DEVELOPMENTS IN MENTAL HEALTH LAW

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Mental Health Courts: Moving Beyond the Drug Court Model

MHCs are relatively new in the realm of therapeutic adjudication. Of particular concern is whether the basic drug court model is appropriate for dealing with the special issues presented by offenders with a mental illness.

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Abstract. Mental Health Courts (MHCs) currently enjoy significant political support and popularity. Hailed as a solution to crowded prisons, strapped state and local budgets, and concerns about the welfare of offenders with a mental illness, since 1997 over a hundred of these courts have been established. MHCs also appear successful. Although research is preliminary, there are indications that MHCs provide offenders with a mental illness a more positive experience than the traditional criminal justice system. Using drug courts as a model for therapeutic justice has offered jurisdictions a readily accessible vehicle for creating and maintaining MHCs. As MHCs continue to develop and expand, deviation from the drug court model will lead to better and more effective treatment for mentally ill offenders.

Introduction

Therapeutic courts have enjoyed a recent surge in popularity. These courts provide an alternative to the traditional criminal justice system and focus on rehabilitation rather than deterrence or retribution.[1] Rather than rely on the adversarial model where the state is pitted against the defendant, these courts seek to promote a coordinated and integrated

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[1] Christin E. Keele, *Criminalization of the Mentally Ill: The Challenging Role of the Defense Attorney in the Mental Health Court System*, 71 UMKC L. REV. 193, 202 (2002).

response by the state to the challenges and needs posed by the offenders that appear before these courts. As a result, the judges in these courts tend to actively interject themselves in the cases brought before them.[2]

The increasing use of therapeutic courts can be traced to the perceived success of drug courts. As will be discussed, drug courts have been highly praised for diverting offenders with minor charges but significant substance addictions away from jail and into more effective and appropriate rehabilitative programs. Not surprisingly, drug courts have been widely used as a model for other specialty courts.

A newly emerging group of therapeutic courts are the mental health courts (MHCs). Many jurisdictions have introduced or plan to introduce MHCs as an alternative to typical criminal adjudication for persons suffering from mental illness. MHCs have arisen partly as a response to the increasing criminalization and incarceration of individuals with a mental illness. In conjunction with the move towards deinstitutionalization, individuals with a mental illness are less likely to be hospitalized and more likely to be found in the community.[3] Whereas in 1960, 500,000 individuals with a mental illness resided in public hospitals, the current census shows that only about 60,000 now live in such facilities.[4] Meanwhile, communities have often failed to provide an adequate support network to help individuals with a mental illness thrive and succeed in the community setting.[5] Not surprisingly, the number of prison inmates with a mental illness has steadily increased to 300,000,[6] and a survey by the Bureau of Justice Statistics found that 16% of the inmates in local jails, 16% of probationers, 16% of state prison

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[2] Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1060 (2003).
[3] H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization,* 52 PSYCHIATRIC SERVICES 1039, 1040 (2001).
[4] Risdon N. Slate, *From the Jailhouse to Capitol Hill: Impacting Mental Health Court Legislation and Defining What Constitutes a Mental Health Court*, 49 CRIME & DELINQ. 6, 12 (2003).
[5] E. F. Torrey, *Jails and Prisons—America's New Mental Hospitals*, 85 AM. J. PUB. HEALTH 1611, 1612 (1995).
[6] Alina Perez et al., *Reversing the Criminalization of Mental Illness*, 49 CRIME & DELINQ. 62, 63 (2003).

inmates, and 7% of federal inmates have reported a mental illness.[7]

The National Alliance for the Mentally Ill estimates that 25-40% of individuals with a mental illness will come into contact with the criminal justice system at some point in their lives.[8] Without adequate community treatment, individuals with a mental illness are more likely to be symptomatic in the presence of law enforcement officers and, subsequently, more likely to be arrested.[9] Officers may arrest a person who exhibits symptoms of mental illness in both an effort to stop disruptive behavior[10] and to help the person find food, safety, and shelter.[11] Rather than deal with the complexities of finding adequate care in the mental health system, assuming this alternative is available, officers may simply route the person into the criminal justice system. An officer's decision may in part rest on a belief that "deviant behavior can be dealt with quicker and more effectively within the criminal justice system than the mental health system."[12] Once taken into custody, an offender with a mental illness may find it difficult to obtain release on bond. As a result, the placement of individuals with a mental illness in this country's correctional facilities continues to increase.

During incarceration, the condition of inmates with a mental illness tends to deteriorate further. The stress of incarceration may exacerbate symptoms.[13] These inmates are prone to assaults, rapes, and other forms of victimization, and to being disciplined, including placement in solitary confinement, "for violation of codes of conduct that they cannot begin to understand while in crisis."[14] Not surprisingly, jail and prison inmates suffering from mental illnesses are more likely to commit suicide.[15] Furthermore, while in a correctional facility, adequate mental health treatment is unlikely. One study reported that "in excess of 20 percent of jails provide no formal access to mental health treatment" and "out of more than 3,000 jails nationwide, only 35 reflect [mental health treatment] models worthy of replication."[16] As a result, the consequences of serving a sentence while mentally ill are far harsher than for a non-mentally ill inmate.

Once individuals with a mental illness enter the criminal justice system, they are likely to recidivate.[17] Individuals with a mental illness "repeatedly cycle through the process, often charged with misdemeanors or low-level felonies as well as disorderly conduct."[18] The accumulation of even "low-level" convictions can in many jurisdictions lead to later, more significant felony convictions for being a "repeat offender."

Involvement with the criminal justice system tends not only to be detrimental to an individual with mental illness, it is also expensive for the community. The revolving door through which such individuals are shuffled costs taxpayers and communities both money and resources.

The increased criminalization of individuals with a mental illness, coupled with the suffering and inadequate treatment they

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[7] Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers: Special Report*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS *at*: http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf (1999).

