highlighting the inevitable tension between beneficence and autonomy. However, we prefer a second possibility, which is to broaden the concept of patient-centeredness to include mandated care under certain circumstances. In our view, patient-centered care aims to promote patients' engagement in their own treatment to the maximum extent consistent with their abilities. Similarly, using incentives and disincentives to facilitate and promote adherence to treatment is patient-centered care to the extent that these interventions are experienced by patients as being clinically grounded in a caring therapeutic relationship.

We do not want to be understood as devaluing the core understanding of patient-centeredness as a component of quality assessment–in most situations, health care should be independently judged according to whether patients view it as having respected their wishes and having "empowered" them to

[14] Institute of Medicine, *Envisioning the National Health Care Quality Report* (Washington: National Academies Press, 2001).

become actively engaged as decisionmakers in their own care. However, not all patients with a mental disorder are capable of achieving such an autonomous role.

The "competence" of people with a mental disorder to make treatment decisions has been studied extensively in the context of involuntary treatment in hospitals. Results indicate that patients hospitalized with a mental disorder–particularly schizophrenia–more often show deficits in their decision-making competence than do patients hospitalized for a medical illness.[15] But competence has yet to be systematically addressed in the very different context of mandated treatment in the community. What does patient-centeredness imply when treatment decisions are made by a guardian or other surrogate decisionmaker for patients who are determined, under the law, to lack decisional competence? What is expected from health care providers for patients whose ability to make treatment decisions is impaired, even though they have not been found to be "incompetent" by a court? These complex questions need to be addressed, not only in relation to the meaning of patient-centeredness as a component of quality, but also in relation to the ethical and legal legitimacy of mandated community treatment.

Our view is that good clinical care requires a more assertive approach in situations of compromised autonomy. In these situations, the quality of the care should be independently judged according to whether it is experienced by patients as having been necessary, respectful, and motivated by beneficence.

**Safety.** One of the dominant legal concerns in mental health care relates to the nature and scope of the clinician's obligation to prevent the patient from harming someone else. In fact, concern about the risk of violence to third parties is at the heart of the debate about mandated treatment (in hospitals or in the community). Should measures of high-quality mental health care include items relating to violence risk assessment and risk management? As usually described, the "safety" component of quality relates to protecting the patient from iatrogenic injury–that is, reducing medical errors. But what if the clinician fails to take appropriate precautions to reduce the risk of harm to third parties? Would a health care organization that systematically fails to protect other people from dangerous patients be rated poorly on the safety component of a health care quality report card?

It is possible to characterize the risk of health care to third parties as being conceptually extrinsic to the "quality" of clinical care. Not every consequence of health care needs to be incorporated into a quality framework. The idea of quality could be sensibly limited to patients, including those exposed to infections (or violence) in hospitals, but not family members exposed to infections (or violence) by contagious (or dangerous) patients outside the hospital.

On the other hand, who would be willing to take this analysis to its logical extreme, saying, in effect, that failing to take well-established steps to prevent the spread of an infection is irrelevant to the quality of the health care system? There is no doubt that such incompetence would breach a duty owed to the population.

**Effectiveness.** How does patient adherence fit into judgments about the effectiveness of care? Medications or other interventions that have proven efficacious in clinical trials will not be effective in practice if patient compliance is poor. Accordingly, in any thorough assessment of health care quality, one indicator of ineffectiveness of care will be poor compliance rates, and improved compliance rates would presumably provide a useful measure of increased effectiveness. As a result, a question of great interest is how improved compliance can be achieved. It is unfortunate that instruments of therapeutic

[15] T. Grisso and P. Appelbaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (New York: Oxford University Press, 1998).

leverage, including incentives and disincentives as well as mandates, are not often mentioned in studies of interventions that aim to facilitate treatment adherence. Rectifying this omission is especially important in the context of mental health care.

**Timeliness.** Under the IOM formulation, the definition of "timeliness" of care assumes that patients are seeking care; the measures of quality relate to whether care is available and provided to the patient when needed. As noted earlier, it is hard to know how to deal with recalcitrant patients within this framework. A mental health services system that routinely deploys outreach services to identify patients who are not seeking care and that hospitalizes many patients involuntarily under broad commitment criteria might rank high on "timeliness" but low on patient-centeredness because it is unnecessarily authoritarian. However, it is also possible that such a system could rank more highly on patient-centeredness if the clinically aggressive (and timely) interventions are experienced by patients as being carried out in a respectful and caring manner.

## Conclusion

Commitment to treatment in the community in the early twenty-first century bears little resemblance to commitment to treatment in a closed institution in the middle and late twentieth century. It can only be understood in the context of a broad movement to apply whatever leverage is available to induce patients' engagement with mental health treatment in the community, a movement that includes the use of the social welfare system, the judicial system, and psychiatric advance directives. Little hard information exists on the pervasiveness of the various forms of mandated treatment for people with mental disorders, how leverage is imposed, or what the measurable outcomes of using leverage actually are. The many vexing legal and ethical questions surrounding mandated treatment have not yet been thoroughly aired. The need for further thought is illustrated by the difficulty of incorporating mandated treatment into the IOM health care quality framework. If policymakers and practitioners in mental health care are to embrace–or to repudiate–some or all forms of mandated community treatment, an evidence-based approach must soon replace polemics.

# The Virginia Human Rights System: Foundation for Respect[1]

The most basic right of all is the right to be heard because it expresses respect for the person and treats him or her with dignity.

By Richard J. Bonnie[2]

### Introduction

I have toiled in many vineyards over the years, but I can assure you that I have done nothing more gratifying, or more important, than serve in Virginia's human rights system.

I am proud to have played a part in the creation of this system, and I am genuinely impressed that the foundation we laid 25 years ago now supports such a large program. When we began to hold these training conferences, we were a cozy group: we had 13 advocates and 13 Local Human Rights Committees (LHRCs), one for each residential facility. Now I understand that we have 25 advocates and 65 LHRCs with more than 450 members.

There have been many important changes, all for the better, as the program has grown and matured. I will note three:

- The Virginia facility-based human rights system was expanded to include community programs while I was chairing the state committee, but the LHRCs for the community programs were separate, as were the regulations governing them, although the State Human Rights Committee (SHRC) had ultimate responsibility for both systems. Now the regulations are integrated, and many LHRCs and advocates have combined jurisdiction over facility and community programs.

- At the beginning, the system did not have any jurisdiction over the private sector. Now it does, with compliance being tied to the licensing system. This change signifies the important point that consistent respect for human rights is a useful measure of the quality of the care provided.

- The first steps have been taken to bring assisted living facilities within the jurisdiction of the system.

I am impressed. I presume that the expansion of the human rights system reflects the confidence of the executive and legislative branches in your capacity to carry out your important mission successfully in all these venues. But I have to say that I am also quite daunted by the broad and diverse responsibilities you now bear. Do you all have the commitment and energy to carry out these responsibilities?

The human rights system serves an absolutely critical role in the delivery of mental health, mental retardation, and substance abuse services. But the system is not self-executing. And it is not meant to play a passive role. The human rights system was designed to serve three core functions: to declare and proclaim basic norms of human rights, infusing them into all aspects of clinical practice and service delivery; to monitor compliance with these legal norms on an ongoing basis; and to resolve individual grievances. In short, the system is meant to be proactive in carrying out its important mission. It is an instrument of education, oversight, and enforcement. Most importantly, it provides a channel for expressing the voice of the community. This is why I have always regarded the LHRCs as the backbone of the system.

As you can see, I am a genuine believer in the virtues of the kind of internal system we have

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[1] This article was adapted from Professor Bonnie's Keynote Address at the Virginia Human Rights Conference on March 31, 2004.

[2] John S. Battle Professor of Law, University of Virginia School of Law; Director, Institute of Law, Psychiatry and Public Policy, University of Virginia.

created in Virginia. In fact, I have tried to replicate the Virginia model all over the world. If it works well, and in particular, if the LHRCs play an active role, it is far superior to a purely external system. An external agency such as the Virginia Office for Protection and Advocacy (formerly DRVD) plays an important complementary role, and meaningful access to the courts is also an essential component of a comprehensive rights-protection system. But I have always believed that a well-functioning internal system provides the best mechanism for achieving the goals I mentioned earlier–education, oversight, and enforcement.

As I was thinking about the best way to inspire you, it occurred to me that I should wind the clock back to the 1970s when the system was created, reflecting on the revolutionary innovations in mental health law that brought it about, and commenting on changes in the services system that have occurred over the past 30 years. Then I remembered that I delivered a speech along these lines in Bratislava, Slovakia, in September of 1993.

After the disintegration of the Soviet Union in 1992 and the collapse of communist regimes in Central and Eastern Europe, I became a board member of a foundation whose mission is to support mental health reforms in the formerly communist world. Our first task was to identify reform-minded psychiatrists to help spearhead the necessary changes, and we then held the first meeting of the Network of Reformers in Psychiatry in Bratislava. In later years, we nurtured the creation of consumer groups and family organizations and other non-governmental organizations (NGOs), and the Network of Reformers now has well over 500 members.

The focus of my speech to the Network of Reformers in Bratislava was mental health care. The audience was composed entirely of psychiatrists; even today, there are few clinical psychologists and social workers in these countries. The mental health and mental retardation services in all these countries were institution-based, and even today, community-based services are scarce. The audience was anxious to move forward, but needed a blueprint for change. I wanted to tell them to be hopeful because we had traveled a similar path only 25 years earlier.

### Speech Given to the Post-Soviet Reformers in 1993

"It wasn't so long ago that psychiatry in the United States was facing many of the same problems that you are confronting today:

- State governments did not spend very much money for psychiatric care and, as a result, many patients were confined indefinitely in inhumane conditions in large public hospitals.

- Psychiatric decision-making was almost entirely discretionary. Doctors decided when patients should be committed to hospitals and when patients should be discharged. The law in many states required a court's approval before a patient could be hospitalized against his will, but in fact, judges did not play a meaningful role in this process. Once in the hospital, patients had no legally enforceable rights. They had no meaningful access to the courts because judges refused to interfere with the administration of psychiatric hospitals.

- Clinical practice and the law each reflected a highly paternalistic and authoritarian attitude toward persons with mental illness. Patients were not expected to make any decisions about their treatment.

"Due to the dedication of reformers like yourselves–reformers in the psychiatric profession, in the legal profession, in the legislatures, and in the courts–the situation has changed dramatically in the United States. But change did not happen overnight; reform of mental health care took many years. Unfortunately, because of the legacy of totalitarian rule, your challenge is much

greater and more daunting than the one we faced. However, I believe that our experience will provide you with useful examples as you face this challenge.

"Many factors contributed to the improvement of mental health care in the United States. They include better science, better clinical training, larger budgets, a shift of mental health services from large hospitals to the communities where patients live, and the interest and involvement of consumers (i.e., patients and their families). Another important factor–I would say an indispensable one–was a revolution in mental health law. New legal norms were enunciated by courts and legislatures. A whole new field of specialization emerged in law and in the mental health professions. And new organizational structures were developed to implement the new legal norms. Thus, this revolution in mental health law had three main elements:

- Changes in legal norms;
- Training of specialists in law and mental health in both professions; and
- Creation of new organizational structures to implement and monitor the changes.

"I want to speak briefly about each of these components of the revolution in mental health law.

**Changes in Legal Norms.** "In the United States, new principles and procedures of mental health law were developed in the 1970s through constitutional litigation and legislative action. Although lawyers and psychiatrists continue to disagree about some matters of detail and emphasis, there is now a strong consensus regarding the most fundamental ideas.

"As I see it, most of the rules and principles of modern mental health law derive from two fundamental concepts of human rights.

"First, every person, including a person thought to have a mental disability, is entitled to be treated with dignity and respect as an individual. Obviously, this cannot mean that every person should have the absolute freedom to do whatever he chooses or to decide whether and how he should receive treatment. But the starting point–the presumption in law–should be on the side of freedom, not on the side of coercion. If the patient will be treated involuntarily, or placed in a seclusion room, or placed in a locked ward, the need for doing any of these things should not be assumed; clinical necessity should be proven. And the law should also presume that every person is competent to make his or her own decisions and is able to participate fully in the life of the community–unless a relevant functional disability is clearly proven in the particular case.

"Second, psychiatric decision-making that restricts a person's freedom must be subject to meaningful legal control.[3] Psychiatric discretion must be disciplined by the rule of law. This is not to say that clinical decisions should be made by judges. Doctors must be permitted to make most clinical decisions without outside interference. But whenever treatment is involuntary, or whenever the patient's freedom is restricted in the interest of society, the psychiatrist is exercising the power and authority of the society and must do so within limits set by the law. Decisions about liberty and involuntary treatment are too important to be left to psychiatrists.

**Specialized Professional Training in Mental Health Law.** "New legal pronouncements mean nothing if they are not understood by people who are expected to comply with them. In this case, psychiatrists must not only be informed about new laws, they must also understand the values and aspirations that lie beneath the new laws. At the same time, successful implementation of the new laws

[3] It is important to understand that, until 1992, the Soviet Union had *no* mental health law at all, and that involuntary hospitalization was governed by secret instructions issued by the Health Ministry.

also requires judges and lawyers to understand psychiatric practice. Training of both professions is essential.

"In training psychiatrists, it is critically important to emphasize, again and again, that respect for human rights is good clinical practice. Legal reform goes hand-in-hand with general improvements in clinical training.

"We hear much in the West about excessive legal regulation–about lawyers against psychiatrists. But do not be misled. Overall, legal reforms and improvements in quality of care mark the same path. The story is law and psychiatry, together, in the struggle to improve and humanize psychiatric care. Let me give an example.

"One of the most difficult problems that we faced in our state mental hospitals 25 years ago–and that you face today–is the paternalistic tendency to make decisions about the patient's treatment without consulting the patient. Usually the patient's objections were completely ignored. But this is not good clinical practice and it is incompatible with a fundamental norm of human rights.

"But what exactly is the important human right? Is it the right to refuse treatment unless certain criteria are satisfied? Is it the right to be treated only if one has given "informed consent"? These ways of describing the legal principle are accurate as far as they go. But, in my opinion, they do not go far enough. They miss the most important idea. The focus should be on the dialogue that should occur *before* a decision is made. In our regulations in Virginia, we refer to a 'patient's right to participate meaningfully in the preparation and implementation' of treatment and discharge plans and 'to express his or her preferences' and have them followed to the maximum extent consistent with his needs and available resources. The law does not tell the psychiatrist to 'always do whatever the patient says.' Instead, the law tells the service provider to 'listen to the patient [client].' I ask you: What right is more fundamental than the right to be heard?

**Establishing New Methods of Independent Review.** "The third important element of successful legal reform is to create new decision-making structures for implementing and enforcing the law.

"The principle of independent review is an indispensable feature of successful human rights reform. The patient whose rights are restricted must have an opportunity to have these restrictions reviewed by an impartial decision-maker, someone independent of the hospital staff. But the principle of independent review can be achieved in many different ways. It does not have to be provided by a court, as long as a dissatisfied patient can eventually appeal the restriction to a court.

"A general absence of independent judicial institutions designed to protect the rights of people with mental disabilities, and an inadequate number of lawyers to represent people who want to object to hospitalization or to other clinical decisions pose difficult problems in your countries, but implementation of the new laws to protect the rights of the patient cannot succeed without a mechanism of enforcement. The task is demanding, but it is not impossible. The solution is to develop your system one step at a time. The first step is to begin to train some specialized judges to review cases of involuntary hospitalization. The second is to develop non-judicial bodies for protecting patients' rights within the hospitals.

"If it were possible to accomplish only one change, the establishment of a human rights program is the first thing I would do. Why do I say this? Because improvement of the quality of care in hospitals is the highest priority of mental health reform, and because a human rights program helps to improve the quality of care. A human rights program does this in two ways. First, it helps to change the attitudes of the hospital staff–even if no more money is available for better equipment or more drugs, it is possible to create a more

humane environment. Second, by bringing advocates and citizen volunteers into the hospital–by opening the windows and doors to the world outside–it is possible to create a constituency for change.

"So, how does one establish a human rights program in psychiatric hospitals? Won't this be expensive? Won't it disrupt the orderly management of the hospital? I hope to persuade you that an effective human rights system can be created without major expense and without disrupting the therapeutic milieu that we are all trying to establish. Let me describe the system we created in Virginia. It has two main features:

- An independent patient advocacy service. The advocates should be responsible to someone outside the facility, either a court, or a prosecutor, or a separate human rights office within the Health Ministry. The advocates should have two primary responsibilities: (1) to represent patients who claim that their rights have been violated so that they have an opportunity to be heard and (2) to monitor conditions within the hospitals to promote compliance with the law.

- A system of human rights commissions to hear and resolve patients' complaints and to provide external oversight of the hospital's compliance with the law. Who should serve on these commissions? Citizens from the community who volunteer to do so. If ordinary citizens, drawn from all professions and all walks of life, are trained to do this, they can do a remarkable job. The use of citizen volunteers on a human rights commission will also have the additional benefit of arousing the interest and good will of the community. When citizens become your allies in the cause of reform, the prospect for success will be much enhanced.

"You have a difficult path to follow, and no one thinks that passing a new law can guarantee your success. But a modern mental health law *can* provide a solid foundation for your efforts by teaching progressive ideas and by broadening the community's support for your cause. The expression of important legal principles and human rights can help to change the authoritarian attitudes that have caused so much pain in the past. And the steps taken to enforce these rights can inspire judges and citizens to become allies in the cause of reform."

**Today's Challenges**

As you can see, I was relying on the reforms that were occurring in Virginia, particularly our internal human rights system, to inspire the new leaders of mental health services in the formerly communist world to create a new foundation for an ethical and humane system of services.

Now I want to use these remarks to inspire you to carry out your mission with enthusiasm and commitment. Together, you bear a profound responsibility.

As I mentioned earlier, much has changed in Virginia since our system was established, and since I delivered these remarks in Bratislava. I cannot speak from personal experience to guide you as you carry out your new responsibilities in a much expanded human rights system, and as you interpret and apply an elaborate new book of regulations that was a decade in the making.

However, even from afar, I do have two concerns. So, I will bring my remarks to a conclusion by offering two pieces of advice.

First, you must be careful to preserve your independence. Your independence is the key to your credibility. It may surprise you to learn that under the first set of regulations, promulgated in 1978, the LHRCs were appointed by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services based on recommendations by the facility directors. Also, a member of the facility staff

sat on the LHRC. In short, the LHRC was effectively under the control of the facility director. In addition, the facility advocates were employees of the facility, hired by the directors. An internal system has many advantages, but being controlled by the facility directors is not one of them. In the second generation regulations, promulgated in 1983, we changed the structure to the one you have today. We tried to make the human rights committees as independent as possible within an internal system–the LHRCs are appointed by the SHRC and the SHRC itself is appointed by the State Mental Health, Mental Retardation, and Substance Abuse Services Board (not the Commissioner). In addition, we disengaged the advocates from the program level, and put them under the authority of the Office of Human Rights directed by an official who reports directly to the Commissioner.

The danger that I see today is that the LHRCs' expanded duties will make them too dependent on the information and advice provided by the facilities and programs that they are overseeing. Instead of a strong, self-confident, genuinely independent role, the LHRCs could begin to function like a bureaucratic appendage of the services system. Even though the LHRCs are formally independent, they may not act like it. The bottom line is that independence is a state of mind.

A related problem is that the LHRCs' dependency on the facilities and programs effectively transfers authority to the advocates to control the LHRCs' agenda. In saying this, I do not mean to criticize the advocates who play a critical role in the whole system, but it is important for the LHRCs to maintain ultimate control of their own agendas in order to preserve their independence.

The situation may be even more challenging for LHRCs that are overseeing private facilities who are naturally more skeptical about the value of the LHRC and jealous of their own autonomy. I have even heard that, in some cases, the facility lawyers are not only observing the LHRC meetings but actually functioning as legal advisers to them. This practice should stop.

Let me emphasize that independence does not mean being adversarial or aggressive. The LHRCs can and must preserve their legitimate prerogatives without becoming antagonistic. Ultimately, the system depends on good will and mutual trust. This also means that the members of the LHRCs must try to work toward consensus within the framework of the regulations, even on issues that divide them deeply, such as coerced treatment.

My second piece of advice relates to the role of the LHRC. As I mentioned, the LHRC is meant to have a proactive role, not limited to reviewing documents and hearing complaints that are brought before it. It also has an important monitoring responsibility, reflected most explicitly in the provision of the regulations (12 VAC 35-115-250 D. 4) that empowers the LHRC, on its own initiative to "review any existing or proposed policies, procedures or practices that could jeopardize the [clients'] rights."

I am worried that the sheer burden of reviewing all the specific actions that the regulations require to be brought before the LHRC–checking approval boxes, as it were–could lead to routinization and bureaucratization that would sap the LHRCs' vitality. I urge all of you not to let this happen. If the members of the LHRCs do not carry out their mission with moral energy, if they fail to provide meaningful oversight, and if they do not express the voice of the community, the system will fall far short of the vision I presented in Bratislava.