[8] Anne M. Hasselbrack, *Opting Into Mental Health Courts,* 26(10) CORRECTIONS COMPENDIUM 4 (2001).

[9] Amy Watson et al., *Mental Health Courts and the Complex Issue of Mentally Ill Offenders*, 52 PSYCHIATRIC SERVICES 477, 478 (2001).

[10] Stephan Haimowitz, *Can Mental Health Courts End the Criminalization of Persons With Mental Illness?* 53 PSYCHIATRIC SERVICES 1226, 1226 (2002).

[11] Slate, *supra* note 4, at 14.

[12] Perez et al., *supra* note 6, at 64.

[13] Hasselbrack, *supra* note 8, at 4. *See also* Keele, *supra* note 1, at 196.

[14] Slate, *supra* note 4, at 13.

[15] Torrey, *supra* note 5, at 1612.

[16] Slate, *supra* note 4, at 14.

[17] Perez et al., *supra* note 6, at 64.

[18] Haimowitz, *supra* note 10, at 1226.

experience while incarcerated, motivated the development of an alternative to the traditional criminal justice system. While the traditional criminal justice system's emphasis on blame and retribution focuses on the past actions of criminal offenders, therapeutic justice embraces a different perspective. Therapeutic courts focus more on the person's future. MHCs in particular target an offender's potential treatment and successful reintegration into the community.[19]

Using Drug Courts as a Model for Mental Health Courts

MHCs are frequently founded on the drug court model. However, there are often significant differences between a substance-abusing offender and an offender with a mental illness. Although substance abuse and mental illness often co-occur, a MHC that recognizes their differences as well will be better suited to respond to the special problems posed by this population.

Drug Courts. While jurisdictions vary in their implementation of a drug court model, there are basic elements they tend to share. These include "immediate intervention, a non-adversarial process, a hands-on judge, treatment programs with clearly defined rules and goals, and a team approach."[20] Drug courts typically involve regular drug testing, coordinated case management, and a graduated system of rewards or sanctions.[21] Offenders that have committed violent crimes generally are not eligible to participate.

Referrals are based on evaluations by judges and probation officers of prospective candidates. These evaluations may consider an offender's criminal record, substance abuse and treatment history, symptoms, level of functioning, mental health history, social and family relationships, and employment status. If accepted, the offender must decide whether to participate in the program offered by the drug court.[22]

Generally, drug courts only admit offenders who submit a guilty plea or acknowledge a parole violation.[23] Few jurisdictions permit pre-trial diversion, which suspends adjudication until the offender has tried the rehabilitation program. Most drug courts opt for pre-diversion adjudication so that the sentence is already in place should the offender fail to successfully graduate from the program.[24]

Although the treatment received by participating offenders varies by jurisdiction, sobriety is always required. Some drug courts refer participants to a community-based rehabilitative program if caseworkers think the participant will respond to a particular program.[25] Other courts offer the same basic treatment to all offenders, varying only by the type of substance the person abused. All treatment programs require random and regular drug testing.

Compliance or non-compliance with treatment is rewarded or punished through a graduated system.[26] Rewards include praise from the judge, praise in front of other participants, or special recognition akin to a "gold star."[27] Punishments range from reprimands from the judge, to more intensive treatment, to short periods of incarceration, to removal from the program.[28]

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[19] Slate, *supra* note 4, at 15.
[20] Watson et al., *supra* note 9, at 478.
[21] Peter Anderson, *Treatment with Teeth, A Judge Explains Why Drug Courts that Mandate and Supervise Treatment Are an Effective Middle Ground to Help Addicts Stay Clean and Reduce Crime,* 14(11) AM. PROSPECT 45, 45 (2003).
[22] Judith S. Kaye, *Delivering Justice Today: A Problem-Solving Approach*, 22 YALE L. & POL'Y REV. 125, 136 (2004).
[23] *Id.* at 136. *See also* Wendy N. Davis, *Special Problems for Specialty Courts*, 89 A.B.A. J. 32, 36 (2003).
[24] Davis, *supra* note 23, at 36. *See also* Anderson, *supra* note 21, at 46.
[25] Eric Lane, *Due Process and Problem Solving Courts*, 30 FORDHAM URB. L.J. 955, 992 (2003).
[26] Anderson, *supra* note 21, at 46.
[27] *Id.*
[28] Lane, *supra* note 25, at 992.

Throughout the course of treatment, judges, attorneys, and social service providers seek to coordinate their efforts.[29] Courtroom participants step out of their traditional, adversarial roles and assume therapeutic ones.[30] When offenders first enter the program, there may be regular courtroom meetings that are preceded by reports from caseworkers and attorneys about each participant's progress.[31] Participants who successfully complete their program usually attend a graduation ceremony where they are congratulated for their hard work and success.[32] The sentence that was imposed when the participant entered a "guilty" plea is then suspended.

The basic drug court model is employed in over a thousand jurisdictions and enjoys substantial political support.[33] Media responses to drug courts have generally been very positive and support for them exists across the political spectrum.[34] For example, these programs are credited with reduced recidivism.[35] Two drug courts reported that recidivism rates for those that completed treatment were 30%, which compared favorably to the usual recidivism rate of 50-70% for drug offenders.[36] In addition, significant cost savings are attributed to these courts. One drug court was estimated to have saved $2 million compared to the traditional criminal justice approach.[37] Another cited advantage of drug courts is their ability to offer the opportunity for rehabilitation and sobriety in a highly controlled and coordinated setting. The success of drug courts spurred the growth of other alternative courts, including MHCs.