**Respect**

I want to close with a broad stroke. Modern mental health law and ethics reflects ongoing tension between the ethics of caring and the ethics of autonomy, between responding to a person's needs and respecting their rights. This tension is reflected in the delicate

balance that is struck throughout the human rights regulations. However, both of these values rest on a common foundation–the respect for human dignity.

Let me illustrate the point with a finding from coercion studies conducted by the MacArthur Foundation Research Network on Mental Health and the Law. We were studying people who had been recently admitted to a psychiatric hospital. It is well-known that most committed patients as well as many "voluntary" patients feel coerced–one might say disrespected–and antagonistic to family members and service providers. It is less well-known that many patients, including some committed ones, do not feel that they were coerced into treatment, and that they are thankful afterwards for the intervention. We wanted to understand what made people feel one way or the other.

What we found was that even when their hospitalizations are involuntary, patients do not perceive themselves to have been coerced if they believe that the doctor or family member who overrode their wishes cares for them and, most importantly, if they feel that someone listened to them before they were hospitalized. As I said earlier, the most basic right of all is the right to be heard because it expresses respect for the person and treats him or her with dignity. That right belongs to everyone, regardless of symptoms, impairments, or legal status.

We have thousands of words in the regulations that establish our human rights system, but all of us–service providers and participants in the human rights system–need to remember only one. That word is respect.

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# S. 1194: Mentally Ill Offender Treatment and Crime Reduction Act of 2003[1]

93% of all counties are without any program to keep non-violent defendants with a mental illness from crowding their jails and committing more crime

By John Monahan[2]

I have been involved in Federally-funded research on mentally ill offenders since the publication of my first book, *Community Mental Health and the Criminal Justice System*, in 1976. I currently direct the Research Network on Mandated Community Treatment for the John D. and Catherine T. MacArthur Foundation, which is concerned with how the criminal justice system can be used as "leverage" to get offenders with a mental disorder to accept treatment for their illness.[3] The Network is now engaged in a productive partnership with the National Institute of Justice to evaluate seven of the mental health courts funded by Congress as part of the 2000 America's Law Enforcement and Mental Health Project Act.[4]

I will begin with the bottom line: the Mentally Ill Offender Treatment and Crime Reduction Act of 2003 (Act) is the most evidence-based piece of federal legislation on mentally ill offenders that I have seen in 30 years as a researcher in this field. I say this for five reasons.

**First, the evidence is that the number of people this Act will affect is staggering.**

In its initial finding, the Act notes that the Bureau of Justice Statistics, using a broad definition of mental illness, concludes that over 16% of adults in contact with the justice system are mentally ill. This means that on any given day in the United States, there would be over 200,000 prison inmates, 100,000 jail detainees, and 700,000 people under the supervision of community corrections—over one million people in all—with a serious mental illness. Three-quarters of these mentally ill people also have a co-occurring substance abuse disorder.[5] Women in the justice system have nearly twice the rate of mental illness as men.[6] But only one-third of the men and one-quarter of the women with a mental illness in jail report receiving any treatment while they were detained.[7]

Another piece of evidence about the magnitude of the problem that the Act addresses is the large number of communities that have taken it upon themselves to do something about people with mental illness in the justice system. The number of mental health courts in the United States has mushroomed from one in 1997, to a dozen in 2002, to close to 100 by June of 2004.[8] By the most recent count, there are almost 300 jail diversion programs now operating in the

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[1] This article contains the testimony of Professor Monahan given on June 22, 2004, to the Subcommittee on Crime, Terrorism, and Homeland Security, Committee on the Judiciary, U.S. House of Representatives.

[2] Henry and Grace Doherty Professor of Law, University of Virginia; Director, MacArthur Research Network on Mandated Community Treatment.

[3] A list of Network publications can be found at http://macarthur.virginia.edu.

[4] A. Redlich, H. Steadman, J. Monahan, J. Petrila, & P. Griffin, "The Second Generation of Mental Health Courts," *Psychology, Public Policy, and Law* (forthcoming).

[5] K. Abram & L. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46 (1991): 1036-1045.

[6] National GAINS Center, *The Prevalence of Co-Occurring Mental Illness and Substance Abuse Disorders in the Justice System* (Delmar, NY: GAINS Center, 2002).

[7] J. Massaro, *Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know* (2nd ed.) (Delmar, NY: TAPA Center for Jail Diversion, 2004).

[8] "Survey of Mental Health Courts" (2004), *available at* http://www.mentalhealthcourtsurvey.com.

United States.[9] This means that 7% of all counties have a police or court-based program to divert defendants with a mental illness from jail.[10] This also means that 93% of all counties are without any program to keep non-violent defendants with a mental illness from crowding their jails and committing more crime.

**Second, the evidence is that we can make a difference: offenders with a mental illness can in fact be dealt with in ways that reduce crime, save taxpayers' money, or both.**

In terms of crime reduction, consider the MacArthur Violence Risk Assessment Study of over 1,000 people who had been hospitalized for mental illness, about half of whom had a prior contact with the criminal justice system.[11] Of the people who received no medication or therapy in the community after they got out of the hospital, 14% soon committed a violent act. Of the people who received an inadequate amount of treatment—about one treatment session a month—the violence rate was reduced from 14% to about 9%. But of the people who received the amount of treatment that they needed—about one session a week—the violence rate went from 14% to less than 3%. Amazingly enough, the people with a mental illness who were receiving adequate treatment were actually less violent than their neighbors in the community who were not mentally ill.

In terms of saving taxpayers' money, consider the pioneering Broward County (Ft. Lauderdale), Florida, Mental Health Court, whose rigorous evaluation is also being supported by the MacArthur Foundation. This court presents mentally ill misdemeanor defendants with the choice of accepting mental health treatment in the community, or having their cases processed in the business-as-usual way, which may well mean jail time. Perhaps not surprisingly, 95% of the defendants given this option choose treatment. Compared to a nearby county without a mental health court, the Broward defendants are twice as likely to actually receive services for their mental illness[12] and are no more likely to commit a new crime, despite the fact that the number of days they spend in jail for the current offense is reduced by 75%, at enormous savings to the public.[13] While the NIJ/MacArthur-funded evaluation of mental health courts receiving federal grants is still in progress, the Broward study demonstrates that courts have a central role to play in responding to people with mental illness in the justice system.

**Third, the evidence is that one size does not fit all in terms of effectively dealing with mentally ill offenders.**

"First and foremost," leading researchers have concluded, "it must be clear that there is no one best way to organize a program [of diverting mentally ill offenders from jail]. An approach that works in one community may not be practical somewhere else."[14]

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[9] TAPA Center for Jail Diversion, "What Can We Say About the Effectiveness of Jail Diversion Programs for Persons with Co-Occurring Disorders?" (2004), *available at* http://www.gainsctr.com/pdfs/tapa/WhatCanWeSay.pdf.

[10] H. Steadman, "A National Perspective on Diversion and Linkage to Community-Based Services" (2004), *available at* http://www. gainsctr.com/ppt/NationalPerspectiveonDiversionanLinkage.ppt.

[11] J. Monahan, H. Steadman, E. Silver, P. Appelbaum, P. Robbins, E. Mulvey, L. Roth, T. Grisso, & S. Banks, *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (New York: Oxford University Press, 2001).

[12] R. Boothroyd, N. Poythress, A. McGaha, & J. Petrila, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization," *International Journal of Law and Psychiatry* 26 (2003): 55-71.

[13] A. Cristy, N. Poythress, R. Boothroyd, J. Petrila, & S. Mehra, "Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court" (submitted for publication).

[14] S. Morris & H.J. Steadman, "Keys to Successfully Diverting Mentally Ill Jail Detainees," *American Jails* (July/August 1994): 47-49.

The Act is remarkably adaptable to local conditions in the programmatic approach it takes to mentally ill offenders. Funded programs may include pre-trial diversion in one jurisdiction, a mental health court in another, a re-entry program from jail or prison in a third, or some combination of these options in a fourth.

What Justice Brandeis wrote in 1932 and the Supreme Court has quoted on three dozen subsequent occasions is true today. "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel . . . experiments without risk to the rest of the country." This Act is one of those happy incidents.

**Fourth, the evidence is that collaboration is essential to get anything accomplished having to do with mentally ill offenders.**

Neither mental health nor criminal justice can do the job alone. This Act provides incentives for cooperation between the Department of Justice and the Department of Health and Human Services, and among agencies at the federal, state, and local levels. Crime and mental illness deeply affect all of our communities, and perhaps for this reason the turf battles and the narrow single-issue concerns that doom many reform efforts seem to have been carefully avoided in drafting this Act.

As the Council of State Governments' *Criminal Justice/Mental Health Consensus Project* concluded after five years of intensive study:[15]

> The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system.

**Finally, the evidence is that we need more evidence.**

We know a lot about how to deal effectively with mentally ill offenders—vastly more than we knew even five years ago. But by no means do we know all we need to state with confidence what the "best practices" are for dealing with different kinds of adult and juvenile mentally ill offenders in different kinds of American communities. By imposing strict requirements for objective assessments of the measurable outcomes of the programs that are implemented with its funds, the Act will generate a self-correcting body of knowledge that uses findings about the effectiveness of past practice to shape improvements in future practice. In mandating empirical evidence of program performance, the Act avoids simply throwing money at a problem. Instead, it assigns accountability and it demands results.

The Act was born of the frustration of criminal justice officials in seeing ever more people with mental illness further crowd their already over-crowded jails, rarely receive the mental health treatment that they so plainly need, and continue to appear before them for the commission of yet another crime. The Act before you can set state and local governments on a course to put a stop to this revolving door.

The time is right. I urge you to pass the Mentally Ill Offender Treatment and Crime Reduction Act of 2003.

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[15] Council of State Governments, "Criminal Justice/Mental Health Consensus Project" (2002), *available at* www.consensusproject.org.

# Postpartum Psychosis and Women Who Kill Their Children: Making the Punishment Fit the Crime

Legislation that makes possible a reduction in the sentencing of these women while still holding them accountable for their crimes provides for a just means of responding to the mental disorders they experienced due to the physiological effects of childbirth that were beyond their personal control.

By Kristine Esme Nelson*

## Introduction

Postpartum psychosis, the most severe form of postpartum depression, is sometimes identified as a possible foundation for an insanity defense raised in response to a mother's killing of her child. In the United States, however, there is an inadequate fit between the insanity test, particularly as used in a majority of the states, and postpartum psychosis. A standard should instead be developed that reflects the doctrine of diminished capacity and the 1938 Infanticide Act enacted by the English Parliament. This proposed standard allows a woman, upon a finding that she was suffering from a postpartum psychosis at the time of the crime, to be sentenced as if the crime of manslaughter had been committed. This approach provides an appropriate response to the crimes of such women, yet serves the needs of justice.

## Overview of Postpartum Depressive Disorders

The period following the birth of a child should be filled with immense joy and a sense of fulfillment for the mother. Some women, however, who have given birth may experience a range of unpleasant and, at times, crippling symptoms caused by the hormonal upheaval that occurs as a result of childbirth. The presence of postpartum mood disorders in childbearing women is well-documented. Hippocrates, in the fourth century B.C., is often credited with the first identification of the link between childbirth and a woman's mental state.[1] Current views and formulations regarding psychiatric mood disorders in the context of pregnancy and the postnatal period can be traced to *Traite de la Folie des Femmes Enceintes,* a book published in 1865 by the French physician Victor Louis Marce.[2] He documents ninety-two cases of postpartum psychosis, a debilitating disorder encompassed within the broad category of postpartum depression.[3]

Although postpartum depression has been recognized in academic circles and studied for over two centuries, it is primarily in the last decade that its documentation has radically increased.[4] Postpartum depression is a general term that refers to a collection of psychiatric disorders that manifest themselves in women after childbirth.[5] It is widely conceptualized as a spectrum comprised of

* McDermott Will & Emery, Washington, D.C.; J.D., University of Virginia School of Law. The author thanks the reviewers of this article for their helpful comments.

[1] Jessie Manchester, Comment, *Beyond Accommodation: Reconstructing the Insanity Defense to Provide an Adequate Remedy for Postpartum Psychotic Women,* 93 J. CRIM. L. & CRIMINOLOGY 713, 719 (2003) (Hippocrates observed and reported "a severe case of insomnia and restlessness that began on the sixth day in a woman who bore twins."). It is now believed, however, that Hippocrates actually observed a type of delirium that often accompanied a condition known as puerperal sepsis, which was quite common in Greece at the time. 1 KAPLAN AND SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1276 (Benjamin J. Sadock & Virginia A. Sadock eds., 7th ed. 2000) [hereinafter 1 KAPLAN & SADOCK].

[2] 1 KAPLAN & SADOCK, *supra* note 1, at 1276.

[3] *Id.*

[4] *Id.*

[5] THE POSTPARTUM RESOURCE CENTER OF NEW YORK, *Learning About Postpartum Depression* (2004), *at* http://www.postpartumny.org/whatisPPD.htm [hereinafter POSTPARTUM RESOURCE CENTER].

three distinct categories: postpartum blues, postpartum depression, and postpartum psychosis.[6] Each category is characterized by a unique set of symptoms that governs the severity of the woman's depressive state, and therefore the potential for long-term or harmful effects.[7]

**Postpartum Blues.** Postpartum blues, also referred to as the "baby blues," identifies the most common postpartum depressive disorder. Experienced by 30% to 85% of mothers,[8] cases of postpartum blues are so common that medical professionals have come to consider postpartum blues a normal facet of motherhood.[9] Postpartum blues are generally regarded as "relatively benign" because the mother experiences only mildly depressive symptoms over a short period of time after the birth of the child.[10] The symptoms typically appear within the first week after the birth of the child and usually retreat by the tenth postpartum day.[11] Symptoms include mood swings, anxiety, irritability, tearfulness, and insomnia.[12] A woman suffering from postpartum blues may also experience changes in appetite, feelings of vulnerability, and feelings of insecurity.[13]

**Postpartum Depression.** The second category of postpartum depressive disorders is known as postpartum depression, which is a more serious and incapacitating psychiatric condition than postpartum blues.[14] Approximately 10% to 15% of mothers experience postpartum depression.[15] Although some women have reported the onset of postpartum depression symptoms directly after the birth of the child, these women are in the minority.[16] Unlike the symptoms of postpartum blues, which usually become apparent nearly immediately after the birth of the child and are transient, the symptoms associated with postpartum depression typically develop gradually between a few weeks after delivery and one year postpartum.[17] Postpartum depression is a considerably less fleeting condition compared to postpartum blues. The symptoms of postpartum depression are generally indistinguishable from the symptoms associated with a nonpsychotic major depressive disorder experienced by nonpostpartum women.[18]

Women suffering from postpartum depression develop many of the same symptoms reported by women suffering from postpartum blues, such as irritability, insomnia, and anxiety.[19] However, women diagnosed with postpartum depression tend to suffer from more intense forms of these symptoms.[20] Additionally, women diagnosed with postpartum depression may experience any of the following symptoms: appetite disturbances, a depressed mood, fatigue, feelings of hopelessness, inability to concentrate, and

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[6] THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF CLINICAL PSYCHIATRY 1519 (Robert E. Hales & Stuart C. Yudofsky eds., 4th ed. 2003).

[7] *See* Connie Huang, Note, *It's a Hormonal Thing: Premenstrual Syndrome and Postpartum Psychosis as Criminal Defenses,* 11 S. CAL. REV. L. & WOMEN'S STUD. 345, 354 (2002).

[8] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.

[9] Sandy Meng Shan Liu, Comment, *Postpartum Psychosis: A Legitimate Defense for Negating Criminal Responsibility?* 4 SCHOLAR 339, 354 (2002).

[10] Huang, *supra* note 7, at 354.

[11] INFANTICIDE: PSYCHOSOCIAL AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL 41 (Margaret G. Spinelli ed., 2003) [hereinafter SPINELLI] (stating that symptoms associated with "baby blues" "peak on day 4-5 postpartum"); 1 KAPLAN & SADOCK, *supra* note 1, at 1278.

[12] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.

[13] Lawrence Kruckman, *An Introduction to Postpartum Illness,* POSTPARTUM SUPPORT INTERNATIONAL (2003), *at* http://www.postpartum.net/postrial2.htm.

[14] Helen W. Jones, *Identification and Classification of Postpartum Psychiatric Disorders,* J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES, Dec. 2001, at 25.

[15] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.

[16] *Id.*

[17] POSTPARTUM RESOURCE CENTER, *supra* note 5.

[18] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.

[19] Huang, *supra* note 7, at 355.

[20] Colleen Kelly, Comment, *The Legacy of Too Little Too Late: The Inconsistent Treatment of Postpartum Psychosis as a Defense to Infanticide,* 19 J. CONTEMP. HEALTH L. & POL'Y 247, 251 (2002).

feelings of inadequacy and guilt concerning the ability to assume a caregiver role with respect to the newborn.[21] A mother suffering from postpartum depression may also have suicidal ideation; however, the suicide rate for women experiencing postpartum depression is low.[22]

**Postpartum Psychosis.** Postpartum psychosis is the most severe postpartum depressive disorder.[23] It is extremely rare, however; it emerges in only one to two births out of a thousand.[24] The onset of postpartum psychosis may be acute and occur as early as forty-eight to seventy-two hours after delivery.[25] The majority of women with postpartum psychosis, however, will exhibit symptoms two to four weeks after giving birth to the child.[26]

The condition has been described as a psychiatric disorder that causes a woman to have "a frenzied mind" and to lose contact with reality for extended periods of time.[27] Early indicators of postpartum psychosis are restlessness, irritability, and insomnia.[28] Other symptoms that emerge include disorientation or depersonalization, irregular mood swings, and disorganized behavior.[29]

A woman experiencing postpartum psychosis will frequently have delusions that focus on the newborn child.[30] For example, the mother may have delusions about the newborn being "dead or defective."[31] She may have delusions about the child having unique powers and believe the child is either God or Satan.[32] In other instances, she may outright deny having given birth to a child at all.[33] Auditory hallucinations are common in cases of postpartum psychosis; a woman will often hear voices commanding her to inflict harm on herself or the infant.[34]

A comparison of postpartum psychosis to psychoses unrelated to child-bearing has found that women with a postpartum psychosis display more psychiatric impairment in the form of thought disorganization, bizarre behavior, lack of insight, delusions of reference, persecution, jealousy, grandiosity, suspiciousness, impaired orientation, and self-neglect.[35] Furthermore, postpartum psychosis is generally linked with greater degrees of confusion and delirium.[36]

Due to the significant risk that the severe break with reality poses to the health and safety of the mother and the newborn child, postpartum psychosis is considered a medical emergency that requires prompt intervention.[37] Given the consequences that may transpire, particularly if a mother takes the life of one of her children, it is not surprising that this disorder has resulted in a contentious intersection between psychiatric knowledge and the legal system.

### Postpartum Psychosis and the Insanity Defense

A mother suffering from postpartum psychosis, who takes the life of her child during the postpartum period, may attempt to utilize the insanity defense to negate criminal

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[21] *See* Stuart Scott et al., *Postpartum Anxiety and Depression: Onset and Comorbidity in a Community Sample,* 186(7) J. NERVOUS & MENTAL DISEASE 420, 421 (1998).
[22] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[23] Kruckman, *supra* note 13.
[24] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[25] *Id.*
[26] *Id.*
[27] KATHARINA DALTON & WENDY M. HOLTON, DEPRESSION AFTER CHILDBIRTH: HOW TO RECOGNIZE, TREAT, AND PREVENT POSTNATAL DEPRESSION 85 (2001); POSTPARTUM RESOURCE CENTER, *supra* note 5.
[28] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[29] *Id.*
[30] *Id.*
[31] Jones, *supra* note 14, at 28.
[32] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[33] Jones, *supra* note 14, at 28.
[34] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[35] SPINELLI, *supra* note 11, at 41.
[36] 1 KAPLAN & SADOCK, *supra* note 1, at 1278.
[37] Jones, *supra* note 14, at 28.

responsibility.[38] The insanity defense rests on the premise that criminal offenders' culpability is directly related to their state of mind at the time the crime was committed.[39] Traditionally, individuals able to exercise free will are deemed blameworthy when their actions fail to comport with the law.[40] However, the law, through the insanity defense, has chosen to recognize a subset of individuals that should not be held answerable because "a mental disability or disease deprives them of even the minimal capacity for rational and voluntary choices."[41] As a result, the insanity defense would seem to dictate that a mother who lacks a blameworthy mental state at the time she took the life of her child should not be held responsible under the law.

Preliminarily, it should be noted that there is little information regarding cases in which women have attempted to use postpartum psychosis as a defense to criminal responsibility. Like most trial court decisions, many such cases are resolved without a judicial opinion being reported.[42] Additionally, many women who might raise their mental status as a defense enter plea bargains before their cases go to trial.[43]

When one examines the cases that have resulted in a reported judicial opinion or have come to the attention of the media, there are clear inconsistencies in the outcomes of these cases.[44] Although some women have been successful in pleading insanity,[45] other women under similar circumstances have been unsuccessful.[46]

These variations in results may be attributed to differences in the insanity defense standards and vagaries in the manner in which the defense is applied. To be found insane, a woman suffering from postpartum psychosis must meet specific criteria under the applicable standard for insanity within a given state.[47] Although other insanity tests exist,[48] the two variations primarily used in the United States are reflected in the M'Naghten test and the American Law Institute's Model Penal Code standard.[49]

**M'Naghten Test.** A majority of United States jurisdictions have adopted the M'Naghten test,[50] which was drawn from an English case decided in 1843.[51] The focus of the

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[38] Tricia Schroeder, *Postpartum Psychosis as a Defense for Murder?* 21 W. ST. U. L. REV. 267, 279 (1993).

[39] *See* RITA J. SIMON & DAVID E. AARONSON, THE INSANITY DEFENSE 4 (1988).

[40] *Id.*

[41] *Id.*

[42] Anne Damante Brusca, Note, *Postpartum Psychosis: A Way Out for Murderous Moms?* 18 HOFSTRA L. REV. 1133, 1159 (1990).

[43] *Id.*

[44] Kelly, *supra* note 20, at 268.

[45] *See, e.g.,* People v. Massip, 235 Cal. Rptr. 868, 869 (Cal. Ct. App. 1990); Kelly, *supra* note 20, at 267 (discussion of the cases of Sheryl Massip and Ann Green); Laura E. Reece, Comment, *Mothers Who Kill: Postpartum Disorders and Criminal Infanticide*, 38 UCLA L. REV. 699, 700-02 (1991) (discussion of the trial involving Ann Green); Schroeder, *supra* note 38, at 282-90 (discussion of the cases of Angela Thompson, Michelle Remington, and Dawn March).

[46] *See, e.g.,* Commonwealth v. Reilly, 549 A.2d 503, 504-05 (Pa. 1988) (defendant, Bernadette Reilly, convicted of third degree murder after insanity defense rejected); Sheri L. Bienstock, *Mothers Who Kill Their Children and Postpartum Psychosis*, 32 SW. U. L. REV. 451 (2003) (discussion of the case involving Andrea Yates who was found guilty of capital murder and sentenced to life in prison after jury rejected an insanity defense).

[47] *See* Kelly, *supra* note 20, at 260.

[48] The five primary variations of the insanity test that have been used in the United States are the M'Naghten test, the "irresistible impulse" test, the *Durham* "product" test, the American Law Institute's Model Penal Code standard, and the federal test. *Id.* at 261. *See generally* RICHARD BONNIE ET AL., A CASE STUDY IN THE INSANITY DEFENSE: THE TRIAL OF JOHN W. HINCKLEY, JR. (2d ed. 2000).

[49] SPINELLI, *supra* note 11, at 145.

[50] Liu, *supra* note 9, at 364; SPINELLI, *supra* note 11, at 145-46.

[51] Daniel M'Naghten's Case, 8 Eng. Rep. 718, 722 (1843) ("at the time of the committing of the act, he was labouring under such a defect of reason, from disease of the mind, as not to know the nature and

M'Naghten test is the defendant's cognitive capacity at the time of the crime.[52] To be considered insane under the M'Naghten test, a person must lack, as the result of a mental disorder, the cognitive ability either to understand the nature and quality of the act or to recognize that the act is wrong. The test has been criticized for its limited scope,[53] in part because it lacks a volitional inquiry.[54] Under this test, there is no exploration of whether the mental disorder at issue impeded the defendant's ability to control his or her behavior.[55]

The M'Naghten test imposes significant limitations on a woman seeking to invoke an insanity defense in response to a crime that occurred while she experienced postpartum psychosis. The well-publicized case of Andrea Yates represents such an instance. Andrea Yates was suffering from postpartum psychosis when she drowned all five of her children, including her six-month-old daughter, in a bathtub one-by-one on June 20, 2001.[56] Yates had undergone psychiatric treatment for two years prior to the incident due to her struggles with postpartum psychosis and schizophrenia after the birth of her fourth child.[57] During this period, Yates had attempted to commit suicide twice and had been hospitalized for psychiatric treatment several times.[58] Additionally, Yates was taking Haldol, a medication prescribed to control hallucinations and other symptoms associated with psychosis.[59]

The record in the case revealed that Andrea Yates waited for her husband to leave for work and then systematically drowned each of her children.[60] She placed four of the bodies on the bed in the master bedroom under a sheet but left her eldest son floating in the bathtub.[61] Yates subsequently telephoned her husband and the police.[62] When the police arrived, she told them she had killed her children.[63] Yates also told the police that she believed that she was a "bad mother" and that, as a result, her children were "damaged."[64] In her reality, she felt compelled to kill her children.[65] She was convinced that if she did kill her children, she would escape the torment of the devil by being punished and sentenced to death.[66] In addition, she believed that by killing her children before they morally deteriorated further, she was saving them from Satan and ensuring their place in heaven.[67]

The district attorney charged Yates with two counts of capital murder and sought the death penalty.[68] Yates entered a plea of not guilty by reason of insanity (NGRI).[69] Significantly, it was not disputed that Andrea Yates suffered from a mental illness.[70] The issue around which the trial revolved was whether her diagnosis of postpartum psychosis would rise to the requisite level of insanity under the strict M'Naghten test used in the state of Texas.[71]

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quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.").

[52] SPINELLI, *supra* note 11, at 145.

[53] *Id.*

[54] *Id.*

[55] BONNIE ET AL., *supra* note 48, at 16.

[56] CNN.COM/ U.S., *Susan Smith's Ex-Husband: Let Yates Father Grieve* (2001), *at* http://www.cnn.com/2001/ US/07/06/Smith.yates [hereinafter CNN.COM/ U.S.].

[57] Evan Thomas, *Motherhood and Murder,* NEWSWEEK, July 2, 2001, at 23; COURT TV'S CRIME LIBRARY, *Andrea Yates*, *at* http://www.crimelibrary.com/notorious_murders/women/andrea_yates [hereinafter COURT TV].

[58] COURT TV, *supra* note 57.

[59] Thomas, *supra* note 57, at 23.

[60] *Id.* at 25.

[61] *Id.*

[62] *Id.*

[63] *Id.*

[64] *Id.* at 24-25.

[65] COURT TV, *supra* note 57.

[66] *Id.*

[67] *Id.*

[68] CNN.COM/ U.S., *supra* note 56.

[69] *Id.*

[70] *See* Ralph Pohlman, *A Deadly Disease*, THE OTTAWA SUN, Mar. 30, 2002, at 14.

[71] *See* Christopher L. Tritico, *The Real Culprit: Mental Health and Judicial Systems Failed the Yates',* 113 FULTON COUNTY DAILY REP. 66 (2002).

The jury ultimately convicted Andrea Yates of capital murder.[72] Yates was spared the death penalty. However, the jury sentenced Yates to life in prison.[73]

In rejecting Yates' NGRI plea, the jury focused on Yates' cognitive ability at the time of the murders, as required by Texas' M'Naghten test.[74] Specifically, the jurors found that at the time of the crimes in question, Yates knew that her actions were wrong.[75] The conclusion was based, in part, on evidence of Yates' actions after the murders were complete; the fact that she called her husband and the police after the murders was considered to indicate that she knew her actions were wrong.[76]

The jury's rejection of Yates' insanity plea under the strict M'Naghten formulation typifies the inherent shortcomings of the M'Naghten standard as applied to women with a post-partum psychosis. A woman with a post-partum psychosis, such as Andrea Yates, may have the cognitive ability to understand that her actions are wrong in the eyes of society; however, her volitional control may be impaired due to psychotic symptoms such as auditory hallucinations and delusions that compel her to inflict harm on her child.[77] Yates, for example, may have understood that killing her children was morally and legally wrong. Nevertheless, she felt compelled to do so and was unable to ignore her deep belief that killing her children would ultimately save them from the devil.

**ALI Model Penal Code Test.** Some jurisdictions have adopted the American Law Institute's Model Penal Code (MPC) standard of insanity.[78] The MPC standard, when compared to the M'Naghten test, is viewed as a significantly more flexible test because it includes a volitional prong in addition to a cognitive prong.[79] Thus, defendants may obtain an insanity verdict by showing that even though they understood their act was wrong, they were unable, as a result of their mental disorder at the time of the crime, to conform their actions to the dictates of the law.[80]

Although not many reported cases have arisen in jurisdictions adhering to the MPC standard, the belief has been expressed that women with a postpartum psychosis who have perpetrated an act of murder against a child fare better under the MPC standard than under the M'Naghten test because of its inclusion of a volitional prong.[81] Proponents of this belief point to five prominent cases in the United States where a woman with a postpartum psychosis was found NGRI of the murder of her child. They note that three of

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Not only does the Texas test not include a volitional prong, but it also does not encompass the absence of a cognitive ability to understand the nature and quality of the act. *See* TEX. PENAL CODE § 8.01(a) (2004) ("It is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong.").

[72] *Id.*

[73] *Parnham Withdrawing as Attorney for Yates,* HOUS. CHRON., Apr. 29, 2004, at A22.

[74] Pohlman, *supra* note 70, at 14.

[75] *Our Opinions: Don't Condemn Yates to Death,* ATLANTA J. & CONST., Mar. 15, 2002, at 21A.

[76] SPINELLI, *supra* note 11, at 176.

[77] Tritico, *supra* note 71, at 66; Liu, *supra* note 9, at 369.

[78] Model Penal Code § 4.01(1) (2004) ("A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.").

[79] *See* Deborah W. Denno, *Who Is Andrea Yates? A Short Story About Insanity,* 10 DUKE J. GENDER L. & POL'Y 1, 12-13 (2003). It is also considered more flexible because it encompasses defendants who lack a *substantial* capacity to *appreciate* the criminality of their conduct or to conform their conduct to the requirements of the law, two modifications that remove it from the all-or-nothing test posed by the M'Naghten standard.

[80] SPINELLI, *supra* note 11, at 146.

[81] *See* Michele Connell, Note, *The Postpartum Psychosis Defense and Feminism: More or Less Justice for Women?* 53 CASE W. RES. 143, 149-50 (2002).

them occurred in states where the MPC standard was in place[82] and that one of the two NGRI verdicts in a M'Naghten state occurred only after a judge overruled the second-degree murder conviction of the jury.[83]

Scholars concerned about the use of the insanity defense in conjunction with postpartum psychosis, have suggested modifications to the standards used. Proposals encompass the inclusion of a volitional as well as a cognitive prong[84] or the development of a "hybrid prong."[85] The latter would "combine elements of cognition and volition to excuse people from punishment who are sufficiently impaired in both respects, such that they should not be held responsible for their conduct, but whose separate impairments in each prong, as these prongs have been interpreted, do not equal a finding of insanity."[86]

However, even in MPC states the insanity defense has been rejected for women with a postpartum psychosis who killed their children.[87] It has also been asserted that the jury would still probably have rejected Andrea Yates' insanity defense even if the volitional prong had been available to her.[88] Moreover, the insanity defense is rarely successful in general.[89]

The insanity defense, of course, fails to accommodate many other types of psychological disturbances as well. However, such cases rarely raise as much concern in the general public as do cases involving established diagnoses of postpartum psychosis, primarily because it has seemed counterintuitive to find a woman sane who has killed her child under these circumstances. Also, it should be noted that in M'Naghten jurisdictions, despite the relatively narrow insanity defense, women with a postpartum psychosis have been found NGRI for the killing of their children.[90]

The confused and arguably inconsistent application of the insanity test to women who, like Andrea Yates, take the lives of their children while suffering from the severe effects of postpartum psychosis should be a more pressing concern to society and the American legal system. The shortcomings of the insanity defense in this context suggest that the legal response to women with a postpartum psychosis who kill their children should take a different form.

### The British Infanticide Act

The Infanticide Act was first enacted in 1922 by the English Parliament, and was reformulated in 1938.[91] The 1938 Infanticide Act (Infanticide Act) establishes that a woman who kills her child in the first twelve months after the child's birth as the result of a mental disorder associated with childbirth, will be charged with infanticide and punished as if she had committed manslaughter rather than murder.[92] It is noteworthy that under this

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[82] *See generally* Schroeder, *supra* note 38 (discussing the cases of Dawn March, Ann Green, and Michelle Remington, which were tried in the MPC states of Connecticut, New York, and Vermont, respectively).

[83] *Id.* at 280-81 (after a California jury convicted Sheryl Massip of second-degree murder for running over her infant son with a car, the trial judge directed a verdict of not guilty by reason of insanity based upon evidence of postpartum depression with psychosis). *See* People v. Massip, 235 Cal. Rptr. 868, 869 (Cal. Ct. App. 1990).

[84] *See generally* Manchester, *supra* note 1.

[85] *See generally* Christine Michalopoulos, *Filling in the Holes of the Insanity Defense: The Andrea Yates Case and the Need for a New Prong,* 10 VA. J. SOC. POL'Y & L. 383 (2003).

[86] *Id.* at 408.

[87] *See* People v. Brown, No. 208982, 1999 WL 33441128, at *5-6 (Mich. Ct. App. June 22, 1999).

[88] Michalopoulos, *supra* note 85, at 383.

[89] *See* Kelly, *supra* note 20, at 260 (noting that "in practice" insanity defenses are rarely successful with roughly only 25% of them resulting in a finding of not guilty by reason of insanity).

[90] *See In re* Collins, No. 17235, 1995 WL 688792, at *2 (Ohio Ct. App. Nov. 22, 1995).

[91] DALTON & HOLTON, *supra* note 29, at 92.

[92] The Infanticide Act, 1938, 1 & 2 Geo. 6, c. 36, § 1 (Eng.) ("[W]here a woman by any willful act or omission causes the death of her child being a

approach, the mother's sentence is the responsibility of the judge and the prosecution is not permitted to present evidence to challenge a showing that the mother suffered from a mental disorder.[93] The English approach is derived from the diminished responsibility doctrine.[94] Specifically, the statute formally recognizes that a woman can experience diminished mental capacity due to the biologically destabilizing impact of childbirth and as a result not be able to commit the specific-intent crime of murder.[95]

The Infanticide Act was a response to a trend that had developed in the way in which mothers in England were treated within the legal system when they killed their children.[96] Prior to the enactment of the Infanticide Act, women who killed their children were subject to the charge of murder like all other individuals who committed a homicide and faced a potential death penalty; no distinction was made between a mother's killing of her infant and her killing of an adult.[97] Nevertheless, mothers who killed their children were rarely convicted of murder and were rarely sentenced to death.[98] In response to this inconsistency, the Infanticide Act not only recognized that hormonal imbalances can lead to a disruption in a woman's mental state after birth, it also embodied the cultural tendency during the early twentieth century to afford leniency to women who committed infanticide. However, even after this reform that reduced the punishment accorded such women, this tendency has apparently continued as most women who are convicted of infanticide in England and Wales do not receive sentences that involve criminal custody, but instead are hospitalized or placed on probation.[99]

Three main arguments have been made by commentators who have criticized the Infanticide Act.[100] Their primary concern is that the statute does not allow for a case-by-case determination of whether a link exists between the mental disorder and the act of murder for which the mother is on trial.[101] They assert that not all mothers with a birth-related mental disorder who take the life of their child within the first twelve months after birth should qualify for an automatic reduction in charge from murder to manslaughter.[102] A second voiced criticism is that "the act singles out homicidal mothers for special treatment" and discriminates against other individuals who commit homicide.[103] Finally, the complaint is raised that the statute, in providing special legal treatment for certain homicidal mothers, ultimately reduces the protections the law should provide to child victims.[104]

While the first criticism that targets the broadness of the Infanticide Act is persuasive, the other two criticisms carry less weight. A gender-specific exception that takes into account biological influences that are out of the control of the individual does not violate notions of equity. Biological differences dictate that only a woman who has given birth

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child under the age of twelve months, but *at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child* or by reason of the effect of lactation consequent upon the birth of the child, then, not withstanding that the circumstances were such that but for this Act the offence would have amounted to murder, she shall be guilty of a felony, to wit of infanticide, and may for such offence be dealt with and *punished as if she had been guilty of the offense of manslaughter* of the child.") (emphasis added). *See* Velma Dobson & Bruce Sales, *The Science of Infanticide and Mental Illness*, 6 PSYCHOL. PUB. POL'Y & L. 1098, 1098-99 (2000).

[93] Bienstock, *supra* note 46, at 464.

[94] SPINELLI, *supra* note 11, at 192.

[95] *Id.* at 191-92

[96] Bienstock, *supra* note 46, at 464.

[97] *Id.*

[98] *Id.*

[99] SPINELLI, *supra* note 11, at 192; *Infanticide*, at http://www.markwalton.net/mdo/infanticide.asp ("of the 59 [infanticide] [British] cases recorded between 1979 and 1988, not one received a prison sentence").

[100] Dobson & Sales, *supra* note 92, at 1109.

[101] *Id.*

[102] *Id.*

[103] *Id.*

[104] *Id.*

to a child will experience postpartum psychosis. Gender-specific exceptions that ultimately favor one biological sex over another have been formulated and utilized in related areas of the law.[105] For example, scientific evidence of the violent propensities of males with XYY chromosome syndrome or high testosterone levels have been sent to the jury with instructions on insanity or its use as a distinct defense.[106] Alternatively, the development of the battered spouse syndrome as a defense has overwhelmingly benefited female defendants.[107]

The assertion that extending leniencies to mothers who take the lives of their children during the postpartum period diminishes the protection that the law should afford to the child victim arises against the social backdrop of increasing concern about and efforts to deter child abuse. Women with postpartum psychosis, however, are unlikely to factor the degree of punishment into their decision-making process before they murder their child because their crime is biologically motivated and not the result of rational thought.[108] Maximizing the ultimate punishment they receive is not likely to deter them or to place a greater number of children at risk.[109] In addition, the reduced sentence afforded these mothers will not generate a general message that child abuse is condoned because postpartum psychosis is a relatively rare phenomenon and only a very small number of cases where documented biological factors are involved will be encompassed. Finally, although the criminal law also serves a retributive function, a woman whose criminal act is the result of a postpartum psychosis is less blameworthy in the same manner as other individuals whose criminal acts are not the result of free will but the result of a mental disorder.[110]

[105] Manchester, *supra* note 1, at 748-49.
[106] Deborah W. Denno, *Gender, Crime, and the Criminal Law Defenses*, J. CRIM. L. & CRIMINOLOGY 80, 126-34 (1994); Kyron Huigens, *Virtue and Inculpation*, 108 HARV. L. REV. 1423, 1440 n.53 (1995).
[107] Manchester, *supra* note 1, at 748
[108] SPINELLI, *supra* note 11, at 14.
[109] *Id.*

### Charting a Different Course for the U.S. Legal System

Twenty-nine other countries, including Canada and Australia, have enacted statutes similar to the English Infanticide Act.[111] In general, these statutes allow a woman, who kills her child within one year after birth while experiencing a mental disorder associated with childbirth, to be charged with a lesser offense than murder.[112] In the United States, the option available to such women is to plead an insanity defense, which as discussed provides an imperfect and inconsistent fit. A better response would be legislative enactments by the various states akin to the Infanticide Act.

The doctrine of diminished responsibility, which provides the conceptual foundation for the Infanticide Act, provides a ready means for incorporating this approach within American jurisprudence. In the United States, a defendant's diminished capacity may be taken into account during either the guilt phase or the sentencing phase of the trial.[113]

During the guilt phase, the diminished capacity doctrine allows a criminal defendant to introduce evidence of a mental disorder to negate an alleged mental element (e.g., specific intent) of a charged crime, which can exonerate the defendant of that charge, and

[110] For such individuals, under both the diminished responsibility doctrine, *see infra* notes 113-20 and accompanying text, and the insanity defense, *see supra* notes 38-41 and accompanying text, the criminal law does not seek to punish to the fullest extent possible.
[111] ABC NEWS.COM, *No Easy Answer: Proving Insanity Could Be Tough for Houston Mom Accused of Killing Kids* (2001), *at* http://abcnews.go.com/sections/us/DailyNews/five_dead010626.html.
[112] Dobson & Sales, *supra* note 92, at 1099.
[113] *See* Stephen J. Morse, *Undiminished Confusion in Diminished Capacity*, 75 J. CRIM. L. & CRIMINOLOGY 1, 1-2 (1984).

result in either an acquittal or a reduction in the degree of crime of which the defendant is convicted.[114] The prosecution is always required to prove the elements of the crime charged beyond a reasonable doubt.[115] Thus, diminished capacity in the guilt phase of the trial is not a "special, affirmative defense."[116] Nevertheless, some jurisdictions, which prescribe to the notion that an assertion of diminished responsibility during the guilt phase amounts to a partial insanity defense, have limited the defendant's ability to challenge the prosecution's prime facie case by disallowing the defendant's presentation of evidence of a mental disorder.[117]

During the sentencing phase, however, proof of diminished capacity can function in a manner that adheres to the spirit of the insanity defense but that does not exonerate the defendant of responsibility for the crime.[118] Defendants essentially proclaim that, as a result of a mental disorder, they were not fully responsible and are less culpable for the crime of which they have been convicted, and thus they should be punished less severely.[119] Although the doctrine of diminished responsibility due to a mental disorder is not specifically recognized by American law in conjunction with sentencing, evidence of a mental disorder is often introduced as a mitigating factor at sentencing.[120]

While the English Infanticide Act, and its attention to a woman's diminished mental capacity to commit murder, centers on the guilt phase of the trial, efforts to incorporate the woman's diminished capacity into criminal proceedings are more likely to succeed in America by turning to legislation that focuses on the sentencing phase. Legislative changes that appear to expand the availability of the insanity defense or the diminished capacity doctrine during the guilt phase are likely to meet resistance because of public skepticism about the link between mental disorders and criminal responsibility. By focusing on the sentencing phase, the mother who has killed her child remains criminally responsible, but her punishment is reduced to reflect the special circumstances surrounding the crime.