Basic Model of Mental Health Courts. Although there is not a single "Mental Health Court" model,[38] in most jurisdictions MHCs operate on the same model as drug courts and share many of the same characteristics. MHCs are usually (i) criminal courts (ii) with separate dockets for offenders with a mental illness (iii) that divert mentally ill offenders away from incarceration and into a treatment program and (iv) monitor progress in the treatment program, rewarding treatment compliance and sanctioning non-compliance.[39] In 1997, Broward County, Florida, became the first jurisdiction to offer a MHC alternative to offenders with a mental illness.[40] Broward County serves as a model of a successful MHC, although other jurisdictions have adjusted this model to suit their communities' needs.

Offenders with a mental illness are first identified following their arrest. MHCs seek early intervention through the timely identification of prospective candidates.[41] Priority may be given to those offenders whose mental illness directly led to their criminal behavior. A variety of mental illnesses may qualify an offender for participation in a MHC, but psychotic disorders tend to predominate.[42] Once a mental illness is identified, a county jail, police department, magistrate judge, attorney, family member, friend, or mental health provider may refer an offender to a MHC.[43] After referral, a judge evaluates, in coordination with attorneys

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[29] James L. Nolan, Jr., *Therapeutic Adjudication,* 39(2) SOCIETY 29, 30 (2002).
[30] *Id.*
[31] Lane, *supra* note 25, at 992.
[32] Anderson, *supra* note 21, at 46.
[33] *Id.* at 45.
[34] Nolan, *supra* note 29, at 29.
[35] *Drug Courts Proven Successful Over Longer Period,* 15(45) ALCOHOLISM & DRUG ABUSE WKLY. 1, 1 (2003).
[36] Anderson, *supra* note 21, at 46.
[37] *Id.* at 47.

[38] *See* John S. Goldkamp & Cheryl Irons-Guynn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*, BUREAU OF JUSTICE ASSISTANCE 1 (Apr. 2000).
[39] Allison D. Redlich et al., *The Second Generation of Mental Health Courts*, PSYCHIATRIC SERVICES (forthcoming) (manuscript at 1).
[40] Henry J. Steadman et al., *Mental Health Courts: Their Promise and Unanswered Questions*, 52 PSYCHIATRIC SERVICES 457, 457 (2001). *See also* Goldkamp & Irons-Guynn, *supra* note 38.
[41] Goldkamp & Irons-Guynn, *supra* note 38, at viii.
[42] Hasselbrack, *supra* note 8, at 25.
[43] Keele, *supra* note 1, at 199.

and mental health professionals, whether the person is eligible and appropriate for diversion.[44] In determining eligibility for diversion, MHCs, like drug courts, may consider the offender's social and criminal history, treatment history, social support network, and substance addiction. For one MHC, gender, prior violent behavior, and a gender-age interaction were the greatest predictors of inclusion in the program.[45] Because diversion is not automatic, there is some concern that only those offenders who are most likely to succeed in treatment or who would have been fine without MHC treatment are diverted, and not necessarily those who are most in need of this treatment.[46]

Like drug courts, if the MHC uses a post-adjudication model the offender typically must enter a guilty plea to participate.[47] In some jurisdictions, an offender can still opt-in to the MHC if found guilty after a trial.[48] The post-adjudication MHC operates on the theory that offenders will be more compliant with treatment if they know the sentence that will be imposed for noncompliance.[49] This approach also rests on the belief that requiring a guilty plea gives the offender an opportunity to acknowledge his wrongful behavior.[50] Upon successful completion of the treatment program, some courts expunge the conviction from the offender's record.[51]

Other MHCs offer pre-adjudication diversion as they prefer to wait-and-see if treatment will be successful before assigning criminal responsibility.[52] Critics of this approach assert that it makes it harder to try cases when people drop-out of the program because much time will have passed, contributing to witness unavailability and memory lapse.[53] Courts that employ pre-adjudication diversion dismiss the charges against the offender when treatment is successfully completed.[54]

Once a defendant with a mental illness has opted into a MHC, the individual receives coordinated treatment from psychiatrists, psychologists, social services, and the judicial system. Like drug courts, the judge plays a prominent role in MHCs.[55] Judges are more active in MHCs than they are traditionally; they offer reprimands, compliments, and support to MHC program participants.[56]

Compliance with treatment in a MHC is usually characterized as taking medication, refraining from criminal behavior, and, for many participants, abstaining from substance abuse.[57] Compliance or non-compliance is rewarded or punished accordingly. Compliance generally brings praise and peer acknowledgement, while non-compliance results in reprimands, more intensive treatment, or, in rare cases, disqualification from the treatment program.[58]

MHCs are relatively new in the realm of therapeutic adjudication. While MHCs are generally considered successful, their deployment, although growing, has been limited. Of particular concern is whether the basic drug court model is appropriate for

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[44] *Id.*
[45] Mary Lee Luskin, *Who Is Diverted? Case Selection for Court Monitored Health Treatment*, 23 LAW & POL'Y 217, 231 (2001).
[46] *Id.*
[47] *See* Goldkamp & Irons-Guynn, *supra* note 38.
[48] *Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform,* JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW (Jan. 2003), *available at* http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/index.htm (last visited Apr. 9, 2004) [hereinafter BAZELON].
[49] *Id.* at 12.
[50] Keele, *supra* note 1, at 202. *See also* John A. Bozza, *"The Devil Made Me Do It": The Legal Implications of the New Treatment Imperative*, 12 S. CAL. INTERDISC. L.J. 55, 71 (2002).
[51] BAZELON, *supra* note 48, at 10.
[52] *See* Goldkamp & Irons-Guynn, *supra* note 38.
[53] Haimowitz, *supra* note 10, at 1227.
[54] Arthur J. Lurgio et al., *Therapeutic Jurisprudence in Action, Specialized Courts for the Mentally Ill*, 84 JUDICATURE 184, 187 (2001).
[55] John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198, 1200 (2001).
[56] *See* Goldkamp & Irons-Guynn, *supra* note 38.
[57] *Id.*
[58] *Id.*

dealing with the special issues presented by offenders with a mental illness. As noted, there are differences "in populations, in diagnoses, in medical and social service needs, and in the issues associated with the identification and processing of cases of mentally ill defendants that may limit generalizations" from drug courts to MHCs.[59]