Presently, courts in the United States are sharply split over whether a mental disorder warrants a downward departure under state sentencing guidelines.[121] Therefore, legislative enactments are necessary to ensure that attention is given during sentencing to the diminished capacities of these women at the time of the offense. To promote uniformity in this approach, a model sentencing statute addressing this group of offenders should be integrated into the Model Penal Code.

**Justifications for Reduced Sentences.** There are a number of justifications for reducing the sentence imposed on a woman who murders her child during a postpartum psychosis. As discussed, a primary reason for why women with a postpartum psychosis should be given protections over and above those already provided by the current legal system is that the causal relationship between postpartum psychosis and infanticide has been recognized and documented.[122] Postpartum psychosis is the most severe postpartum psychiatric illness and is marked by the mother's severe mental break with

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[114] *Id.* at 1.
[115] *Id.* at 5.
[116] *Id.* at 6.
[117] *Id.* at 6-7.
[118] *Id.* at 20.
[119] *Id.*
[120] Stephen J. Morse, *Diminished Rationality, Diminished Responsibility*, 1 OHIO ST. J. CRIM. L. 289, 289 (2003).

[121] Marjorie A. Shields, *Downward Departure Under State Sentencing Guidelines Permitting Downward Departure for Defendants with Significantly Reduced Mental Capacity, Including Alcohol or Drug Dependency*, 113 A.L.R. 5TH 597 (2003-2004) (citing judicial opinions from Florida, Michigan, and Minnesota that held that a downward departure was warranted, while a downward departure was held to be not warranted in decisions from Florida, Minnesota, Pennsylvania, and Washington).
[122] Dobson & Sales, *supra* note 92, at 1100.

reality.[123] Several epidemiological studies have provided scientific support for a clear link between postpartum psychosis and childbirth.[124] As noted, a mother with post-partum psychosis will experience delusions and auditory hallucinations that often center on harming the child.[125] Furthermore, women with a postpartum psychosis tend to experience greater psychiatric impairments and more severe periods of confusion and delirium than individuals experiencing psychoses unrelated to childbirth.[126] Thus, postpartum psychosis is a severe mental disorder that results in significant cognitive and volitional impairment, yet does not adequately fit within the predominant tests for insanity.[127] But because of the severe and significant alterations that the condition causes in the mental state of postpartum mothers, the legal system should at least take this condition into account when sentencing these women.

Some might ask why a specific response should be available for defendants with a postpartum psychosis and not for other defendants with a mental disorder, who are also frequently unable to successfully avail themselves of the insanity defense.[128] The fact that the insanity defense fails other types of defendants, however, is not a reason to bar a distinct response for women with a postpartum psychosis in light of the severity of their disorder and society's apparent conflicted views towards them and sense that they are not fully blameworthy.[129]

A further justification for reducing the sentences of women who kill their children during a postpartum psychosis comes from an examination of the provocation doctrine. Under this doctrine, a defendant will be punished for manslaughter instead of murder if it is determined that the killing occurred while the defendant was in a "sudden heat of passion" due to "adequate provocation."[130] "Adequate provocation" is a circumstance that would cause a reasonable person to lose self-control.[131] It has been asserted that the provocation doctrine injects a recognition of diminished capacity into sentencing; the defendant, because of the surrounding circumstances, is essentially held not to be fully responsible for the crime committed and is punished less severely.[132] It has further been argued that it is irrational to allow such mitigation when sentencing individuals who are "provoked" and not to allow it for arguably even less blameworthy defendants whose behavior results from a psychiatric condition over which they had no control.[133] Such an analysis suggests that the sentences of women with a postpartum psychosis who take the lives of their children should similarly be reduced because their actions are also the result of a mental disorder beyond their control.

**The Model Statutory Standard.** Accordingly, the model statute would be based on the doctrine of diminished capacity and reflect the goals of the English Infanticide Act. Specifically, it would provide the following:

> A woman convicted of murder for killing any of her biological children while suffering from postpartum psychosis during the twelve month period after the birth of one of her biological children shall be sentenced under the laws of the

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[123] *See supra* note 27 and accompanying text.
[124] Dobson & Sales, *supra* note 92, at 1106.
[125] *See supra* notes 30-34 and accompanying text.
[126] *See supra* notes 35-36 and accompanying text.
[127] *See supra* notes 38-90 and accompanying text.
[128] *See supra* note 90 and accompanying text.
[129] It is, on the other hand, a reason to reevaluate the insanity defense and question why the majority of United States jurisdictions continue to use an insanity standard that was developed in 1843, a time when knowledge about mental illness was extremely limited. Society's collective understanding of psychiatric illness has significantly developed since the 1800s, and the standards of insanity employed should reflect the advancements in the understanding of mental illness.
[130] WAYNE R. LAFAVE, PRINCIPLES OF CRIMINAL LAW §14.2(b) (2003).
[131] *Id.*
[132] Morse, *supra* note 113, at 29.
[133] *Id.* at 30.

jurisdiction in which the crime was committed as if she committed the crime of manslaughter.

Under this model, at trial the fact finder[134] will be required to initially determine whether expert testimony established that the woman suffered from postpartum psychosis at the time of the crime and whether this disorder was instrumental in the death of the child. If so, and the woman is convicted of murder,[135] a sentence that corresponds with a sentence for manslaughter must be assigned.

The proposed model overcomes shortcomings of the English Infanticide Act while preserving the more lenient treatment of women who commit infanticide while suffering from postpartum psychosis. As critics have noted, the Infanticide Act is broad in its sweep; any woman who experiences a mental disorder due to the birth of a child, and who consequently kills that child within twelve months after its birth, will qualify for the reduction in charge from murder to manslaughter. The Infanticide Act thus makes the reduction in charge available to a woman who experiences postpartum blues, postpartum depression, or postpartum psychosis. However, as discussed, postpartum psychosis is the most severe of the three birth-related mental disorders and causes particular symptoms that specifically endanger the infant in the mother's care.[136] Furthermore, the inappropriateness of applying the charge reduction to women suffering from the less severe postpartum blues and postpartum depression has been noted by psychologists who have explored the impact of the Infanticide Act.[137] The more lenient treatment associated with the proposed model legislation, as a result, is limited to women suffering from postpartum psychosis at the time of the crime.

Another weakness of the Infanticide Act, as previously noted, is the lack of a case-by-case determination of whether the mother's mental disorder was linked to the crime. Under the proposed model statute, the fact finder will decide, based on the evidence presented at trial, not only whether the mother experienced postpartum psychosis, but also whether this disorder played a role in the crime. Only after both questions have been answered may the woman's sentence be reduced to one that corresponds to manslaughter.

While the Infanticide Act is overly broad in some respects, it is also unduly narrow in others. Specifically, under the Infanticide Act, if a woman with a postpartum psychosis kills a biological child that is not under the age of twelve months, the woman will not qualify for the reduction in charge from murder to manslaughter. Thus, if Andrea Yates had killed her five children in England, she likely would not have been able to avail herself of the Infanticide Act with regard to her four older children. Although the scope of the Infanticide Act is appropriately limited to disorders that have an onset precipitated by the birth of a child within the past twelve months, it ignores the familial reality of many such mothers. The mother may not be simply caring for a newborn child; she may also be responsible for the care of her older children as well. Expanding the reach of the proposed model statute to encompass the murders of "any of her biological children" addresses a family context that is likely to arise, and encompasses the individuals who can be expected to be the victims of behavior driven by this disorder. Some may consider this too expansive. However, the death of these other biological children is essentially as irrational as the murder of the mother's infant. Also, it is worth emphasizing that the model statute is not an instrument for acquitting such women; it only reduces the sentence.

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[134] If a jury has been requested, the jury will fill this role; if a jury has not been requested, this responsibility falls to the presiding judge.

[135] The woman's murder conviction indicates that any insanity defense that was raised has failed, as well as any assertion that she lacked the requisite mens rea.

[136] *See supra* notes 23-37 and accompanying text.

[137] *See generally* Dobson & Sales, *supra* note 92.

A related question that may be raised is why the reduced sentence is made available following the murder of the woman's biological children, but not for the murder of other children (e.g., adopted or foster children) or adults who are also in her care or home at the time of the murders. Although it can be argued that they are also logical targets of a woman with a postpartum psychosis, it is necessary to draw a line somewhere. The fact that the murder of victims who are not biologically related to the woman with postpartum psychosis has not historically provoked in observers the same sense of "madness" buttresses the argument for limiting the scope of the proposed statute to the murder of a woman's biological children.

**Procedural Issues.** This model legislation has adopted from the Infanticide Act the twelve-month period after giving birth to a child as the qualifying period in which the postpartum psychosis and related behavior must occur. However, this time period may not accurately reflect the period that coincides with the increased risks associated with postpartum psychosis.[138] As more research is done with regard to the onset and duration of postpartum psychosis, consideration should be given to revising this qualifying period.

This model legislation does not contain a position on who should be assigned the burden of proof at trial to establish that the woman suffered from postpartum psychosis at the time of the crime and that the disorder was instrumental in the death of the child. Nor does it establish what level of proof is required. In recent years the states have split on who carries the burden of proof with regard to the insanity defense and what the applicable standard of proof should be.[139] In light of the parallels between the insanity defense and the model statute, a given state may want to apply the same burden and standard of proof to the fact finding associated with this model statute as it applies to a determination of insanity. On the other hand, to the extent a state desires to make reduced sentencing more or less available to women who have killed their children while suffering from a postpartum psychosis, it may alter the burden and standard of proof accordingly.[140]

This model statute is also not intended to supplant either the insanity defense or mens rea requirements at trial. They represent separate conceptual and policy considerations. Only after a woman has been found guilty of the murder of her children should attention turn to whether the presence of a postpartum psychosis should result in reduced sentencing. Similarly, it is not intended that the model statute supplant the Guilty But Mentally Ill verdict and the mental health treatment that might be made available to these women as the result of such a verdict.[141]

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[138] *But see* AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINE FOR THE ASSESSMENT AND TREATMENT OF PATIENTS WITH SUICIDAL BEHAVIORS 85 (2003) ("[M]others who develop postpartum psychosis need to be assessed for suicidal and homicidal impulses directed toward their newborn or other children. The risk is especially high in the first postnatal year.") (citations omitted).

[139] RALPH REISNER, CHRISTOPHER SLOBOGIN, & ARTI RAI, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 536-37 (4th ed. 2004) ("By far the majority of the states require the defendant to prove insanity by the preponderance of the evidence standard. About one-third of the states place the burden of disproving insanity on the prosecution beyond a reasonable doubt.").

[140] It should be noted that the assignment of the burden and standard of proof may have largely symbolic value. Research has indicated that there is little relationship between a particular burden of proof with regard to insanity and the outcome. *Id.* at 538.

[141] At least fourteen states have authorized the fact finder to return a verdict of "guilty but mentally ill." *Id.* at 604. Although the nature of this approach varies, it basically results in the defendant being sentenced to a term appropriate for the offense but provides the defendant with an opportunity for placement within a mental health program. *Id.* When that treatment is concluded, the defendant is placed in a correctional facility for the remainder of his or her sentence. *Id.*

## Conclusion

Postpartum psychosis is a mental illness that carries the potential for significant consequences. Although rare in prevalence, the condition leads mothers to experience devastating psychiatric symptoms that lead to the deaths of their children. The American legal system as it currently exists is not equipped to respond in an appropriate fashion to these crimes. The United Sates has lagged behind a number of other countries that have carved out a special response to this unique group of offenders. This article proposes an approach that reflects these developments but in a fashion more akin to the current legal climate in this country. Legislation that makes possible a reduction in the sentencing of these women while still holding them accountable for their crimes provides for a just means of responding to the mental disorders they experienced due to the physiological effects of childbirth that were beyond their personal control. Our emerging understanding of psychiatric conditions should inform the law's response to individuals with a mental illness. A change in the treatment of women who suffer a postpartum psychosis is a good place to start.

# *Cases in the United States Supreme Court*

**Managed Care Companies Not Subject to State Malpractice Claims for Wrongfully Denying Benefits**

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to protect employees participating in employer-sponsored benefit plans by providing a uniform regulatory regime to cover these plans. To this end, ERISA includes expansive preemption provisions to move routinely disputes about such plans out of state courts into federal court.

In recent years, managed care plans have grown to be a powerful force in the delivery of health and mental health services, with some 140 million people in the United States currently covered by an employment-based health care plan. Complaints have arisen that managed care organizations (MCOs), in the course of their cost-control efforts, inappropriately refuse to cover treatment that a doctor has deemed medically necessary. If ERISA provides the sole basis for pursuing such claims, they must be resolved in federal court where the recovery of damages is significantly limited. Texas and nine other states (Arizona, California, Georgia, Maine, New Jersey, North Carolina, Oklahoma, Washington, and West Virginia), in an effort to expand this recovery, passed laws to give patients enrolled in a managed care plan the right to pursue their claims in state court.

Two claims filed in Texas state courts provided the factual focus of a challenge to these state laws. In one case, a treating physician recommended a longer stay for a hospitalized patient but the discharge nurse for the MCO refused to authorize it. The patient developed complications at home and had to return to the emergency room several days later. In the other case, an expensive medication was prescribed but the health care plan only authorized it for patients who had first tried and failed to benefit from two less expensive drugs. One of those drugs caused a complication that placed the patient in critical care for five days and brought him close to death.

In a unanimous opinion, the Court held that ERISA provides the exclusive remedies for alleged wrongful denials of benefits by MCOs and does not permit states to recognize independent claims. The Court asserted that ERISA represented a "careful balancing" between encouraging the creation of employee benefits plans and ensuring fair and prompt enforcement of rights under these plans.

A concurring opinion urged Congress to revisit what is "an unjust and increasingly tangled ERISA regime" that preempts virtually all state law remedies but provides very few federal alternatives, and those that it does provide do not make wronged persons "whole." Aetna Health Inc. v. Davila, 124 S. Ct. 2488 (2004); Linda Greenhouse, *Justices Limit Ability to Sue Health Plans*, N.Y. Times, June 22, 2004.

**Enhancements of Criminal Sentences for Factors Other Than Prior Convictions Must Be Based on Jury Findings**

Mental health professionals often provide testimony at criminal sentencing hearings, including assessments of the dangerousness of convicted defendants. In some states, judges are authorized to enhance the sentence given based on factual findings made by the judge at these hearings.

In a case before the Supreme Court, a man diagnosed at various times with psychological and personality disorders, including paranoid schizophrenia, pled guilty to kidnapping his estranged wife. The crime carried a maximum penalty of 53 months under Washington's statutory sentencing guidelines, based on various pre-identified factors deemed relevant to the crime (the longest sentence available for this crime under Washington law was 10 years). The trial judge increased the sentence

to 90 months after finding the defendant had acted with "deliberate cruelty," a statutorily enumerated ground for departure from the sentencing guidelines in domestic-violence cases. Faced with an unexpected increase of more than three years in his sentence, the defendant objected.

The Court, on a 5-4 vote, ruled that relying on factual findings that were neither admitted by the defendant nor found by a jury violated the defendant's constitutional right to a jury trial and held that any factor that increases a criminal sentence, except for prior convictions, must be proven to a jury beyond a reasonable doubt. The court reasoned that a judge's authority to sentence derives solely from the jury's verdict and juries, rather than "a lone employee of the State," should make these decisions.

This ruling invalidates the criminal sentencing scheme of the State of Washington, is reported to likely affect sentencing in a number of other states (Alaska, Arkansas, Florida, Michigan, Minnesota, North Carolina, Ohio, Oregon, Pennsylvania, and Tennessee), and may jeopardize the federal sentencing guidelines.

The dissent argued that the majority's ruling undercut 20 years of sentencing reform and efforts to afford "guided discretion" to judges to enable them to treat like cases alike. The dissent also asserted that the ruling placed in jeopardy "tens of thousands" of sentences already assigned and left the criminal justice system with a range of unattractive options, including the use of a second sentencing jury. On the other hand, it has been suggested that the Court's ruling could have significant ramifications for criminal defendants as state legislatures respond to the restriction on judges considering aggravating factors at sentencing by authorizing extremely high sentences from which judges may or may not depart downward at their discretion based on mitigating factors. Blakely v. Washington, 124 S. Ct. 2531 (2004); Linda Greenhouse, *Justices, in 5-4 Vote, Raise Doubts on Sentencing Rules*, N.Y. Times, June 24, 2004.

**Suspect's Youth, Inexperience Not a Required Consideration When Determining Whether Suspect in "Custody" and *Miranda* Warnings Necessary**

Police officers are required to provide *Miranda* warnings before questioning a suspect that is in their custody. The Supreme Court has ruled that a person is in "custody" if a "reasonable person" would feel that he or she was not at liberty to end the interrogation and leave. The Court prefers this so-called "objective test" because it does not place on the police the burden of anticipating the "frailties or idiosyncrasies" of the person being questioned. The issue arose whether this test should specifically take into account the youth or inexperience with the criminal justice system of a suspect because such individuals would be less likely in general to express a desire to end an interrogation. In a case brought before the Court, the suspect was 17 years old and had no prior history of arrest or police interviews.

In a two-part ruling, the Court first expressly excluded prior experience as a factor to be considered. The Court reasoned that in most cases police officers will not know a suspect's interrogation history and it would be too difficult to speculate whether a suspect's past experiences would lead a reasonable person under these circumstances to conclude he or she was not free to leave.

The Court acknowledged that the youth of the suspect was a harder question and that "fair minded jurists" could disagree over whether this youth was in custody, citing facts supporting alternative conclusions. Ultimately, the Court concluded that the state court decision, which had held that this youth's age was not relevant, was not "unreasonable" and should be upheld.

Because it was a 5-4 decision, Justice O'Connor's concurring opinion is pivotal. She stated that there may be cases in which a suspect's age will be relevant to the *Miranda* "custody" inquiry. In this case, however, she noted that the suspect was almost 18 years

old at the time and the police could not be expected to recognize that a suspect is a juvenile when he was so close to the age of majority or what impact it would have on the likelihood that the suspect would feel free to leave. She added that youths of this age vary widely in their reactions to police questioning and many can be expected to behave as adults. In contrast, the dissent cited several reasons why even youths of this age would not feel as free to break off a police interrogation as an adult and would feel themselves to be in custody. Yarborough v. Alvarado, 124 S. Ct. 2140 (2004).

**Ruling That Upheld Officer's Interrogation of a Suspect with a Mental Illness and Daughter Hospitalized for Behavioral and Drug Problems Not Disturbed**

Police interrogations of individuals with a mental illness suspected of a crime and alleged child victims of sexual abuse have raised considerable concern in recent years. The Supreme Court declined to review a ruling that involved both.

In May 1994, a man's youngest daughter experienced behavioral and drug problems that led to her hospitalization. While receiving treatment, she claimed her father sexually abused her. The man lived with his wife and three daughters. Responding to a police detective's request, the father went to the local police station, where the officer gave him his Miranda rights. He then interrogated the man for the next eight hours without a break for food or water. The officer would raise his voice but never yelled or used physical violence. He did call the father a liar and told him his daughters would be forced to testify if he did not confess. The father initially denied he sexually abused his daughter. He was taking medication for a bipolar disorder and asked to call his therapist, a request that was rejected. Ultimately, the father signed a confession in which he admitted abusing all of his daughters. The officer then interviewed the two older daughters, who denied the alleged abuse. The officer then visited the youngest daughter at the hospital. She initially denied the abuse, but after a number of hours and having been told that she would have to stay at the hospital until she disclosed her father's abuse, she described incidents of abuse. The officer then revisited the other two daughters who now admitted to being abused by their father.

The man pled guilty to sexually abusing his daughters, but after spending five years in prison, the conviction was vacated and the local prosecutor dropped all charges. The man subsequently filed a federal civil rights action against the police officer claiming that the investigation amounted to a violation of his constitutional rights.

On appeal, the Ninth Circuit dismissed the case after finding the investigation did not constitute a constitutional violation. The court noted that the Constitution guarantees the right to be free from coercive interrogation and that a coercive interrogation exists when the officer's tactics undermine a suspect's ability to exercise free will. The court determined such was not the case here because the officer did not refuse to give breaks for food or water, never yelled, and did not use violence or the threat of violence. The court added that (1) the officer's suggestion that the suspect's cooperation could lead to treatment rather than prison was also not coercive; (2) there is no constitutional right to call a therapist during an interrogation; (3) confessions can be voluntary even if the effects of medication influence a suspect's statements; and (4) the suspect's mental disorder did not invalidate his confession because he had not shown that the officer used coercive techniques that took advantage of this disorder.

Because the suspect's confession was legal, the Ninth Circuit also ruled it was reasonable for the officer to continue the investigation by further interviewing his daughters. The daughters' initial failure to corroborate the confession was not considered to be sufficient to require the officer to cease the investigation. The court reasoned that it is common for sex abuse victims to suppress memories of the assault or deny that it

happened. The court added it may have been inappropriate for the officer to tell the one daughter that she could not leave the hospital until she acknowledged the abuse, but this did not constitute a violation of the man's constitutional due process right not to be subjected to criminal charges on the basis of false evidence that was deliberately fabricated by the government. Interviewers of child witnesses suspected of sexual abuse, the court stated, are entitled to exercise discretion in deciding when to accept initial denials at face value and when to reject them. The Ninth Circuit concluded the officer's interviews were not so coercive and abusive that he knew or should have known that he would receive false information. Cunningham v. Wenatchee, 345 F.3d 802 (9th Cir. 2003), *cert. denied sub nom.*, Cunningham v. Perez, 124 S. Ct. 2070 (2004).

**Ruling That Dismissed Suit Claiming Jail Provided Inadequate Training to Officers on How to Manage Inmates with a Mental Illness Not Disturbed**

As recognition grows of the large percentage of jail and prison inmates who have a mental disorder, questions arise as to how to respond to such individuals during incarceration. A suit filed in a federal court in Tennessee attributed the death by heart failure of a jail inmate with a mental illness to the use of excessive force by jail officers. The suit claimed this excessive force was the result of a failure to train jail officers in how to "recognize, handle, and appropriately apply force to mentally ill or emotionally disturbed" inmates. The lawsuit asserted that an officer used excessive force against an inmate whose bipolar disorder and manic depression led him to resist wildly officers during intake and his subsequent transfer to the jail's medical unit. The Supreme Court declined to review a ruling of the Sixth Circuit that dismissed this lawsuit.

To prevail, the Sixth Circuit said the plaintiff must show (1) that the existing training program inadequately addressed the tasks that officers must perform, (2) that the inadequacy was the result of the city's deliberate indifference to inmates' rights, and (3) that the inadequacy was closely related to or actually caused this inmate's injury.

The Sixth Circuit concluded the plaintiff did not establish that the county responsible for the inmate's care failed to maintain an adequate training program for its correctional officers. The Sixth Circuit noted the county followed the guidelines of the Tennessee Corrections Institute for dealing with emotionally or psychologically disturbed inmates. It also cited the existence of an instructor's guide that described various psychological disorders that officers are likely to encounter in inmates and guidelines for handling mentally ill inmates. In contrast, the court found that the plaintiff had not provided any evidence that these instruction materials were in fact not used. The court determined that an officer's failure to recognize that an inmate was mentally ill, despite a number of glaring indications that he was, did not, by itself, demonstrate that the training was inadequate.

The Sixth Court also ruled the second required showing was not satisfied because no evidence had been presented regarding a pattern of similar violations at the jail or by this particular officer. Finally, the court held that the third requirement was not met because the plaintiff failed to demonstrate that the injury would have been avoided had the officer been trained under a program that was not deficient. Carey v. Helton, 70 Fed. Appx. 291 (6th Cir. 2003), *cert. denied*, 124 S. Ct. 1506 (2004).

**Ruling That Upholds Use of Correctional Facility Housing and Reliance on Group Therapy and Polygraph Exams for Individuals Civilly Committed as Sexually Dangerous Person Not Disturbed**

The Supreme Court declined to review a ruling of the Seventh Circuit that rejected a challenge brought by 27 individuals committed under the Illinois Sexually Dangerous Persons Act. Under this Act, persons charged with sex offenses may be diverted before trial to a mental health program if a mental illness of at

least one year's duration led to the criminal charge. Those who complete treatment successfully are released and the criminal charges dismissed.

These individuals complained that they are confined in a correctional facility where they mingle with convicted inmates during meals and on some other occasions. The Third Circuit ruled that this housing arrangement was permissible because criminal charges were still pending against them. As pretrial detainees, the court determined, they could be subjected to ordinary conditions of confinement and they had not established that their situation was worse than typically experienced by a pretrial detainee.

The court also rejected a complaint about the treatment offered these individuals. Reliance on group rather than individual therapy, the court concluded, was acceptable as officials had reasonably determined that the best treatment for sex offenders is group therapy in which the offenders admit their crimes, acknowledge the urges that drive them to perpetrate their crimes, and assist each other in overcoming those urges. The court also ruled that the use of polygraph examinations to check whether participants are being candid was permissible, as was the use of statements made by participants during therapy sessions in subsequent criminal proceedings. Allison v. Snyder, 332 F.3d 1076 (7th Cir. 2003), *cert. denied*, 124 S. Ct. 486 (U.S. 2003).

**Ruling That Incompetence During Post-Conviction Appeals of a Death Sentence Can Stay These Proceedings Not Disturbed**

Criminal defendants typically pursue a series of appeals after receiving a death sentence. If sentenced in a state court, they are required to initially pursue their appeals in the court system of that state. After exhausting those appeals, they may then file an appeal in a federal court asserting that their constitutional rights were infringed during their criminal trial or subsequent sentencing. One question that has arisen is whether this appellate process must be put on hold, effectively delaying the defendant's execution, if the defendant becomes incompetent.

The Ninth Circuit rejected an effort by a lower federal court to appoint an attorney as an incompetent defendant's "next friend" to continue to pursue the defendant's federal court appeals rather than grant a stay of these proceedings. The Ninth Circuit ruled that the appointment of a next friend was not an acceptable alternative in the case before it. The Ninth Circuit determined that the key question raised by the defendant's incompetence in this context was whether the defendant was capable of rational communication. The Ninth Circuit reasoned that the ability to communicate information that the defendant may alone possess can play a key role in the pursuit of these appeals and the appointment of a next friend may not adequately redress a lack of competence to communicate this information to and assist counsel.

The Ninth Circuit noted two possible claims in the case before it where information that only the defendant could provide, if he was competent, could be pivotal: (1) that the defendant was incompetent to stand trial and that trial counsel were constitutionally ineffective for failing to pursue a competency hearing and (2) that trial counsel presented inadequate mitigating evidence during the penalty phase. As a result, the Ninth Circuit remanded the case for a review of whether the defendant currently has the capacity to understand his position and to communicate rationally with counsel. This ruling was appealed to the Supreme Court but the Court declined to review the ruling. Woodford v. Rohan, 334 F.3d 803 (9th Cir. 2003), *cert. denied*, 124 S. Ct. 809 (U.S. 2003).

**Ruling That Mental Health Interviews Triggered by Suicide Threat Admissible at Defendant's Criminal Trial Not Disturbed**

The Supreme Court declined to review a ruling of the Ninth Circuit that upheld the admission into evidence of jailhouse

interviews of a criminal defendant by three mental health professionals who had not provided a Miranda-like warning prior to these interviews. The Ninth Circuit found these interviews admissible because they had been conducted in response to the defendant's suicide threats and not to provide law enforcement officials with incriminating information. When the defendant placed his mental state in issue at trial by raising a sanity defense, the Ninth Circuit determined that the use of these interviews to rebut this defense did not violate the defendant's Fifth Amendment privilege against self-incrimination. Dustin v. Ramirez-Palmer, 80 Fed. Appx. 542 (9th Cir. 2003), *cert. denied*, 124 S. Ct. 1417 (2004).

**Ruling That Refused to Recognize "Dangerous Patient" Exception to Federal Psychotherapist-Patient Testimonial Privilege Not Disturbed**

The Supreme Court declined to review a ruling of the Ninth Circuit that concluded that although therapists have a duty to warn authorities about patients' threats to inflict serious harm on others, this does not mean therapists may testify in subsequent federal court proceedings about these statements. In this case, the defendant suggested during therapy sessions that he might kill or injure FBI agents and other individuals. The defendant was subsequently convicted of threatening to murder federal agents after the psychotherapist testified at trial about the defendant's threats,

The Ninth Circuit held the psychotherapist's testimony should not have been admitted because the defendant's conversations with her were protected by the federal psychotherapist-patient testimonial privilege. The court refused to recognize a "dangerous patient" exception to this privilege. The court determined that just because therapists have a duty to warn authorities about patients' threats, this does not mean they may testify in court proceedings about confidential statements made during therapy sessions. The court reasoned that the urgency to act that creates a duty to warn will normally have subsided by the time the case is brought to trial. The court concluded the protection of society would increase only slightly by allowing this testimony and it would not outweigh the harm done to the psychotherapist-patient relationship. The Ninth Circuit ruling is consistent with that of the Sixth Circuit, but contrary to that of the Tenth Circuit. United States v. Chase, 340 F.3d 978 (9th Cir. 2003), *cert denied,* 124 S. Ct. 1531 (2004).

**Rulings That Alcohol Abuse Does Not Have to Be Specifically Delineated in Capital Jury Instructions as a Potential Mitigating Factor Not Disturbed**

The Supreme Court declined to review a ruling of the Fifth Circuit that rejected a capital defendant's argument that the jury during his sentencing hearing had been provided inadequate instructions regarding his alcohol abuse. Texas law delineates issues the jury must address in reviewing potentially mitigating evidence during sentencing. The defendant argued this framework was unconstitutional because it did not specifically identify alcohol abuse as a potential mitigating factor.

In rejecting this argument, the Fifth Circuit noted that the Supreme Court in *Penry v. Lynaugh*, 492 U.S. 302 (1989), established that a sentencing jury must be given adequate means of giving effect to mitigating evidence of severe mental retardation and abuse. The Fifth Circuit, however, determined that *Penry* also established that this type of evidence is limited to evidence that demonstrates a "uniquely severe permanent handicap with which the defendant was burdened through no fault of his own" and that neither evidence of alcoholism nor evidence of intoxication at the time of the offense constitutes this type of evidence. Furthermore, the Fifth Circuit added, the jury was able to give mitigating effect to evidence of the defendant's alcoholism under instructions to consider the deliberateness of the defendant's conduct and his future dangerousness. Harris v. Cockrell,

313 F.3d 238 (5th Cir. 2003), *cert. denied sub nom.*, Harris v. Dretke, 124 S. Ct. 1503 (2004).

The Supreme Court also declined to review a similar ruling of the Fifth Circuit that in more abbreviated fashion dismissed a defendant's assertion that the Texas capital sentencing scheme was unconstitutional because it did not specifically direct the jury to consider the mitigating evidence of his drug and alcohol use at the time of the offense, a history of drug and alcohol abuse, a long history of severe abuse as a child, a pattern of suicide attempts and substance abuse within his immediate family, and impairment of his mental, academic, social, and behavioral functioning. Miniel v. Cockrell, 339 F.3d 331 (5th Cir. 2003), *cert. denied*, 124 S. Ct. 1413 (2004).

**Ruling That Stalkers Can Be Banned from a County Not Disturbed**

The Supreme Court declined to review a ruling by the Court of Appeals of Wisconsin that upheld the issuance of what was characterized as a "get out of Dodge" court order that banished a non-resident from a county in Wisconsin following decade-long stalking behavior, the ignoring of previous cease and desist orders, and two instances in which the banished person had used her automobile as a dangerous weapon. The Wisconsin court said the order was justified because the woman posed a constant and dangerous threat any time she was present in the county and because her statements on the record "indicate an absolute fixation" on the targets of her stalking. The court said a more narrowly tailored order would not deter the woman from harassing and endangering the lives of the victims and this geographical restriction would provide them with a "margin of territorial safety in which they can live in peace."

A concurring judge to the Wisconsin ruling asserted that although the order would prevent the woman from visiting her mother, the woman's dangerous behavior and the need to protect the victims' constitutional rights provided grounds for the order. This judge recognized four distinct categories of stalkers: stalkers who suffer from delusional erotomania, stalkers who suffer from borderline erotomania, "former intimate" stalkers, and sociopathic stalkers. The judge also noted that stalking is a gender-neutral crime; that it is typically an escalating behavior, with almost one-half of all victims reporting that their stalkers directly threaten them; that victims do not just suffer physical injuries but also profound, long-term emotional injuries; and that 70% of all protective orders are violated by the stalker. O'Connor v. Predick, 660 N.W.2d 1 (Wis. 2003), *cert. denied*, 124 S. Ct. 809 (2003).

**Ruling That Kindergarten Student Can Be Suspended for Saying "I'm Going to Shoot You" to a Friend During Recess Not Disturbed**

The Supreme Court declined to review a ruling of the Third Circuit that upheld the three-day suspension of a New Jersey kindergarten student that said "I'm going to shoot you" to his friends while playing cops and robbers in the school yard during recess. In reaching its conclusion, the Third Circuit determined that the school officials' actions were justified in part by a widely-reported shooting two weeks earlier of a six-year-old child by another six-year-old child at an elementary school in Michigan. S.G. v. Sayreville, N.J., Bd. of Educ., 333 F.3d 417 (3d Cir. 2003), *cert. denied*, 124 S. Ct. 1040 (2004).

**Ruling That High School Teacher Can Be Fired for Non-School Related Activities as Member of Organization That Advocates Pedophilia Not Disturbed**

The Supreme Court declined to review a ruling of the Second Circuit that held that a school board could fire a high school teacher who belonged to an international organization that advocated the legalization of sexual relations between men and boys. The teacher had taught high school science for over 30

years at one of three highly selective science-oriented high schools in New York City, and had received several commendations for his school activities and teaching. He is a self-described pedophile although there was no evidence he engaged in any illegal or inappropriate conduct at the school. His outlet for his proclivity was his participation in the international organization, which he joined around 1980. He founded a publication of the organization, for which he served as editor and contributed articles. Following a television program on public school teachers who were members of the organization, many parents expressed anger at the teacher's affiliation and sought his removal, which subsequently occurred.

The Second Circuit, while noting the constitutional protection afforded the rights of freedom of association and speech, upheld the teacher's termination. The court determined that the State has greater discretion to regulate the speech and activities of its employees than it does private citizens in general because of its interest in promoting the efficiency of the public services it performs through its employees.

The court employed a two-part test. Under the first part, the court determined that the teacher's speech related to a matter of public concern (i.e., advocacy for a change in public perception and law) and so was entitled to a certain level of protection.

Under the second part, however, the court concluded that the state's interest in efficient public service outweighed free speech concerns, notwithstanding that (1) the activities occurred outside the workplace and were largely unconnected to it, and (2) the school board's basic justification for the termination was the community's reaction to these activities and the probability of future rather than past disruption to school activities.

The court emphasized that the role of public school teacher requires a degree of public trust not found in many other positions of public employment and that in this context the teacher's activities struck such a sensitive chord as to justify the school board's action. The court reasoned that the teacher's presence would compromise the learning environment because (1) it was likely to provoke anxiety and be a disruptive experience for the average student, and (2) parents would so fear his influence and predilections that they would remove their children from the school and impair both their children's education and the operations of the school. Meltzer v. Board of Educ., 336 F.3d 185 (2d Cir. 2003), *cert. denied*, 124 S. Ct. 1424 (2004).

**Ruling Not Disturbed That ADA Claims Against the Government Do Not Require a Showing That Nondisabled Persons Treated Better**

The Supreme Court declined to review a ruling of the Second Circuit that individuals with a disability who claim the government has failed to reasonably accommodate their disability as required under Title II of the Americans with Disabilities Act (ADA) do not have to show that the government treated nondisabled individuals better (i.e., that there was a "disparate impact"). The case involved a lawsuit by HIV-infected individuals who allege New York City violated the ADA by not providing them with adequate access to public social service benefits such as food stamps, welfare benefits, and Medicaid coverage. The city responded there was no ADA violation because the plaintiffs received the same—albeit difficult to obtain—access to services as persons without disabilities.

The Second Circuit rejected this defense and ruled it was sufficient for the plaintiffs to show their disability was making it difficult for them to access these benefits, even though access was also difficult for individuals without a disability. The court concluded the ADA and the Supreme Court's interpretation of the ADA in *Olmstead* do not require disabled plaintiffs to identify a comparison class of similarly situated individuals given preferential treatment. Instead, it is sufficient for them to show they are being denied access to public

benefits to which they are legally entitled and it does not matter that this lawsuit will have the effect of providing plaintiffs with benefits beyond those made available to eligible individuals in general. Henrietta D. v. Bloomberg, 331 F.3d 261 (2d Cir. 2003), *cert. denied*, 124 S. Ct. 1658 (2004).

**Ruling That Permanent Guardian Should Be Appointed for a Woman with an Obsessive Compulsive Disorder Not Disturbed**

The Supreme Court declined to review a ruling of the Appeals Court of Massachusetts that upheld the appointment of a permanent guardian for a woman with an obsessive compulsive disorder. The Massachusetts test for appointing a guardian is that there must be a finding that the individual is incapable of taking care of himself/herself by reason of mental illness. To establish that a person is incapable of taking care of himself/herself, there must be a showing that the person is either (1) unable to think or act for himself/herself regarding personal health, safety, and general welfare, or (2) unable to make informed decisions as to property or financial interests.

In this case, the Massachusetts appeals court determined these requirements were met by findings that the woman has a failure of memory so pervasive that it affects her ability to function; a mental condition rendering it difficult for her to maintain a habitable environment; an inability to manage independently her nutrition or follow a medication schedule; a lack of understanding of the value of her house, its condition, how to renovate it, or the need to renovate it; and an unrealistic fixation on shortly returning to live in an uninhabitable house. The court further determined that these findings should not be disturbed simply because the woman's primary care physician a year earlier had stated that she did not require a guardian. The court noted that the physician identified a decline in the woman's condition as the reason for her change of opinion. Similarly, the court ruled that a contrary finding made at a conservatorship hearing over a year earlier was not controlling. At the same time, the presiding judge could rely on findings made three months earlier when there was evidence of mental illness and resulting incapacity so severe that it would be highly unlikely to dissipate. Finally, the court concluded that a medical certificate was not necessary to establish a guardianship or conservatorship, but instead they could be based on any sufficient evidence. Guardianship of Gill, 792 N.E.2d 718 (2003), *cert. denied sub nom.*, Gill v. Guardianship of Gill, 124 S. Ct. 1440 (2004).

**Court to Review Ruling That Execution of Juvenile Offenders Is Unconstitutional**

The U.S. Supreme Court agreed to review a decision by the Missouri Supreme Court that bans the execution of juvenile offenders. Fifteen years ago, the U.S. Supreme Court in *Stanford v. Kentucky*, 492 U.S. 361 (1989), ruled it was constitutional to execute offenders who were 16 or 17 years old when they committed their crimes.

The Missouri Supreme Court, however, took the relatively unusual step of holding that if the U.S. Supreme Court was to re-examine this issue in light of developments since the *Stanford* decision, it would now find such executions to be unconstitutional. The Missouri Supreme Court applied the test recently used by the U.S. Supreme Court to bar the execution of mentally retarded offenders. The Missouri court determined that recent legislative enactments, the unwillingness of juries to impose death sentences on juveniles, the views of respected national religious, social, and professional organizations, and its judgment that juveniles are less culpable than adults compelled it to conclude that evolving standards of decency necessitated its ban of juvenile executions. Roper v. Simmons, 112 S.W.3d 397 (Mo. 2003), *cert. granted*, 72 U.S.L.W. 3310 (U.S. Jan. 26, 2004) (No. 03-633).

**Request to Forcibly Treat Non-Dangerous Criminal Defendant to Restore Competence Denied**

In one of the first applications of the U.S. Supreme Court's recent decision in *Sell v. United States*, 123 S. Ct. 2164 (2003), a federal district court in Virginia denied a request to forcibly medicate a criminal defendant to restore him to competence to stand trial. The defendant is alleged to have threatened a Department of Agriculture employee after the defendant received a past due notice on his housing loan. The charged crime is classified as a misdemeanor under federal law. The court held that this offense met the *Sell* requirement of a "serious offense" but did not meet the *Sell* requirement that there be an important governmental interest at stake in pursuing prosecution.

The court stated that defendants may be involuntarily medicated to restore competence only in "rare" circumstances when an "essential" or "overriding" state interest is present. One such set of circumstances is if the defendant poses a danger to himself or others or is considered gravely ill. No such assertion was made here. Absent this, the court determined that *Sell* establishes a four-part test: (1) there must be an important governmental interest at stake, (2) the medication must be substantially likely to render the defendant competent and must be substantially unlikely to cause side effects that will interfere significantly with the defendant's ability to assist in his trial defense, (3) alternative, less intrusive treatments must be unlikely to restore competency, and (4) the administration of the medication must be medically appropriate.

Applying the first factor, the court found that *Sell* establishes that the government interest in bringing an individual to trial is important only when the individual is accused of a "serious crime" but that *Sell* does not define what constitutes a serious crime. The court determined that the appropriate dividing point is a term of imprisonment exceeding six months. Because the potential penalty for the charged crime in the case before it was up to one year of imprisonment, the court held that the defendant was charged with a serious crime.

However, this did not end the court's analysis under the first factor. The court said *Sell* establishes three "special circumstances" as also relevant: (1) the potential for further confinement if forcible medication is not ordered, (2) whether the defendant has already been confined for a significant amount of time for which the defendant will receive credit during sentencing, and (3) whether a delay in prosecution will prejudice the government in that its witnesses might become unavailable or their memories are likely to fade.