Altering the Drug Court Model for a Better Mental Health Court

Screening of Candidates. Drug court participation is generally only offered to those individuals who receive a referral, plead guilty, and are not violent offenders. Such requirements result in programs where participants are less dangerous and more committed to success, and thus are the most likely to benefit from the drug court's services.[60] These requirements coincide with the perception of American society that substance addiction is not a disease that needs treatment.[61] By not permitting every substance abuser to participate, drug courts are better able to avoid allegations that they are "soft" on crime. Furthermore, because most people do not believe that addiction should absolve an offender of responsibility for criminal behavior,[62] requiring a guilty plea to enter a drug court satisfies public demand that individuals benefiting from these programs accept responsibility for their behavior.

Because perceptions about mental illness may differ from perceptions about drug addiction, the criteria for entering a MHC should perhaps be different from those employed by drug courts. While it is considered important to screen out individuals who will not benefit from a drug court, a MHC may not need to engage in such restrictive screening. There is little dispute that individuals with a mental illness generally need treatment. Because such individuals can routinely benefit from MHC treatment programs, any person with a mental illness should have the opportunity to opt into a MHC. Limiting MHCs to individuals who fit a referral profile or for whom it has been established that their crime was the result of a mental illness delays treatment for those that do not qualify, notwithstanding that they have a similar need for medical and social services.

Nevertheless, there are valid reasons why a community may screen out some MHC candidates. In many jurisdictions, mental health resources are already stretched thin. Limiting MHCs to those who are most likely to benefit from the treatment provided can conserve scarce financial and community resources.

In addition there may be pragmatic reasons for limiting diversion to a MHC. While it may be difficult to divert only those individuals whose mental illness caused their criminal behavior, this limitation helps MHCs garner support in their communities. If a person's mental illness did not lead to the criminal activity, public opinion probably supports incarceration over diversion. The public considers these individuals to be responsible for their criminal actions and the law has historically dictated that they be punished for their behavior.

In contrast, if mental illness led to the criminal activity, these offenders tend not to be considered responsible for their behavior,[63] although they may still be viewed by the public as dangerous.[64] The insanity defense is supposed to provide a dispositional alternative for individuals whose mental illness caused their criminal behavior, but it has a low success rate and has been characterized by some as "an irrelevant option."[65] By diverting only mentally ill offenders whose criminality

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[59] Luskin, *supra* note 45, at 218-19.
[60] Anderson, *supra* note 21, at 47.
[61] Bozza, *supra* note 50, at 74.
[62] *Id.*
[63] Haimowitz, *supra* note 10, at 1226.
[64] Bernie A. Pescosolido et al., *The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons with Mental Health Problems*, 89(9) AM. J. PUB. HEALTH 1339 (1999).
[65] *Id.*

resulted from their illness, MHCs may enhance their public support and the likelihood of their continued operation.

The challenge of readily determining whether a mental illness directly caused criminal behavior, however, is illustrated by the criminal justice system's struggle to determine whether a person is "not guilty by reason of insanity." Screening out individuals whose mental illness did not cause their criminal behavior may therefore be too difficult and could lead to mini-trials before diversion. To avoid a drawn-out process, communities may find it expedient to simply open MHCs to any offender displaying symptoms of a mental illness at any point in the judicial process. Opening MHCs to more offenders risks that some will feign symptoms to gain entrance into a program seen as a much better alternative than jail. Although malingering is a real concern, MHCs can examine a candidate's history of mental illness and closely screen candidates who have no prior documentation of a mental illness.

Mandatory Guilty Pleas. Requiring that a person plead guilty to the charged offense to become eligible to participate may not be a suitable criterion for a MHC. While drug courts effectively use the sentence imposed after a guilty plea as a threatened sanction for non-compliance with treatment, this sanction may not be effective and may be inappropriate for individuals with a mental illness. If offenders with a mental illness are in some sense less responsible for their criminal conduct (but unable to successfully raise the insanity defense), then threatening to impose a sentence on them may not act as a deterrent or achieve any meaningful retribution.[66] In addition, because the defendant's mental status may be questionable, challenges might be raised regarding the viability of these pleas. Individuals who need mental health treatment should be able to get it without having to first plead guilty to a criminal offense.[67] Because treatment for a mental illness is often vital, eliminating this criterion for diversion to a MHC may ensure that more offenders with a mental illness receive needed treatment.

Although some jurisdictions that require adjudication of guilt before permitting diversion to a MHC expunge the conviction after successful completion of the program, expungement is not universal. Furthermore, even in jurisdictions that expunge the offender's record, the person must often make a special request for it,[68] which may prove a difficult task for someone with a mental illness. The consequences of a guilty plea can make it more difficult for these offenders to effectively cope with their mental illness. A criminal conviction reduces access to employment and housing, both of which these offenders need to successfully integrate into society and to cope with their mental illness.[69] A post-adjudication model that automatically expunges a conviction or a pre-adjudication model insures that these opportunities are not foreclosed to mentally ill defendants who successfully complete their treatment program.

The Inclusion of Non-Violent Felons. In addition to reducing the criteria for diverting offenders to MHCs, the range of offenses for which people can be diverted should be relatively broad. Here, the drug courts offer an excellent model. In many jurisdictions, as long as the offender has not committed a violent crime, he or she may be diverted into the drug court.[70] In contrast, when jurisdictions first introduced MHCs, most only accepted misdemeanants for diversion. Today, many jurisdictions are expanding the availability of diversion and now allow non-violent felons to enter MHCs.[71] For example, Broward County now makes third-degree felons (for acts like grand theft, burglary, and

[66] BAZELON, *supra* note 48, at 7.
[67] Davis, *supra* note 23, at 36.
[68] BAZELON, *supra* note 48, at 12.
[69] *Id.*
[70] Anderson, *supra* note 21, at 46.
[71] Redlich, *supra* note 39, at 8-9.

being a "repeat offender") eligible for diversion.[72]

Individuals with a mental illness who are charged with a felony may also greatly need and benefit from the programs provided by a MHC. If one of the justifications for MHCs is that offenders with a mental illness are less responsible for their actions, this rationale applies no less to felons than to misdemeanants. These arguments, coupled with the apparent success of MHCs with misdemeanants, should encourage jurisdictions to expand access to MHCs to all non-violent felons.

Capping the Length of Mandated Treatment. Particularly with regard to misdemeanants, one reason offenders may be reluctant to accept diversion to a MHC is that there is a chance that they will spend more time under supervision than they would have spent incarcerated. A similar dilemma is faced by defendants pondering whether to raise the insanity defense and risk involuntary hospitalization and subsequent supervision in the community for an indefinite period or accept a finite period of incarceration.

Some jurisdictions address this problem by mandating that MHC treatment for misdemeanants cannot exceed the normal criminal penalty for a misdemeanor. Other jurisdictions have specifically chosen not to create MHCs for misdemeanants because they know that supervision by a MHC is greater and more restrictive than the offenders would have experienced under the traditional judicial model.[73] Many arrests of individuals with a mental illness are precipitated by the need of the police to control inappropriate, misdemeanor-level behavior, coupled with an inability to access mental health services as an alternative to arrest.[74] Offering MHCs to these misdemeanants can help secure the services they need. Disproportionate periods of supervision should not be permitted to become an impediment to the use of the programs provided by MHCs.

Measuring Treatment Compliance. While a large percentage of individuals with a mental illness are also substance abusers,[75] there are some fundamental differences in attempting to measure the "success" of a participant in a MHC as opposed to a drug court. Program compliance in a drug court is readily assessed by whether the participant has stayed sober and avoided crime. While compliance in a MHC generally means taking medications as prescribed, it is harder to measure whether success has been achieved.[76] Some individuals may not respond significantly to medication or therapy, while those that do may still experience effects from their mental illness or suffer recurrent episodes, or, as discussed below, they may find that the side effects associated with their prescribed medication to be a considerable deterrent to treatment compliance.

While the success of a person in a drug court may be readily demonstrated by completing a year of treatment and staying sober, the criteria of success for an offender with a mental illness are less clearly defined and obtainable.[77] Because mental illness tends to be a chronic disease, relapses can be expected and may not reflect a failure to comply with a mandated treatment program. While there is evidence that the longer individuals stop abusing substances, the more likely they are to stay sober permanently,[78] there is not as strong a correlation between the length of medication and the absence of symptoms in individuals with a mental illness. Although regular compliance with prescribed medications can reduce symptoms and the risk of relapse, some mental illnesses are

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[72] *Mental Health Courts Expanding to Include Felonies*, 13(39) MENTAL HEALTH WKLY. 1, 2 (Oct. 13, 2003).
[73] *Id.* at 1.
[74] Haimowitz, *supra* note 10, at 1226.
[75] *Id.*
[76] BAZELON, *supra* note 48, at 16.
[77] Goldkamp & Irons-Guynn, *supra* note 38, at xii.
[78] Patricia A. Griffin et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVICES 1285, 1288 (2002).

relatively treatment resistant.[79] For example, schizophrenia, among the most debilitating of psychiatric disorders, is often chronic and associated with high relapse rates.[80] Individuals whose mental illness does not respond well to treatment may be unfairly sanctioned for a relapse that is largely beyond their control.

The "one size fits all" universal emphasis on sobriety may be effective in drug courts, but a MHC needs a more nuanced approach. MHCs may choose to emulate drug courts when addressing the substance abusing behavior of its participants by requiring sobriety, drug tests, and abstinence from criminal conduct. However, MHCs should employ multiple and more complex definitions of success for its participants. Success should be assessed on a more individualized basis because the required course of treatment and its effects will vary considerably across individuals.

Noncompliance and Sanctions. Drug courts use a variety of rewards and sanctions as incentives for offenders to comply with treatment. Rewards generally include extensive praise during status meetings with the offender.[81] Sanctions range from more intensive treatment requirements to reprimands from the judge to disqualification from the program and incarceration. Perhaps reflecting the fact that the two models are often similarly employed, a study of 20 MHCs found that 36% of them sanction non-compliant participants by adjusting services; 27% employ lectures, more court appearances, and judicial persuasion; 64% will consider using jail; and 18% will disqualify participants from the program.[82] While this graduated system of rewards and sanctions may be appropriate for substance-abuse offenders, its efficacy with offenders with a mental illness is less clear.

Praise and validation from the judge is probably an effective reward for treatment compliance in a MHC. However, the sanctions used by a drug court may be less suited for a MHC. With substance abuse, society often attributes a failure to stay sober to a lack of willpower.[83] Drug court sanctions are intended to enhance offenders' commitment to treatment. In contrast, noncompliance with treatment for mental illness stems from a variety of causes, most notably, the mental illness itself.[84] Persons diagnosed as paranoid schizophrenic may fear that their medications are not for their benefit but are part of an effort to attain control of their mind. The negative side effects of medication can also lead to noncompliance.[85] When it is an individual's mental illness or side effects from the medication that limits treatment compliance, it may be unfair and counterproductive to impose sanctions for noncompliance. The individual is not necessarily displaying a lack of willpower.[86] Before imposing sanctions, a MHC should assess whether the noncompliance was willful or unjustified.[87]

In addition, the treatment that is initially assigned by a MHC may not be effective. There is general consensus on the treatment regimen needed for graduation from a drug court and what is required is adherence to this regimen.[88] For a MHC participant, the treatment that is first selected may be relatively ineffective.[89] MHCs should define "compliance" as compliance with any

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[79] Davis, *supra* note 23, at 37; *Schizophrenia,* NATIONAL INSTITUTE OF MENTAL HEALTH, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES (Aug. 2002), *available at* http://www.nimh.nih.gov/publicat/schizoph.cfm#schiz3 (last visited Apr. 10, 2004).