The court concluded these three factors undercut the government's interest in prosecuting the case before it. First, the court found that because the defendant suffered from a long-standing serious mental illness (paranoid schizophrenia), the absence of treatment was likely to result in his continued confinement in a mental health institution, thereby lessening any danger he might pose to others or any risk that he might flee before prosecution. Second, the court found that the defendant had already been held in custody for over a year and even if he was convicted and sentenced to the maximum term, he would not serve any time in jail because he would receive credit for the time he had been in custody since his arrest. Finally, the court noted the government had not produced evidence that a continued delay would prejudice its ability to eventually prosecute the defendant.

As a result, the court held the importance of the government's interest in having the defendant treated over his objection was not sufficiently strong and denied the

government's request to forcibly medicate him to restore his competence to stand trial. In addition, the court found that without antipsychotic medication the defendant was unlikely to be restored to competence in the foreseeable future. This suggests that the requirement established in *Jackson v. Indiana*–that an unrestorably incompetent defendant be released, civilly committed, or civilly certified–was now applicable. United States v. Evans, 293 F. Supp. 2d 668 (W.D. Va. 2003).

**Psychotic Disorder Does Not Preclude Individual from Being Found Competent to Be Executed**

Percy Levar Walton, who was sentenced to death for killing three neighbors in 1996 in Danville, Virginia, was found competent to be executed by a federal district court in Virginia. Following conflicting evidence on whether Walton was competent to be executed, a forensic psychiatrist was appointed as the court's expert. This expert opined that Walton suffers from a significant psychiatric disorder, most likely schizophrenia, that he has limited cognitive ability, that he is not malingering, that he believes that after his execution he will go to heaven and come back to see his family, that he knows he is in jail for murdering three people, and that he knows he is to be executed.

In making its ruling, the Western District Court of Virginia adopted the test articulated by U.S. Supreme Court Justice Powell in his concurring opinion in *Ford v. Wainwright*, 477 U.S. 399 (1986), a standard also adopted by the Fifth and Eighth Circuits. This test requires courts to examine whether the defendant understands (1) he is to be punished by execution and (2) why he is being punished. The court concluded that this test does not prevent a defendant from being executed merely because he or she suffers from a mental illness. The court determined that even though Walton suffers from a psychotic disorder, he understands that he has received an execution sentence for murdering three individuals and being executed means he will die. Thus, the court held Walton is competent to be executed. Walton v. Johnson, 306 F. Supp. 2d 597 (W.D. Va. 2004).

In a companion ruling, the court held that the Commonwealth of Virginia, which by statute precludes post-conviction review in state court of a defendant's claims that he is mentally retarded or incompetent to be executed, must demonstrate why it should not bear the cost and expenses of related proceedings that occur in federal court. Walton v. Johnson, 306 F. Supp. 2d 602 (W.D. Va. 2004).

**Mental Health History Insufficient Mitigating Evidence to Undercut Death Sentence**

The Virginia Supreme Court upheld the conviction and death sentence given Paul Warner Powell for the killing of a young woman during the commission of a rape. On appeal, Powell argued his history of mental health problems and a lack of adequate treatment when he was in state custody as a juvenile militated against the death penalty. In rejecting this argument, the court noted that Powell's mental health expert did not offer a specific diagnosis of Powell's mental health problems but merely suggested he had an anti-social personality disorder and a mood disorder. The court found this testimony failed to address the test for a mental health based mitigating factor established by the Virginia Code, namely, whether there was a significant impairment of the defendant's capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. As a result, the court determined the jury had properly concluded that Powell's history of mental health problems did not mitigate his offense. Powell v. Commonwealth, 590 S.E.2d 537 (Va. 2004).

**Death Penalty Avoided for Law School Shooter Because of Concerns About Mental Status**

A plea bargain was struck between prosecutors and the former student who killed

three people and wounded three others at the Appalachian School of Law in 2002. Peter Odighizuwa pleaded guilty to the shootings in exchange for life in prison. Although found mentally competent to stand trial, he had been diagnosed as paranoid schizophrenic. Prosecutors issued a statement that they had "concerns over the mental issues in the case and thus the commonwealth determined this was the most just result." Chris Kahn, *The Associated Press*, Feb. 28, 2004.

**911 Report from Neighbor That Person Is Suicidal Is Not Sufficient Basis for Police Officer to Seize Person for Emergency Mental Evaluation When Officer Observed Person and Saw Nothing Indicating a Danger to Self**

Riding his bike while intoxicated, a 41-year-old North Carolina man fell down in his neighbor's yard. The neighbor called 911, which led to a report to the police that he was intoxicated and had told his neighbor that he was depressed and going home to commit suicide. After returning home, the man was visited by a responding police officer.

Although disputed, there was evidence that the man invited the officer into the house, resumed eating his lunch at a dining room table, and in response to a series of questions denied any thoughts of suicide. There were no weapons or any other indications of preparations for a suicide attempt in view. After five minutes of questioning, the officer was apparently satisfied and the man asked the officer to leave, escorted him out of the house, and closed the front door.

As the first officer stepped onto the porch, a second officer arrived to whom the first officer may have said "we're going to have to do something." The second officer then knocked on the front door. After telling the second officer that the suicide report was "crazy," that the officers "need[ed] to leave," and that he was going to call his lawyer, the man attempted to close the door. The second officer grabbed the man's arm in an attempt to pull him onto the porch, a fight ensued, and in the course of being subdued the man was struck in the face multiple times, kicked in the back, handcuffed, and dragged by his feet to the curbside. Stitches and repeated surgeries were needed to repair the injuries the man incurred. The man sued the officers, arguing the officers did not have probable cause for an emergency mental health evaluation. The officers responded the neighbor's 911 report had established the needed probable cause.

The Fourth Circuit rejected the officers' assertion. The court noted there is a general right to be free from a mental health detention unless there is probable cause to believe the individual poses a danger to him or herself or others. The court added it has been clearly established that a police officer may not detain someone for an emergency mental health evaluation based only on a 911 report that the person is suicidal when the officers are able to observe the person and see nothing indicating the person might be a danger to himself.

The court determined the officers had no evidence to support the assertion in the 911 report that the man was suicidal. The court noted the man denied the suicide reports and was not visibly distraught, there were no weapons or other suicide preparations evident, and the first officer had voluntarily left the house after talking to the man for five minutes. The court acknowledged that what constitutes "dangerousness" in the mental health seizure context is not precisely defined, but asserted that no reasonable officer upon seeing another officer voluntarily leave a house could have thought the person within the house was in such imminent danger of harming himself that immediate seizure was required without any additional investigation, deliberation, or consultation with the first officer who had just been inside the house. The court also concluded that the amount of force used was excessive.

A dissenting opinion argued that rarely, if ever, will a person serious about suicide admit as much in response to an officer's inquiry and there was probable cause for the officer's detention. Bailey v. Kennedy, 349 F.3d 731

(4th Cir. 2003), *reh'g denied & en banc reh'g denied*, 360 F.3d 470 (4th Cir. 2004).

**Parental Rights of Woman with Bipolar Disorder Terminated When She Failed to Maintain Treatment Regime**

The Virginia Court of Appeals upheld a decision to terminate the parental rights of a woman with a bipolar disorder. Two years previously the woman had called the Richmond Department of Social Services and indicated she was unable to care for her two infant children. Her home was found in disarray, the children were removed from the home, and the mother admitted herself to a psychiatric ward. During the next 18 months, efforts were made to reunite the family. However, a psychiatrist who worked with the mother during this time testified that, although the mother's condition was treatable, it could only be controlled if the mother took her medications regularly as prescribed, and the mother consistently failed to do so. Evidence was also provided that the mother was still unable to provide for her children, was unable to maintain consistent employment or suitable housing, and was unable to complete parenting and anger classes.

Notwithstanding the mother's protestations that she had greatly improved in recent months, the court concluded that it was not in the best interests of children to spend a lengthy period of time waiting to find out when or if their parents will be capable of resuming their responsibilities. The court found that the mother had not provided a stable environment for children and had been unable to address her lack of parenting skills, and thus terminated the mother's parental rights. Sanchez v. Richmond Dep't of Soc. Servs., Nos. 1125-03-2, 1677-03-2, 2003 WL 22232770 (Va. Ct. App. Sept. 30, 2003).

**Grandparent Visitation Rights Not Established by Death of One Parent**

A claim that a grandparent was entitled to court-ordered visitation rights following the death of a child's mother was rejected by the Virginia Court of Appeals. Although the father conceded the grandmother had a valuable relationship with the child and supported its continuation, he opposed court-ordered visitation. The court noted that absent a showing of "actual harm" to the child's health or welfare without such visitation, it must be presumed that fit parents act in their children's best interest. The court refused to order grandparent visitation when there was no showing that the father was not a "fit, loving, and responsible parent" who did not exercise parental authority in an appropriate way. Although mentioned, the fact that the child's parents had not married did not appear to influence the court's decision. O'Leary v. Moore, No. 3187-02-2, 2003 WL 21524689 (Va. Ct. App. July 8, 2003).

**Lawsuit Settled That Prison Use of Stun Gun Represented Excessive Use of Force**

Virginia reportedly paid $350,000 to settle a lawsuit that claimed that a "supermax" prison inmate's death resulted from the use of undue force by prison officers. The inmate, who suffered from diabetes, experienced hypoglycemia the morning of the events in question. He was taken to the prison's infirmary, where prison officials said he became combative and was shocked several times with an Ultron II, a stun gun that delivers 50,000 volts of electricity. According to the complaint filed by family members, the inmate was then placed in five-point restraint, was left alone as he fell into a coma, and, although ultimately released, died five days later. 18(27) Virginia Lawyers Weekly 655 (Dec. 8, 2003).

# *Cases in Other Federal Courts*

## Second Circuit

### Relaxed Rules Governing Admissibility of Evidence During Capital Sentencing Hearings Upheld

Mental health professionals are often called to testify about possible mitigating factors pertaining to the defendant during capital sentencing hearings. The Second Circuit was asked whether the rules of evidence that govern the admissibility of evidence during the guilt phase of a federal trial, must also apply during the capital sentencing phase. In particular, the court was asked to resolve whether the Federal Death Penalty Act of 1994 (FDPA) could constitutionally permit the admission of evidence (e.g., hearsay evidence) during the penalty phase of a capital trial that would not be admissible during the guilt phase under the Federal Rules of Evidence (FRE).

The Second Circuit ruled that the FDPA's broader admissibility of evidence standard during capital sentencing hearings was permissible as it did not infringe the defendant's Constitutional right to a fair trial. While recognizing that "heightened reliability" is essential to the process of imposing a death sentence, the court noted that the goal of the FDPA is to admit more evidence, not less, on the presence or absence of aggravating and mitigating factors. The court asserted that a long line of Supreme Court cases addressing capital sentencing have emphasized the importance of allowing the jury to have full and complete information about the defendant. The court added that the facts relevant to sentencing are far more diffuse than matters relevant to guilt for a particular crime, with inquiries into the defendant's character appropriate for sentencing but not for determinations of guilt. The court emphasized that under the FDPA evidence whose probative value is outweighed by the danger of unfair prejudice was still excluded. United States v. Fell, 360 F.3d 135 (2d Cir. 2004).

### Medical School Not Required to Waive Licensing Exam for Student with Dyslexia and ADD

The Second Circuit ruled that a medical school did not violate the Americans with Disabilities Act (ADA) when it dismissed a student suffering from dyslexia and attention deficit disorder after she failed a required licensing examination three times. The court stated that to prevail under the ADA the student had to show that she (1) was a "qualified individual" with a disability and (2) was discriminated against by reason of her disability.

The court first found she was not "otherwise qualified" to continue as a medical student. The court noted that her undergraduate grade point average and her composite MCAT score were significantly lower than those of her colleagues and she herself had shown the difficulties she experiences with basic memory function, vision, and reading comprehension. Thus she did not meet the essential eligibility requirements for participation in the program.

In addition, the court found no evidence that she was discriminated against on account of her alleged disability. Rather, the court noted the extensive efforts the medical school had made to help her succeed in its program, including providing her with tutors and giving her multiple opportunities to remediate classes she had previously failed.

The court added the school was not required to waive the requirement that she pass this licensing exam because to permit a student who did not prove her mastery of basic medical sciences to advance into the later stages of medical school and become a treating physician would unreasonably alter the nature of this program and was not required by the ADA. The court also noted that when reviewing the substance of an academic decision, courts should accord the faculty's professional judgment great

deference. Powell v. National Bd. of Med. Exam'rs, 364 F.3d 79 (2d Cir. 2004).

## Fourth Circuit

### *Ake* Does Not Require the Appointment of a "Forensic" Mental Health Expert

The Fourth Circuit upheld a North Carolina judge's refusal to appoint a forensic psychiatrist in a capital murder case. For some time before and after the offense, the defendant was treated by a psychiatrist and a psychologist. At a pre-trial hearing, the defendant sought state-funded appointment of a forensic psychiatrist, arguing that this type of expert was needed to help him prepare his legal defense of insanity. The trial court, however, denied the request because the defendant could utilize the assistance of the treating psychiatrist and psychologist.

Applying the Supreme Court ruling in *Ake v. Oklahoma*, 470 U.S. 68 (1985), the Fourth Circuit determined that the defendant must show that (1) he will be deprived of a fair trial without the requested expert assistance or (2) there is a reasonable likelihood that this assistance will materially assist him in the preparation of his case. The court concluded that if the defendant already has access to a competent psychiatrist who can assist his defense, sufficient access to a mental health expert is assured and the state need do no more. The Fourth Circuit added that there was no showing that the two mental health professionals who were treating the defendant would be unable to assist him in his defense or that they would be unavailable to testify on his behalf.

The Fourth Circuit rejected defendant's assertion that *Ake* mandates access to a forensic mental health expert when sanity will be a significant factor at trial. The court determined *Ake* only requires the aid of a "competent" psychiatrist, not a "forensic" psychiatrist, and was unwilling to rule that a non-forensic mental health expert is categorically "incompetent" to assist a defendant. Page v. Lee, 337 F.3d 411 (4th Cir. 2003).

### Claim Against Case Manager and Health Plan for Rampage Following Release of West Virginia Inpatient Dismissed by Fourth Circuit

A lawsuit was brought against an entity that managed the behavioral healthcare component of a preferred provider organization (PPO) plan and one of its case managers for their role in the release of a man from an inpatient mental health care facility. The West Virginia man, eight days after his release, murdered his wife and daughter, injured his son, and then committed suicide. He had been hospitalized following an assault of his wife and his attempted suicide after learning his wife was having an affair with another man. Following four days of inpatient treatment for depression, his treating physician determined the man was neither delusional nor psychotic, no longer posed a risk of harm to himself or others, and could not be held against his will under West Virginia law. Arrangements were made for him to receive outpatient care in his community but scheduled appointments were not kept. The case manager was alleged to be negligent in her (1) monitoring of the outpatient treatment, (2) failure to obtain rehospitalization once non-compliance with outpatient treatment services became apparent, and (3) failure to warn family members who were foreseeable victims of the man's mental illness.

The Fourth Circuit ruled the claims were pre-empted by the federal Employee Retirement Income Security Act (ERISA) and were properly moved from state court to federal court because the defendants were not engaged as treatment providers, did not make any treatment decisions, and were not involved in the treatment decisions made by the man's physicians. The court emphasized that the case manager did not talk to the doctors who did treat the man or influence their treatment decisions. This preemption had the effect of defeating any state malpractice claims against these two defendants.

The Fourth Circuit then proceeded to dismiss the ERISA claim that defendants had breached their fiduciary duty to administer the insurance plan in an appropriate manner. The court found there was insufficient evidence to support a claim the case manager and her employer had denied a benefit to which the man was entitled or had administered the plan in such a manner as to cause him injury. The court noted the man insisted on leaving the inpatient facility to return to work, expressed a preference for the outpatient facility selected, and was released only after a team of health care providers determined he could not be kept against his will based on his medical condition at the time. The court concluded the thrust of the complaint was directed at this medical decision and not against the administration of the insurance plan by the case manager and her employer. While this might form the basis for a state malpractice claim against the healthcare providers, it did not support a claim against the case manager and her employer for breach of their fiduciary duty in violation of ERISA. Marks v. Watters, 322 F.3d 316 (4th Cir. 2003).

**Maryland School Board Not Required to Provide Immediately Equivalent Therapeutic Placement for Autistic Child When Services Previously Provided Become Unavailable**

The Individuals with Disabilities Education Act (IDEA) guarantees a free appropriate public education to children with disabilities. A seven-year-old autistic child had been receiving 20 hours per week of Lovaas therapy in his home from a state-approved provider pursuant to an Individualized Education Program (IEP) prepared by the school board and agreed to by his parents. When the services provided were discontinued, the school board proposed a new IEP, which the parents of the child challenged. The IDEA contains a "stay put" provision that the parents asserted requires the school board to propose an alternative, equivalent placement when the student's current placement becomes unavailable. The Fourth Circuit rejected this position and determined that the "stay put" provision only prohibits a school board from removing a student with a disability from a current placement during proceedings designed to resolve the services to which the child is entitled. The court held that this provision did not impose any affirmative obligation on the school board to identify alternative placements when a previously provided service became functionally unavailable. The Fourth Circuit indicated that although various remedies were available to the parents, this was not one of them. Wagner v. Board of Education of Montgomery County, 335 F.3d 297 (4th Cir. 2003).

## Sixth Circuit

**HHS Fine Imposed on Ohio Skilled Nursing Facility for Escapes, Assaults by Residents**

A long-term care skilled nursing facility (SNF) in Ohio, which participated in the federal Medicare and Ohio Medicaid programs, housed 43 residents, more than two-thirds of whom displayed behavior symptoms of dementia. Facility surveys identified numerous incidents in which residents escaped from the facility or assaulted other residents. The United States Department of Health and Human Services (HHS) imposed a Civil Monetary Penalty of $33,650 after determining the SNF failed to provide "adequate supervision and assistance devices to prevent accidents" in violation of a federal regulation that requires such facilities to prevent accidents or the risk of accidents to residents. The HHS found the SNF had not taken relevant security precautions, such as closer supervision of residents known to be violent or flight risks, better counseling and medication of such residents, and more effective perimeter security.

The Sixth Circuit upheld the penalty. The court rejected the SNF's argument that the federal regulation cited as the basis for the penalty was not applicable because none of

the incidents were "accidents" but rather were intentional acts by the residents. The court reasoned that regardless of whether the incidents were accidents or not, they demonstrated a failure to adequately supervise the residents to prevent accidents. The court also rejected the SNF's argument that this imposed a strict liability standard because the incidents were unprovoked, unpredictable, and unpreventable. The court responded that the fault could be attributed to the SNF's failure to take all reasonable precautions to prevent residents' accidents. Incidents the court cited included allowing one resident to continue to share a room with a helpless resident whom he had already severely assaulted on several occasions, failure to restrain another resident after several prior escape attempts that night, and keeping a third resident in a room with a large, unlocked window even though he was known to be an escape risk.

Finally, the court rejected the SNF's assertion that the penalty should be reversed with regard to the residents that eloped because there was no showing that serious harm resulted and thus the residents were not in "immediate jeopardy" as required under the relevant federal regulation. The court concluded that given the number of elopements over the course of a few months, the vulnerable state of the residents, and the dangers of the outside world to residents in such a state, there was sufficient evidence to establish that sooner or later the elopements would likely cause serious injury and a "widespread potential for more than minimal harm" is sufficient to sustain the imposition of such a penalty. Woodstock Care Ctr. v. Thompson, 80 Fed. Appx. 962 (6th Cir. 2003).

## Seventh Circuit

### Bank That Closes Account After Customer Experiences Series of Epileptic Seizures in Lobby Not Subject to Claim for Intentional Infliction of Emotional Distress

A customer with epilepsy, depression, and a schizoid personality disorder sued his bank for intentional infliction of emotional distress under Illinois law when it closed his account after he experienced a series of epileptic seizures in its lobby. The Seventh Circuit rejected the claim when it ruled that, although the bank may have reacted callously, the customer failed to prove that the bank knew he would experience emotional distress if his account was closed. The court determined that even if the bank should have inferred from the customer's behavior that he has epilepsy, there was no evidence that this particular condition carries a heightened risk of emotional distress of which the bank should have been aware. The court added that the outcome might have been different if the bank's employees possessed medical training or if they had known that the customer was depressed or had another condition linked to emotional fragility. Sanglap v. LaSalle Bank, 345 F.3d 515 (7th Cir. 2003).

## Ninth Circuit

### Apartment Owners May Be Required to Adjust Their Financial Screening to Accommodate a Prospective Tenant with a Disability

The federal Fair Housing Amendments Act (FHAA) requires apartment owners to reasonably accommodate persons with a disability. The Ninth Circuit, disagreeing with the Second and Seventh Circuits, held that this requires apartment owners to take into account the inability of individuals with a disability to generate income by working. In this case, the apartment owner's policy was to require residents to have a minimum gross salary of three times the rent. Because the prospective tenant could not work because of his disability, he did not meet this financial requirement. However, his mother did meet it and offered to pay the rent as a cosigner on her son's lease agreement. The apartment owner rejected the rental application, citing its policy against allowing cosigners on lease agreements.