[80] Raphael J. Leo & Paul Del Regno, *Atypical Antipsychotic Use in the Treatment of Psychosis in Primary Care,* 2 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 194, 195 (2000).

[81] Anderson, *supra* note 21, at 46.

[82] BAZELON, *supra* note 48, at 15.

[83] Davis, *supra* note 23, at 37.

[84] *Id.*

[85] Leo & Del Regno, *supra* note 80, at 197.

[86] Davis, *supra* note 23, at 37.

[87] BAZELON, *supra* note 48, at 16.

[88] Goldkamp & Irons-Guynn, *supra* note 38, at xii.

[89] BAZELON, *supra* note 48, at 16.

mandated treatment. Defining compliance as "taking the prescribed medications over a fixed period of time" reduces the likelihood that the offender will be inappropriately sanctioned for noncompliance when this noncompliance can be attributed to the failure of the treatment program rather than a lack of effort on the part of the offender.

The most severe sanctions employed by drug courts, namely, incarceration and disqualification from the program, may also be unsuitable for a MHC. When drug courts impose these sanctions for noncompliance, it is typically because a criminal act has occurred, such as ingesting an illegal substance. As a result there is a clear and widely understood definition of failure to adhere to the treatment program's requirements. In addition, a MHC participant's failure to take a prescribed medication, the predominant form of noncompliance in MHCs, is not criminal behavior.[90] As described above, this failure also may be attributed to a number of factors that are unrelated to the participant's efforts to comply with the program.

For drug courts, the threat of incarceration is considered a powerful and effective means of enhancing treatment compliance.[91] Substance abusers have the ability, at least while sober, to appreciate the impact of incarceration. Individuals with a mental illness may, in some cases, be unable to appreciate its consequences. Even if jail is an effective sanction, it may not be an appropriate sanction. MHCs exist to divert offenders with mental illness from the stress and mistreatment often associated with incarceration, as well as to reduce jail overcrowding.[92] Resorting to jail as a sanction tends to undermine these goals.[93]

Disqualification from a MHC program for noncompliance presents a similar dilemma as the imposition of incarceration. The purpose of diversion is to facilitate treatment. If a person's mental illness, adverse reaction to medication, or ineffective treatment leads to treatment noncompliance, it makes little sense to punish the individual by cutting off treatment and returning that person to the criminal justice system. Disqualification only delays access to necessary services.

Sensitivity to Potential Treatment Side Effects, Alternatives, and Expense. Drug courts have a limited need to be cognizant of the potential negative side effects of the treatment they mandate. With the exception of the initial period of withdrawal from an abused substance, mandated sobriety has few side effects for the participant. In contrast, the side effects of the medications typically used to treat mental illness can, depending on the medication, be severe and debilitating. In addition, whereas the treatment programs of drug courts are relatively uniform, there are a number of alternative medications available to treat mental illness and they may differ considerably in the risk they pose for the recipient.

Conventional medications used to treat mental illness can produce significant and even life-threatening side effects such as parkinsonism, akathisia, acute dystonia, and tardive dyskinesia.[94] They also may pose a range of less debilitating, but still disturbing side effects, such as dry mouth, constipation, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, and increased heart rate.[95] Recently introduced medications reduce the risk of some of the more debilitating side effects, but they may still

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[90] Aubrey Fox, *Is There a Fit? Drug Courts and the Mentally Ill Addict,* 41(1) JUDGES' J. 25, 27 (2002).
[91] Griffin et al., *supra* note 78, at 1288.
[92] Davis, *supra* note 23, at 37.
[93] BAZELON, *supra* note 48, at 16.
[94] *Medications,* NATIONAL INSTITUTE OF MENTAL HEALTH, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES (Apr. 2002), *available at* http://www.nimh.nih.gov/publicat/medicate.cfm#ptdep4 (last visited Apr. 10, 2004).
[95] *Id.*

interfere with an individual's daily functioning and be very unpleasant to experience. Side effects associated with the new generation of medications include sexual problems, headaches, nausea, insomnia, agitation, weight gain, and constipation.[96] There also remains some risk of more severe side effects, such as the development of diabetes.

Because even the newer medications used to treat mental illness may have significant side effects, one of the issues that MHCs may face more frequently than drug courts is how to respond when participants object to or even refuse to take prescribed medications for relatively valid reasons. Voluntary participation in a treatment program is generally associated with better treatment outcomes. In addition, the establishment of a therapeutic alliance with participants is one of the hallmarks of MHCs. As a result, probably to a greater extent than drug courts, MHCs need to be relatively responsive to complaints from participants about the treatment they are receiving. At a minimum, they need to be prepared to respond when participants refuse to take prescribed medications because of existing or likely side effects.

Many participants in MHCs will have a long history of medication and they may have valid insights into which medications are likely to be ineffective or to cause significant adverse side effects for them. At the same time, because of the complexity of these medication decisions, it is critical that MHCs have access to the guidance of qualified and experienced mental health professionals. These professionals can help MHCs weigh the validity of treatment non-compliance and propose alternative courses of treatment that participants may find less objectionable.