The Ninth Circuit ruled the FHAA requires apartment owners to make reasonable

modifications to otherwise applicable financial requirements, even though this accommodation may result in a preference for individuals with disabilities over otherwise similarly situated nondisabled individuals. The court noted the prospective tenant would have met the financial requirements if still able to work in the position he held before becoming ill and thus a direct causal link existed between the impairment, his inability to work, and his inability to comply with the financial requirement. The Ninth Circuit added that accommodations need not be free of all possible cost to the landlord, although the costs must still be reasonable. The court concluded that allowing the prospective tenant's mother to cosign was a reasonable accommodation. Giebeler v. M & B Assocs., 343 F.3d 1143 (9th Cir. 2003).

## Tenth Circuit

### Loss of Visitation with Young Daughter and Good Time Credit Not Impermissible Consequences for Prisoner's Refusal to Admit During Sex Offender Treatment Program That He Committed Charged Offense

A convicted sex offender while incarcerated was directed by prison officials to participate in a sex offender treatment program. This program mandated that the offender admit he had committed the offense (sexual assault of a minor) for which he was incarcerated. When the offender refused to do so, he lost a number of privileges, including visitation with his three-year old daughter and an opportunity to earn good time credits that would hasten his release. The offender asserted these limitations violated a number of his constitutional rights.

The Tenth Circuit rejected the prisoner's assertions. In addressing the denial of visitation, the court applied the Supreme Court's recent decision in *Overton v. Bazzetta*, 539 U.S. 126 (2003), which established that the Constitution allows prison officials to impose reasonable restrictions upon visitation. The court acknowledged that parents have an important constitutionally protected liberty interest in having a reasonable opportunity to develop close relations with their children and that visitation may significantly benefit both the prisoner and his family. However, the court found that two legitimate penological interests supported the ban, namely, the need to protect these children and the need to further the rehabilitation of convicted sex offenders. The court emphasized that prison administrators had offered some evidence that this contact could adversely affect both the child and the offender and the burden was on the prisoner to disprove the validity of their judgment, a burden that this prisoner had not met. The court also noted that the prisoner was allowed to contact his children by letter and telephone and that this provided a sufficient, even if not optimal, means of maintaining contact with his children. The court did recommend that prison officials seriously consider less draconian restrictions such as closely monitored, noncontact visitation.

The Tenth Circuit also applied the Supreme Court's recent decision in *McKune v. Lile*, 536 U.S. 24 (2002), in rejecting the prisoner's assertion that these actions constituted coercion in violation of his Fifth Amendment right not to incriminate himself. The Tenth Circuit was guided by Justice O'Connor's concurring opinion in *McKune* and determined that the test was whether the consequences of the prisoner's refusal to participate were "so great as to constitute compulsion." The court noted that most of the consequences faced by the prisoner resembled those faced by the prisoner in *McKune*, namely, a reduction in privileges and a transfer to a maximum security prison, and that Justice O'Connor characterized those changes as "minor." However, the Tenth Circuit noted two additional consequences here: lost opportunities to accrue good time credits and to visit with one's *own* children. Nonetheless, the court ultimately determined that neither constituted compulsion in violation of the Fifth Amendment. Wirsching v. Colorado, 360 F.3d 1191 (10th Cir. 2004).

## District of Columbia Circuit

### Michigan Medicaid Requirement That Forces Drug Manufacturers to Agree to Provide Rebates to Medicaid Beneficiaries or Be Placed on List Requiring Prior Authorization of Their Drugs Upheld

Medicaid continues to be the nation's largest provider of treatment services to individuals with a mental illness. As the increasing costs of Medicaid continue to press state budgets, many states have sought means to limit those costs and have often targeted the high costs of prescription drugs. Michigan, for example, adopted the "Michigan Best Practices Initiative," under which drug manufacturers are required to sign a rebate agreement with Michigan or their drugs will be placed on a list requiring "prior authorization" for reimbursement under the state's Medicaid program. Because prior authorization is expected to decrease demand for a given drug and diminish the profits of the drug manufacturer, this plan is expected to encourage drug manufacturers to agree to reduced prices for their drugs.

In upholding Michigan's program, the District of Columbia Circuit of the United States Court of Appeals said its analysis was enlightened by the Supreme Court's recent decision in *PhRMA v. Walsh*, 538 U.S. 644 (2003), which gave approval, although limited, to Maine's efforts to reduce drug costs for state residents by using Medicaid to pressure manufacturers to grant price rebates. The District of Columbia Circuit concluded the Michigan program did not violate the federal Medicaid Act or the Commerce Clause of the federal Constitution. Pharm. Research & Mfrs. of Am., 362 F.3d 817 (D.C. Cir. 2004).

## Alabama

### Landmark Case of Wyatt v. Stickney Ends

One of the landmark cases in mental health law has been brought to a close after 33 years. The original lawsuit, Wyatt v. Stickney, was filed in 1970 in federal district court and challenged the care provided a patient at Bryce Hospital, a state mental health facility in Tuscaloosa, Alabama. The case was ultimately expanded to encompass all mental health facilities in the state of Alabama and landmark rulings were issued on the rights of individuals placed in state mental health facilities that required significant changes in Alabama's mental health system. These rulings also became the model for change in other states. The case was recently dismissed at the request of attorneys representing both sides who said the state had met the requirements of a settlement agreement reached in 2000. When the case was filed, Alabama had 15,000 individuals placed in institutions and no community-based mental health system. Today, 1,500 individuals are in institutions and 100,000 people are reportedly served through community-based services. Phillip Rawls, *The Associated Press*, Dec. 6, 2003.

## District of Columbia

### GAO Issues Report on District of Columbia Mental Health System's Progress in Attempting to Comply with Court Order to Move to Community-Based System

In 1974, a class action lawsuit was filed in the U.S. District Court for the District of Columbia on behalf of residents of the District who were institutionalized at St. Elizabeths Hospital. In 1975, the court determined that the District had a statute-based responsibility to provide the plaintiffs community-based treatment in the least restrictive conditions when clinically appropriate. This ruling is known as the Dixon Decree. In 1980, the parties agreed on a plan that included the submission of periodic reports on progress in establishing a community-based system.

In 1997, the court found that the District had failed to comply with the Dixon Decree. The court placed what was then the District of Columbia Commission on Mental Health Services in receivership and appointed two successive receivers, one in 1997 and one in 2000. Both receivers were charged with

implementing the transition from treating consumers in an institutional setting to delivering a broader array of mental health services in the community. These services are to include counseling, supported employment, and housing.

In 2002, the District regained full control of its mental health system, but remains under court order to implement a plan for ending the lawsuit. In December 2003, the court approved a set of explicit exit criteria, which focus on consumer satisfaction, consumer functioning, consumer service delivery, and system performance, and 17 related specific performance targets. The U.S. General Accounting Office (GAO) was asked by Congress to report on the status of the District's effort to establish a community-based system of mental health care.

The GAO in its 56-page report (which includes a response from what is now the District of Columbia Department of Mental Health) provides a relatively comprehensive account of the required transition from an institution-based mental health system to a community-based system and the District's current efforts to comply with the court's order. The Report focuses on the District's efforts to develop and implement (1) a mental health department with the authority to oversee and deliver services, (2) a comprehensive enrollment and billing system that accesses available funds such as Medicaid, (3) a consumer-centered approach to services, and (4) methods to measure the District's performance as required by the court's exit criteria.

The Report contains a range of findings, including challenges faced by mental health care providers in managing cash flow in a fee-for-service system where service demand varies throughout the year and where providers did not always receive claims' payments on a timely basis in fiscal year 2003. It also noted gaps in documentation of consumer participation in treatment planning for 41% of the records reviewed.

In addition, the GAO concluded the District faces major challenges in accurately measuring its performance, including establishing methods to collect electronic data, correcting known data deficiencies, and working with providers to submit accurate data. The Report also noted that while the number of occupied beds at St. Elizabeths Hospital has declined about 18% from 2000 to 2003, the absence of additional community acute care beds, services, and supports has limited further reductions.

Although the court expects the District to implement the court-ordered plan and begin measuring its performance against the exit criteria by no later than 2007, the GAO Report suggested the District faces several challenges in meeting this expectation. United States General Accounting Office, *District of Columbia: Status of Reforms to the District's Mental Health System* (GAO-04-387) (March 2004), *at* http://www.openminds.com/indres/gaod04387.pdf (last visited June 2, 2004).

## Illinois

### Health Plan Required to Pay for Autism-Related Therapies

A health plan's refusal to cover various therapies for the autistic son of a participant in the plan was ruled to be arbitrary and capricious by a federal court in Illinois. The health plan refused to pay for physical/occupational/applied behavioral analysis therapies, sensory integration therapy, and speech therapy not related to prior ear infections. The explanations given were that (1) the plan did not cover chronic conditions or conditions of developmental delay and (2) the effectiveness of sensory integration therapy had not been proven. The court rejected the asserted explanations for the denial of coverage, finding that autism was a covered condition under the plan, the denials were not based on the language of the plan, and the cursory denials were not connected to the specific situation and the boy's diagnoses. The court concluded that because the plan

failed to make a rational connection between the evidence, the plan language, and its conclusion to deny benefits, the plan's refusal to provide coverage was improper. Wheeler v. Aetna Life Ins. Co., No. 01 C 6064, 2003 WL 21789029 (N.D. Ill. July 23, 2003).

## Michigan

### Intentional Fatal Overdose of Psychotropic Medication Defeats Claim for Related Medical Expenses Even if Death Was Not Intended

A health plan refused to pay medical expenses incurred after a participant in the plan was taken to an emergency room following the fatal self-ingestion of the psychotropic agent benzodiazepine, as well as codeine, meperidine, and morphine. Prior to his death, the individual had been treated for an opioid-type drug dependence and received weekly methadone and counseling treatments. The health plan refused to pay for the emergency room expenses on the ground the plan did not cover charges for self-inflicted injuries.

A federal court in Michigan upheld the health plan's refusal. The court noted that several courts have upheld claim denials subsequent to self-inflicted injury that was the result of the intentional misuse of drugs. The court determined the plan could reasonably conclude this individual intentionally ingested the drugs for a recreational, rather than a therapeutic, purpose and that because of his experience with these drugs he knew or should have known of the risks involved in taking them for an improper purpose. The court added that nothing in the records indicated he accidentally ingested the drugs or was not aware of the inherent dangers of their improper use. The court stated the pivotal question was whether the individual was aware that ingestion of drugs or engaging in other risk behavior could produce some injury. Thus, it was irrelevant that the individual may not have intended his death or the specific injury that resulted. Landis v. Healthcare Resources Group, LLC, No. 1:02-CV-530, 2003 WL 21684264 (W.D. Mich. July 3, 2003).

## New York/Puerto Rico

### Classification of Bipolar Disorders and Depression as Mental Disorders Upheld, Thereby Defeating Claims Seeking Long-Term Disability Benefits

A federal court in New York ruled that the administrator of a long-term disability benefit plan did not act unreasonably when it categorized a claimant's bipolar disorder as a mental rather than a physical disability and thereby limited the claimant's benefits to a maximum of 18 months. If her disorder had been classified as a physical disability she was entitled to benefits through the age of 65. The claimant had argued that her bipolar disorder was a physical disease because the disorder is rooted in the complex biochemical processes that occur within the brain.

While acknowledging that a bipolar disorder may have a physical cause and that medical authorities may ultimately determine that it is a physical condition, the court determined that the administrator was entitled to considerable deference in making the classification and that it was not unreasonable to determine that it was a mental disability given that it is listed in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV). The court was not dissuaded by the caveat contained in the DSM-IV's introduction that many disorders classified as mental disorders have physical components and that distinguishing between mental and physical disorders is a reductionistic anachronism. Fuller v. J.P. Morgan Chase & Co. Benefits Appeal Comm., No. 02-CV-5906, 2003 WL 21531005 (E.D.N.Y. July 1, 2003).

Similarly, a federal court in Puerto Rico upheld the decision by the administrator of a long-term disability benefit plan to classify a claimant's depression as a mental disorder, thereby limiting the claimant's benefits to a maximum of 24 months. The claimant alleged that he suffered from "frontal lobe syndrome," an organic condition in the brain, and

therefore was entitled to the more extended benefits available for a physical disability. The court noted the debate among the practitioners in this case and the medical community in general as to whether the symptoms of the claimant were indicative of an organic or a mental disorder. However, the court concluded that its role was not to resolve this debate but only to determine whether there was substantial evidence to support the administrator's finding that this illness was not a physical condition. The court found that the plan possessed such evidence when it acquired the supporting opinions of one of its own physicians and two independent physicians, conducted multiple and thorough reviews of the claim, and offered the claimant opportunities to submit new medical support for his claim. Vega-Muniz v. Metropolitan Life Ins. Co., 278 F. Supp. 2d 146 (D.P.R. 2003).

## Tennessee

### Settlement Approved of Lawsuit Designed to Supply More Home and Community Based Services for Individuals with Mental Retardation Who Are Eligible for Medicaid But Have Been Placed on Waiting Lists

The settlement of two class action lawsuits that focused on the lack of community services for individuals with mental retardation has been approved by the U.S. District Court for the Middle District of Tennessee. Plaintiffs had alleged that the state did not provide adequate services for individuals with mental retardation who are eligible for Medicaid services and have been placed on a waiting list or could have applied for waiver services but have not. The lawsuits complained about (1) the delay in receiving home and community based services after being placed on the waiting list, (2) the lack of available services, and (3) the lack of adequate information about the home and community based services program. They also complained that potentially eligible individuals were discouraged from applying for services.

Under the approved settlement, the State of Tennessee agreed to enroll nearly 2,000 people in new and existing community based mental retardation services provided by the state through its Medicaid program over the next two years. The settlement also establishes periods of time in which individuals eligible for waiver services should receive these services, with persons in a "crisis" category to receive them within 30 days of notification of eligibility and those persons not in "crisis" within 90 days. The agreement also requires the state to conduct an ongoing public information campaign to inform persons who are eligible for these services about what services are available and how they may apply for them. Brown v. Tennessee Dep't of Fin. & Admin., No. 3:00-0665 (M.D. Tenn., *settlement approval* 4/12/04); People First of Tenn. v. Neel, No. 3:01-0272 (M.D. Tenn., *settlement approval* 4/12/04). A copy of the settlement, which was approved without objection, can be found at <http://www.state.tn.us/mental/mrs/mhmr_announc.html> or <http://www.tpainc.org>.

## Wisconsin

### P&A Group Entitled to County Coroner's Investigation into the Death of a Prisoner with a Mental Illness

A federal court ruled that the Wisconsin advocacy group established under the 1986 Protection and Advocacy for Mentally Ill Individuals Act was entitled to obtain the records of a county coroner's investigation of a mentally ill prisoner's death. The coroner had cited state public record laws in delaying release of the records. The U.S. District Court for the Eastern District of Wisconsin determined that access to death investigation reports is essential to patient and advocacy systems' fulfillment of their federal statutory task of investigating the abuse and neglect of mentally ill individuals that leads to death, and preempts state laws restricting access to such records. Wisconsin Coalition for Advocacy Inc. v. Busby, No. 02-C-871 (E.D. Wis. 2003); 12(41) BNA's Health Law Reporter 1598-99 (Oct. 16, 2003).

# *Cases in Other State Courts*

## California

### Failure to Complete a Substance Abuse Diversion Program, by Itself, Is Not a Sufficient Basis for Disciplining a Physician

A California appellate court ruled that a physician's medical license could not be revoked solely because the physician failed to complete a substance abuse diversion program. The court concluded that the mere failure to complete a diversion program did not establish that the physician's ability to practice medicine was impaired due to misuse of drugs or alcohol. Medical Bd. v. Superior Court, 4 Cal. Rptr. 3d 403 (Ct. App. 2003).

### Punitive Damages Available for Elder Abuse by Health Care Providers

California has established various procedural requirements that limit a patient's ability to obtain punitive damages in a professional malpractice action against a health care provider. California has also established heightened civil remedies that can be pursued against health care providers that egregiously abuse elders in their custody. The question arose whether the punitive damages limitations applied to the elder abuse remedies. The California Supreme Court, in a unanimous opinion, has ruled they do not.

The plaintiffs had filed a suit for damages caused by defendants' care and treatment of their now-deceased father during the eight weeks that their father resided in defendant's skilled nursing facility in Los Angeles. Among other things, plaintiffs asserted that their father, who suffered from Parkinson's disease and was unable to care for his personal needs, was left unattended in his bed for long periods of time, was not provided assistance with feeding or hydration, became malnourished and lost much of his body weight, and was left in his excrement for long periods of time.

In permitting the plaintiffs to pursue their claim for punitive damages, the court noted that the California legislature in 1991 had expanded the remedies and damages available under the Elder Abuse Act to promote the cause of elderly persons and dependent adults subjected to physical abuse, neglect, or financial abuse. The court noted this Act was designed to address the failure of those responsible for attending to the basic needs of elderly or dependent adults to carry out their custodial obligations. The court concluded the Act encompassed an area of misconduct distinct from professional negligence and thus the California limits on punitive damages in professional malpractice actions against health care providers was not applicable. Covenant Care, Inc. v. Superior Court, 11 Cal. Rptr. 3d 222 (2004).

### Case Settled in Which Accusation of Elder Abuse Tied to Failure to Provide Pain Relief

A doctor and a Northern California nursing home settled a lawsuit accusing them of elder abuse for refusing adequate pain relief to a patient. At least two similar lawsuits have been filed in California that assert that to deny older patients proper pain management constitutes elder abuse, one of which resulted in an award of $893,888. Tomlinson v. Bayberry Care Center, No. C02-00120 (Cal. Super Ct., *settlement* 7/9/03); 12(34) BNA's Health Law Reporter 1310 (Aug. 21, 2003).

### Duty to Prevent Mentally Ill Persons from Leaving Their Care Not Imposed on Ambulance Drivers

After returning from a visit to an emergency room, a woman who had been acting strangely for several days continued her strange behavior and complained "[t]hey're coming." At 2 a.m., she left the house where she was staying and began walking down the street. A sheriff's deputy was summoned by the family of the woman but found the woman

articulate and calm. He determined that her mental status did not permit him to detain her under California law. Because the woman indicated a desire to go to a hospital and speak with a psychiatrist, the deputy summoned an ambulance. The two emergency medical technicians (EMTs) who responded discussed the woman's mental state with the deputy and pointed out that transport to the hospital under these circumstances would be voluntary and could be terminated by the woman. The woman, accompanied by her husband, agreed to go. The EMTs recorded in their log that they believed that detention by the deputy would have been appropriate. During the ride, the woman developed a feeling that the EMTs were going to confine or harm her in some way. When the ambulance reached the hospital and the door of the ambulance was opened, the woman dashed out of the ambulance. Neither EMT attempted to stop the woman. The woman crossed a highway, climbed over a median barrier, and was hit and killed by a vehicle.

A California Court of Appeals ruled that EMTs do not have a legal duty to prevent a person who voluntarily rode in their ambulance from leaving that ambulance, despite their belief or suspicion that the person was "mentally unbalanced." The court determined that a "special relationship" did not exist between the EMTs and the woman that imposed on the EMTs a duty to protect her from the harm she suffered. The court rejected the notion that persons who have accepted responsibility to care for others automatically owe them a duty of reasonable care to prevent harm if they learn these individuals may pose a danger to themselves. Before such a duty arises, the court held, a special relationship has to have been established and this typically requires a promise to protect and a reliance on that promise.

In this case, the court found no such promise or reliance. The court refused to conclude that merely because the EMTs agreed to transport the woman, at her request, to a hospital, they also undertook to "protect her from her own suicidal, reckless or irrational subsequent conduct." The court added it was reluctant to recognize such a duty because it might make such emergency services less available to individuals with a mental illness. The court also noted the lack of a causal connection between the EMTs' conduct and the woman's death and doubted they knew she was likely to be a danger to herself or others. Hernandez v. KWPH Enters., 10 Cal. Rptr. 3d 137 (Ct. App. 2004).

## Connecticut

### Physicians Who Submitted Reports About Competence of Psychiatrist to Practice Safely Not Entitled to Absolute Immunity

The Appellate Court of Connecticut allowed a psychiatrist whose license to practice had been suspended to sue four other physicians for alleged malicious submission of false reports about him to the Connecticut Department of Public Health. The four physicians had asserted that their reports, which expressed their concern about the psychiatrist's ability to practice psychiatry safely, were entitled to absolute immunity from civil liability.

The court ruled that the physicians were only entitled to qualified immunity, which could be overcome if the psychiatrist presented proof of malice (i.e., that the four physicians did not reasonably believe their assertions to be true) in the submitting of the reports. Even though under Connecticut law the physicians were entitled to absolute immunity for statements made in connection with quasi-judicial proceedings, the court determined that the legislature had modified this rule when it enacted the state's health care provider reporting statute and that this modification controlled. The court concluded the legislature wanted to discourage individuals, who otherwise would be protected, from acting out of an improper motive in light of the potentially devastating impact of these reports on a physician's ability to practice medicine. As a result, the case was returned to the trial court so that the psychiatrist might have an

opportunity to establish the physicians had acted with malice in filing their reports.

A dissenting judge asserted that the physicians were entitled to absolute immunity because anything less would fail to defuse the chilling effect the threat of a lawsuit can have on the willingness of individuals to file reports that a physician cannot provide competent medical care. The dissent also noted the number of other contexts in which absolute immunity is afforded in quasi-judicial proceedings. Chadha v. Charlotte Hungerford Hosp., 822 A.2d 303 (Conn. App. Ct. 2003).

## Florida

### Appointment of Guardian for Fetus of Mentally Incapacitated Woman Rejected

In a much-anticipated decision, a Florida court of appeal has ruled that the fetus of a mentally incapacitated woman who was raped while living in a group home is not entitled to the appointment of a separate guardian in a state action to establish protective services for the woman. *In re* Guardianship of J.D.S., 864 So. 2d 534 (Fla. Ct. App. 2004).

### Parental Notification Requirement When Minors Seek Abortions Rejected as Infringing Minors' Right to Privacy

Addressing the decision-making competence of minors, the Florida Supreme Court ruled that a state law requiring that parents be notified if their minor child seeks an abortion impermissibly intrudes on a minor's explicit right to privacy under the Florida Constitution. Characterizing this as a "fundamental right," the court said the state failed to demonstrate a compelling state interest in imposing the notification requirement. The court determined that the state's asserted rationale that such notification was necessary to allow parents to assist in providing post-abortion care to their minor child had not been sufficiently established. North Florida Women's Health and Counseling Services, Inc. v. Florida, 866 So. 2d 612 (Fla. 2003).

## Georgia

### Georgia Supreme Court Rules Jury Not Required for Determination of Whether Capital Defendant Is Mentally Retarded and Beyond a Reasonable Doubt Standard for This Determination Is Constitutional

The Georgia Supreme Court, on a 4-3 vote, ruled the federal constitution does not establish that a jury must determine whether a defendant is mentally retarded in a capital case or prevent the state from requiring that a claim of mental retardation be established by proof beyond a reasonable doubt. In reviewing the impact of *Ring v. Arizona*, 536 U.S. 584 (2002), the court concluded it only requires a jury determination of facts that establish the *upper* limit of punishment for particular criminal conduct and did not establish a right to have a jury determine factors, such as mental retardation, in mitigation of punishment. After applying *Atkins v. Virginia*, 536 U.S. 304 (2002), the court also ruled that *Atkins* did not adopt any particular standard of proof in prohibiting states from executing individuals with a mental retardation and thus Georgia was not precluded from imposing the beyond a reasonable doubt standard on claims of mental retardation during capital sentencing.

The dissenting judges rejected this analysis and asserted that Georgia could impose no more than a preponderance of the evidence test. They stressed the considerable risks of an erroneous determination, noting that mentally retarded offenders are more prone to make false confessions, have a lesser ability to make a persuasive showing of mitigation, may be less able to give meaningful assistance to their counsel, are typically poor witnesses, and may exhibit a demeanor that creates an unwarranted impression of lack of remorse for their crimes. Because their diminished capacities leave them vulnerable to a significant risk of being wrongfully executed, the dissent asserted the state should be prohibited from executing defendants once they have shown that it is more likely than not that they are mentally

retarded. The dissent added that Georgia is the only state that requires defendants to show their mental retardation beyond a reasonable doubt. Head v. Hill, 587 S.E.2d 613 (Ga. 2003).

It might be noted that in 2003 the Virginia General Assembly established a statutory scheme for determinations of mental retardation in capital sentencing. Va. Code § 19.2-264.3:1.1. Under the Virginia framework, a preponderance of the evidence standard is applied. In addition, the determination of the presence or absence of mental retardation during capital sentencing must be made by the jury if the initial trial was held before a jury; if the trial was before a judge (i.e., the defendant waived his or her right to a jury trial), then the determination of mental retardation in capital sentencing is to be made by the judge.

## Illinois

### First Capital Defendant in Cook County Found Ineligible for Death Penalty Because of Mental Retardation

A capital defendant in Cook County in Illinois was found to be mentally retarded and ineligible for the death penalty after having been measured as having an IQ of 75. This was reported to be the first individual in Cook County, and perhaps in the state of Illinois, to have had the prospect of a death penalty in a capital murder case removed by a determination that the individual is mentally retarded. Jeff Coen, *IQ Knocks Out Death Penalty: Defendant Found Mentally Retarded*, Chicago Tribune, Apr. 20, 2004.

## Louisiana

### Employee Not Subject to Criminal Prosecution for Watching Fellow Employee Abuse Group Home Resident

A mental health care facility employee who witnessed another employee physically abuse a resident of a group home for mentally disabled individuals cannot be prosecuted under a Louisiana law prohibiting cruelty to the infirm according to a Louisiana appellate court. The complaint alleged that the victim had been taken to a room where the victim was cursed and struck on the buttocks with a long wooden board. The court ruled that, according to the existing statute, only those individuals who knowingly participated in the planning or execution of a crime could be prosecuted and mere presence at the scene of the crime did not suffice. Simply witnessing an offense by another did not constitute the requisite intentional or criminally negligent mistreatment or neglect of the victim. The court noted the prosecution did not allege that the defendant actively participated in the offense, that she had a duty to intervene on behalf of the victim, or that she had a duty to report the abuse and failed to do so. State v. Walker, 853 So. 2d 746 (La. Ct. App. 2003).

## Michigan

### Psychiatrist Not Liable for Fraudulent Claims Submitted Under His Name When He Did Not Sign the Submissions and Was Not Aware of the Claims or Involved in Providing the Claimed Services

The Michigan Court of Appeals ruled a psychiatrist could not be held liable for fraudulent Medicaid submissions made by the company for which he worked as a consultant, even though the submissions were made under his name. Between 1991 and 1993, the company billed the state's Medicaid program for $142,560, using the psychiatrist's typed name and provider number, for services the psychiatrist did not provide. In conjunction with his employment, the psychiatrist had completed a form supplied by the state that allowed the company to use his provider number to submit claims and receive Medicaid payments. The form stated that both the company and the psychiatrist would be "jointly and severally liable" for any overpayments.

The court determined the psychiatrist was relieved from liability because the claim forms did not meet the statutory certification requirements as they contained neither his

signature nor the name of the person typing his name on the claim forms. Thus, because the claims should not have been paid in the first place, the court concluded the psychiatrist could not be held jointly and severally liable for the overpayments. The court rejected the state's argument that the psychiatrist had a duty to ensure that all claims submitted under his provider number were accurate because here the psychiatrist was neither involved in providing these services nor did he have knowledge of the claims or payments. Silverman v. Director of Mich. Dep't of Community Health, No. 236473, 2003 WL 21702519 (Mich. Ct. App. July 22, 2003).

## New Jersey

### Physician Who Incorrectly Told Patient He Was HIV-positive Held Liable for Emotional Damages

A jury award of $300,000 against a physician who, following a blood test, incorrectly told a patient he was HIV-positive was upheld by the New Jersey Superior Court, Appellate Division. In 1991, the plaintiff had visited his girlfriend's family physician to be tested for HIV. A couple of weeks later the physician called the girlfriend and informed her that the plaintiff had tested positive for HIV. Plaintiff called the physician, who said there was no possibility the results were a mistake. The physician referred the plaintiff to a physician at an AIDS clinic, who did not retest the plaintiff but subsequently referred plaintiff to another medical center when the plaintiff did not qualify for any clinical trials. On visiting this medical center, plaintiff informed staff that he was HIV-positive. He was monitored for two-and-a-half years but was never retested. In 1994, plaintiff sought counseling from a therapist because he was considering suicide. The therapist was suspicious of the HIV diagnosis and had plaintiff retested, which showed he was HIV negative. Plaintiff continued to suffer psychological problems, including depression.

In upholding the jury verdict, the appellate court said there was sufficient evidence to justify a finding that the physician breached the applicable standard of care by failing to give the plaintiff pre-test and post-test counseling, by misinterpreting the test results, by incorrectly advising plaintiff that he was HIV-positive, and by giving the results over the telephone rather than informing plaintiff in person. The court added that the physician may also have breached standards of confidentiality by disclosing the test results to the plaintiff's girlfriend. The court also ruled that the jury could consider alleged emotional distress damages that occurred after the patient learned he was not HIV-positive. Doe v. Arts, 823 A.2d 855 (N.J. Super. Ct. 2003).

### New Jersey Upholds Grandparent Visitation Law and Permits Expert Testimony on Impact of Terminating Long-Standing Relationship with Grandparent

In contrast to the Iowa Supreme Court, which recently struck down that state's law authorizing grandparent visitation, *In re* Marriage of Howard, 661 N.W.2d 183 (Iowa 2003), the New Jersey Supreme Court ruled that New Jersey's grandparent visitation statute does not offend the rights of fit parents to determine the care and custody of their children. Furthermore, the court ruled that grandparents need only show by a preponderance of the evidence, rather than by clear and convincing evidence, that the child would be harmed if visitation were denied. The court added that expert testimony may be used to assess the effect on the child of terminating a long-standing relationship between the grandparents and the child. Moriarty v. Bradt, 827 A.2d 203 (N.J. 2003).

## New York

### Kendra's Law, Which Authorizes Court Orders Mandating Outpatient Treatment, Upheld by State's Highest Court

New York, like many states, has sought means to enhance treatment compliance by individuals with a mental illness who live in the community. The New York legislature in 1999 enacted what is known as Kendra's Law in

response to the death of a woman who was pushed before an oncoming subway train by a man diagnosed with paranoid schizophrenia who had not taken his prescribed medication. The law authorizes courts to issue orders that mandate compliance with an outpatient treatment plan if they find that an adult with a mental illness (1) is unlikely to survive safely in the community without supervision, (2) has a history of lack of compliance with treatment for mental illness, (3) is unlikely to voluntarily participate in recommended treatment, (4) is in need of assisted outpatient treatment to prevent a relapse or deterioration that would be likely to result in serious harm to the individual or others, and (5) will benefit from assisted outpatient treatment. The court must also find that assisted outpatient treatment is the least restrictive alternative. If the individual fails to comply with the ordered treatment, a physician may initiate, without a judicial hearing, the temporary placement for up to 72 hours of the individual in a hospital for an examination to determine whether continued hospitalization is required.

The New York Court of Appeals held the statute is constitutional. The court rejected an assertion that a judicial finding of incapacity should be required before a treatment compliance order can be issued. Although such a finding is required in New York before treatment can be provided over objection, the court determined that orders under Kendra's Law can not be used to mandate treatment over objection. The court stressed that violation of the order carries no sanction but only triggers heightened scrutiny on the part of the physician and possible temporary removal of the individual to a hospital for examination under traditional involuntary commitment standards.

The court also rejected an assertion that failure to provide notice and a hearing prior to temporary removal to a hospital violated due process. The court reasoned that the deprivation of liberty associated with this removal was outweighed by the fact that the risk of an erroneous detention was minimal and that a pre-removal hearing was not likely to reduce this risk. The court noted the number of findings that a court must make before authorizing an outpatient treatment plan. It also asserted that a court was not better situated than a physician to determine whether the grounds for detention had been met. The court added that the state had a "quite strong" interest in immediately removing from the streets noncompliant individuals previously found to be, as a result of their noncompliance, at risk of a relapse or deterioration likely to result in serious harm to themselves or others, including avoiding the longer periods of hospitalization that otherwise tend to accompany relapse or deterioration. *In re* K.L., 774 N.Y.S.2d 472 (N.Y. 2004).

## Ohio

### Capital Defendant Found Competent to Waive Right to Counsel and to Waive Right to Present Mitigating Evidence; Competency Evaluation Not Automatically Required When Both Waived

The Ohio Supreme Court upheld the death penalty issued to a defendant who had represented himself at trial after waiving his right to counsel and who had waived his right to present mitigating evidence during the sentencing hearing. On appeal and now represented by counsel, the defendant's attorneys asserted he was incompetent to waive both of these rights. They further argued a competency evaluation should be required whenever a capital defendant chooses both to represent himself and to waive presentation of all mitigating evidence.

In determining the defendant was competent to waive these rights, the court found no "indicia of incompetence" justifying a competency hearing. The court noted the U.S. Supreme Court in *Godinez v. Moran*, 509 U.S. 389 (1993), has established that the standard of competence to waive counsel is the same as the standard for competence to stand trial and that the Ohio test for ordering a competency hearing is whether the record contains "sufficient indicia of incompetence" to require an inquiry into the defendant's

competency. The court noted the prosecutor at trial had raised the issue of competence, both of the defendant's advisory attorneys disclaimed any concerns about the defendant's competence, and the trial judge did not see or observe anything about the defendant that called his competence into question.

The court applied a somewhat higher standard in evaluating the defendant's competence to waive the presentation of mitigating evidence. The test here was whether the defendant fully comprehended the ramifications of his decision and possessed the ability to reason logically (i.e., to choose means that relate logically to his desired ends). The court concluded that "nothing inside or outside the record" called the defendant's competence to waive his right to present mitigating evidence into question. The defendant had not exhibited irrational or erratic behavior or been disruptive during the proceedings, neither of his advisory counsel raised any questions about the defendant's competence, and his signed waiver of this right was "strong proof" that the waiver was valid. The court also dismissed the notion that a competency evaluation was required simply because the defendant chose to represent himself and rejected defendant's assertion that Ohio should join other states that do not permit waiver of mitigating evidence regardless of a capital defendant's wishes. State v. Jordan, 804 N.E.2d 1 (Ohio 2004).

**Licensure Revocation Not Required to Be Reversed Because Physician Purportedly Incompetent When Hearing Held**

An appellate court in Ohio upheld the permanent revocation of a physician's license to practice medicine in Ohio by the State Medical Board of Ohio (Board). The physician had been found to have engaged in repeated acts of criminal trespassing, aggravated menacing, telephone harassment, domestic violence, and probation violations and, following a hearing, was found to have demonstrated an inability to practice according to acceptable and prevailing standards of care by reason of mental or physical illness.

On appeal, the physician claimed that his behavior could be explained by a diagnosis of HIV Encephalopathy, a form of dementia, that he received following the hearing and that the Board had discriminated against him on the basis of his HIV in violation of Ohio law. The court noted the physician acknowledged the Board was unaware that he had HIV at the time of the hearing and thus the Board could not have discriminated against him on that basis.

The physician also asserted the hearing should not have been held because he was incompetent as a result of the effects of the HIV Encephalopathy at the time of the hearing and that the two-year statute of limitations on the filing of appeals of the Board's ruling should be extended because he had been of unsound mind. The court rejected both of these arguments after a review of the record showed that he had represented himself for two days, put on witnesses, and submitted exhibits at the hearing, notwithstanding his assertion as a physician that he was incompetent. Hosseinipour v. State Med. Bd., No. 03AP-512, 2004 WL 503941 (Ohio Ct. App. Mar. 16, 2004).

**West Virginia**

**West Virginia High Court Upholds Sex Offender Lifetime Registration and Public Notification via Internet Requirements**

In a ruling that tracks the reasoning applied by the U.S. Supreme Court in resolving similar federal claims, the high court of West Virginia ruled that the state's Sex Offender Registration Act (Act) and its imposition on certain sex offenders, in particular those found guilty of a sexual offense involving a minor, of lifetime registration requirements and mandated disclosure of personal information through community meetings and internet publication, do not violate the West Virginia Constitution.

First, the court ruled these provisions were permissible notwithstanding that they were imposed on individuals who had been convicted of their criminal offense prior to the enactment of these provisions. The court determined the Act was civil and nonpunitive in nature because the public records of each individual's conviction already persist for the life of these individuals and thus the registration and public dissemination requirements do not amount to an additional punishment that would violate the West Virginia *ex post facto* clause.

Second, the court found these requirements did not violate these individuals' procedural due process rights. The court rejected the assertion that such individuals should be entitled to a hearing to demonstrate that they have rehabilitated themselves and that any public disclosure of information should be limited to that reasonably necessary in light of each individual's risk of re-offending. The court noted that hearings must be held before a more onerous "sexually violent predator" label can be assigned and that a person can request a hearing to have this label removed due to rehabilitation. While indicating that it might be better if all sex offenders on whom a life-time registration requirement is imposed had a similar opportunity to end their registration requirement, the court concluded this was not sufficient to strike down the law under the West Virginia Constitution.

Finally, although the court chose not to rule on a substantive due process argument because it had not been raised before the lower court, it did indicate in a footnote that the individuals did not present strong factual support for their position when they failed to produce evidence that they had completed any courses of treatment, received counseling, or had a mental health professional that was willing to offer an opinion that they were not likely to re-offend. The court also noted that they all committed crimes at an age and of a nature that suggested a likelihood of re-offense. Haislop v. Edgell, 593 S.E.2d 839 (W. Va. 2003).

## Wisconsin

### Functional Incapacitation Related to Mental Illness Can Extend Period for Filing Medical Malpractice Claims in Wisconsin

A patient sued various mental health providers, claiming they had negligently treated her multiple-personality disorder with hypnosis to recover memories of childhood sexual abuse that were later found to be untrue. The providers asserted that the period of time allowed under Wisconsin law to file a medical malpractice action had passed. The patient responded that she was entitled to an additional period of time because she was mentally ill at the time the alleged negligence occurred.

The Wisconsin Supreme Court ruled that the relevant Wisconsin statute extended the usual three-year limit for filing a medical malpractice claim up to five additional years when the patient was mentally ill during this period. At the same time, the court ruled that not all diagnoses of mental illness qualified for this extension. The court determined that in this context "mental illness" is a legal term, not a medical standard, that focuses on functional incapacitation. Here, the court found, the disability must relate to one's inability to bring suit. The test adopted was whether a mental condition existed that rendered the person (1) functionally unable to understand or appreciate the situation giving rise to the legal claim so the person could assert a legal right or (2) functionally unable to understand legal rights and appreciate the need to assert them. After providing a relatively lengthy discussion of what has been recognized in other states and what constitutes the relevant functional incapacity, the court concluded that a "seriously disabling mental condition" was required. The court noted that a develop-mental disability might qualify, but not senility. The court added that retention of legal counsel did not automatically signal that the plaintiff's functional incapacity had ended. Storm v. Legion Ins. Co., 665 N.W.2d 353 (Wis. 2003).

# *Other Legal Developments*

**First Mental Health Court Established in Virginia**

Nearly 100 mental health courts have been established in the United States during the past few years. Concurrent with this development, the first mental health court has been established in Virginia. The Norfolk Circuit Court has begun to process separately eligible defendants with a mental illness. Rather than send individuals with a mental illness convicted of non-violent crimes to jail, the purported goal is to encourage treatment compliance through a program of court supervision similar to that used in local drug courts.

A team from mental health and social services will develop individualized plans for individuals with a mental illness charged with a non-violent crime and a program coordinator will facilitate interaction among the parties typically involved, including probation officers, the commonwealth's attorney, and the public defender's office. Participants are to be assigned a case manager and counselor and will be required to report back periodically to the court. Those who follow their treatment plan could have their required court appearances reduced. Participants may be required to plead guilty to the crime with which they are charged before being allowed to enter the treatment program and the presiding judge reserves the right to send non-cooperating participants to jail if he sees fit. Matthew Philips, *Norfolk Starts State's First Mental Health Court*, 18(32) Lawyers Weekly 1, 20 (Jan. 12, 2004).

**Virginia Will Supply License Status of Health Care Professionals to Interested Businesses Electronically**

On March 3, the Governor of Virginia, Mark Warner, announced the launch of an e-mail notification service to inform businesses of the license status of health care professionals in the state. Virginia is purportedly the first state to create such a program. Primary users of the service are expected to be hospitals, insurance companies, and health care corporations. Subscribers provide the license numbers of the individuals they want to track and e-mail notices will be sent when a health care professional's license is due to expire or has not been renewed, or when a disciplinary action has been taken. Users of the program pay an annual subscription fee, plus an additional monthly cost based on the number of licenses tracked. The service can be accessed at http://www.virginia.gov/dhp/demo/dhpserviceinfo.html. *Gov. Warner Announces E-Mail Service on State Licensing of Health Care Providers*, 13(11) BNA's Health Law Reporter 359 (Mar. 11, 2004).

**Report Finds Police and Prosecutors Endorse Electronic Recording of Criminal Interrogations and Call Made to Increase Their Required Use**

Illinois, Maine, and the District of Columbia require electronically recorded custodial interrogations in homicide investigations. Alaska and Minnesota further require that all custodial interrogations conducted in a place of detention be similarly recorded. A recent survey of 238 law enforcement agencies around the country that record the questioning of felony suspects found enthusiastic support for the practice among police and prosecutors. They reported that it eliminated the problem of suspects changing their stories and allowed juries to satisfy themselves that a confession was obtained honestly. A New York Times editorial recommended that more states enact laws adopting this practice. Thomas P. Sullivan, *Police Experiences with Recording Custodial Interrogations* (Center on Wrongful Convictions, Northwestern University School of Law, Summer 2004), *at* http://www.law.northwestern.edu/depts/clinic/wrongful/documents/SullivanReport.pdf (last visited June 23, 2004); *Recording Police Questioning*, N.Y. Times, June 15, 2004.

*Developments in Mental Health Law*
Institute of Law, Psychiatry & Public Policy
University of Virginia Law School
UVA Health System Box 800660
Charlottesville, VA 22908-0660