An additional obstacle is that the newer generation of drugs tends to be significantly more expensive than the older medications.[97] Many of the participants in a MHC will not have the resources to afford these medications. At the same time, the resources of the MHC may be limited. Unlike drug courts, MHCs may have to weigh the costs of the treatment they are mandating and make decisions that take affordability into account. A key to a successful MHC will be having sufficient resources or being able to access such resources to enable participants to obtain appropriate medications.

Individualized Treatment Plans and Responses. While sobriety is an effective approach to treatment for all drug court models, MHCs need to take a more individualized approach in devising and implementing treatment plans for its participants. MHCs will typically see a wide range of psychiatric diagnoses among the participants in the program. Even when two participants share the same diagnosis, the manifestations and impact of the mental illness tend to vary considerably, as will the appropriate treatment response and the course of treatment. Because of the complexity associated with determining an appropriate treatment program, monitoring and gauging compliance, and responding appropriately to identified treatment failures, MHCs must engage in a more individualized process with participants.

Coercion: Ensuring That Program Admission Is Voluntary. The mental illness of MHC participants can present special problems related to the admission of candidates into the program. Coercion can be both internal and external. When individuals with a mental illness are deciding whether to stand trial for a charged offense or to plead guilty and accept diversion to a MHC, their attorney or the trial judge may be tempted to advocate for diversion.[98] Because treatment is viewed positively and considered beneficial to individuals with a mental illness, regardless of whether they actually perpetrated a crime, there may be a tendency to push for diversion. As a result, they may have a relatively compelling defense but waive trial because counsel or the bench has encouraged

[96] *Id.*
[97] Leo & Del Ragno, *supra* note 80, at 202.
[98] BAZELON, *supra* note 48, at 10.

treatment instead.[99] A mental illness may leave a person particularly vulnerable to such encouragement. This encouragement may be appropriate when the likelihood of success at trial is low or the consequences of a failed defense substantial. Sometimes, however, such encouragement may be driven by concerns about crowded dockets and large caseloads, misperceptions about the consequences of diversion, stereotypes concerning individuals with a mental illness, or a failure to explore or appreciate the views of the individual.

Even absent such encouragement, individuals with a mental illness may not understand the nature of their choice. Studies of civil commitment have found that some individuals did not know whether their hospitalization was voluntary or involuntary even immediately after the conclusion of their hearings.[100] Candidates for a MHC may similarly be unaware of the nature of their participation. Special care must therefore be taken by the MHC to explain the voluntary nature of the program.

Even when the court is careful to explain that opting into a MHC is voluntary, individuals with the most severe mental illness may not understand[101] and may be incompetent to make this decision.[102] Some MHCs may consider incompetency irrelevant as the purpose of the court is to help such individuals receive treatment, not punish them. But just as accepting a guilty plea from an incompetent defendant is a violation of due process, accepting a waiver to a MHC by someone who is incompetent may also violate due process. This may particularly be so when non-compliance with a mandated treatment program can result in incarceration. At a minimum, waivers under such conditions may induce suspicion in the MHC participant that will ultimately undercut the voluntary nature of participation, a key component of these programs.

Co-Occurring Mental Illness and Substance Abuse. Because a high percentage of individuals with a mental illness have a co-occurring substance abuse problem (some estimate a co-occurrence as high as 75%),[103] it might be argued that drug courts are the only necessary therapeutic court. To the extent a MHC essentially replicates the drug court model, this argument may carry some weight.

However, as has been generally discussed above, the presence of a mental illness necessitates a different model, including waivers, assessments, monitoring, and programmatic responses that take into account the special needs of individuals with a mental illness. Although drug courts may be willing to accept offenders with a mental illness,[104] they were not created with these offenders in mind. In contrast, because of the high rates of substance abuse among individuals with a mental illness, MHCs are more likely to be familiar with this co-occurrence and better prepared to respond to it.[105] Some communities may not have the resources necessary to support two therapeutic courts, however, and therefore it may be necessary to converge services within the ambit of a single court.

Priorities for Limited Resources. Relatedly, one concern regarding MHCs, not yet established, is that MHCs will ultimately divert resources from other existing mental health programs.[106] Some mental health advocates note the paucity of treatment programs for individuals with a mental illness that already

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[99] *Id.*
[100] Norman G. Poythress et al., *Perceived Coercion and Procedural Justice in the Broward Mental Health Court,* 25 INT'L J. L. & PSYCHIATRY 517, 519 (2002).
[101] *Id.*
[102] Watson et al., *supra* note 9, at 479-80. *See also* Keele, *supra* note 1, at 201.
[103] Hasselbrack, *supra* note 8, at 25.
[104] Fox, *supra* note 90, at 26.
[105] *Id.* at 28.
[106] Steadman et al., *supra* note 40, at 458. *See also* Watson et al., *supra* note 9, at 481; Hasselbrack, *supra* note 8, at 25.

exists, and are concerned that limited treatment resources may be diverted to MHCs and away from individuals who are in greater need of these services.[107]

In response, supporters of MHCs argue that individuals with a mental illness who are involved in criminal behavior and facing incarceration need mental health services more urgently than others.[108] Few would argue with the observation that individuals with a mental illness that are placed in the criminal justice system are very vulnerable and their condition is likely to be exacerbated by this placement. There is a danger that without diversion to a MHC such individuals will not only lose their freedom but also their opportunity for effective mental health services. Although most crimes perpetrated by individuals with a mental illness are not violent and cause little harm, they do nonetheless reflect socially-defined criminal behavior. Because they have engaged in unlawful behavior, such individuals present a societal danger that other individuals with a mental illness have not presented. While incarceration may prevent re-occurrences for the time being, offenders with a mental illness will ultimately return to the community where they may pose a danger to society again, a danger that may have been enhanced because of the lack of adequate mental health treatment services within the criminal justice system. Diversion to MHCs may defuse these cycles of dangerousness, a result that may justify the diversion of resources from other mental health services.[109]

Second, further study of MHCs may show that services provided by them are particularly effective. There is evidence that drug courts, with their threatened sanctions for noncompliance, prove more effective in treating substance abusers than traditional voluntary treatment programs.[110] While the success (and propriety) of coercive treatment may not be mirrored in MHCs,[111] it is at least arguable that this mechanism may be a particularly effective way to treat mental illness and, if so, may justify the diversion of resources from other mental health programs.

Finally, it may be that this is not a "zero-sum" game. Because of society's particular concerns about crime and offenders with a mental illness, there may be a willingness to supply resources for a MHC without taking them from existing mental health treatment programs.

Conclusion

Mental Health Courts currently enjoy significant political support and popularity. Hailed as a solution to crowded prisons, strapped state and local budgets, and concerns about the welfare of offenders with a mental illness, from 1997 to December of 2004, 110 MHCs have been established in the United States.[112] In 2000, Congress passed "America's Law Enforcement and Mental Health Project Act."[113] This Act offered federal funds to local jurisdictions interested in establishing or expanding MHCs or other diversion programs.[114] This funding provided considerable momentum to the development of MHCs, and more jurisdictions are considering MHCs as a viable diversion program.

MHCs also appear successful. Although research is preliminary, there are indications that MHCs provide offenders with a mental illness a more positive experience than the traditional criminal justice system. A survey of participants in the MHC in Broward County indicated that they perceived little coercion

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[107] Hasselbrack, *supra* note 8, at 25.
[108] Davis, *supra* note 23, at 37.
[109] *Id.*
[110] *Id.* at 36.
[111] *See generally* Sarah D. Rain et al., *Perceived Coercion and Treatment Adherence in an Outpatient Commitment Program,* 54 PSYCHIATRIC SERVICES 399, 401 (2003).
[112] *Survey of Mental Health Courts* (2004), *available at* www.mentalhealthcourtsurvey.com/ (last visited Jan. 6, 2005).
[113] Steadman et al., *supra* note 40, at 457.
[114] *Id.*

and were generally satisfied with their outcomes as compared to typical criminal proceedings.[115] MHCs also appear to be in high demand, as one report noted that when offenders were given a choice of having their case heard by a mental health court or by a regular court, 95% of them chose the mental health court.[116]

Using drug courts as a model for therapeutic justice has offered jurisdictions a readily accessible vehicle for creating and maintaining MHCs. As MHCs continue to develop and expand, deviation from the drug court model will lead to better and more effective treatment for mentally ill offenders. MHCs should consider exclusive use of the pre-adjudication model, inclusion of felony defendants in the program, more individualized services, and limiting sanctions to reprimands and altered services. While each program should carefully evaluate the problem of coercion, co-occurrence of substance addiction, financial impact, and the consequences of treatment, these hurdles do not appear prohibitive.

More effective MHCs will ensure that individuals with a mental illness get the services they need and spare them the distress, humiliation, and neglect of incarceration. MHCs offer a support system that deinstitutionalization has thus far failed to provide. Furthermore, MHCs can help individuals with a mental illness who have run afoul of the law avoid criminalization and promote their reintegration into the community.

[115] Poythress et al., *supra* note 100, at 528-29.
[116] Monahan et al., *supra* note 55, at 1200.

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Incorporating Mental Health Assessments of Future Dangerousness Into Pretrial Detention Decisions

Clinical and actuarial assessments of the risk of dangerousness posed by individuals can play an important role in improving pretrial detention decisions involving criminal defendants.

By Andrew H. Ellis*

Abstract. Pretrial detention of criminal defendants based upon the predicted dangerousness of the defendant has evolved considerably in recent years. The pretrial detention procedures established by the Federal Bail Reform Act of 1984 incorporated many of these changes. This article will examine this legislation, as well as its model, the District of Columbia Bail Act of 1970, and describe a series of judicial rulings regarding preventive pretrial detention and the prediction of dangerousness in general. An assessment of the accuracy of non-scientific pretrial detention decisions for predicted "dangerous" defendants will then be provided, followed by an appraisal of current research regarding the ability of clinical evaluations and actuarial assessments to better determine the risk posed. Finally, several commonly stated objections to the detention of individuals for anticipated but unconsummated violent behavior will be addressed, with a concluding observation that although predictions by mental health professionals of future dangerous behavior by criminal defendants are not without error, they are sufficient to warrant the participation of these professionals in the pretrial decision making process.

Introduction

State and federal legislatures have increasingly identified violent crime committed by defendants awaiting trial as a serious problem. In response, a multitude of pretrial detention procedures have been developed to preventively restrain defendants thought to pose a significant risk to the community. Yet this preventive detention is often criticized as an inappropriate exercise of government authority that echoes Orwellian themes of social control and that heralds the erosion of the presumption of innocence. Whatever the merits of these more esoteric considerations, pretrial detention does impose serious costs on both criminal defendants and society.[1] Thus, pretrial detention proceedings and the mechanisms employed need to be examined to determine whether they accurately predict which defendants will pose a serious danger to the community.

A History of Pretrial Detention Based Upon Predicted Dangerousness

The use of pretrial detention as a means of preventing crime and restraining criminal defendants thought to pose a danger to the community has grown steadily for the last forty years. The two driving influences behind this expansion can be traced back to the 1960s. First and foremost was the revolution in criminal procedure initiated by the Warren Court, which included placing limitations on the seizure of evidence, the obtaining of confessions, and the conduct of police lineups. The protections afforded criminal defendants by these procedural changes led many to conclude that the scales of justice were unfairly tipped against law enforcement officials because scrutiny tended to focus "more on the conduct of the police than on the

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[1] Incarceration is expensive. Each detained federal defendant (pretrial or otherwise) costs the taxpayer approximately $19,800 per year. Additionally, "the price to the defendant of pretrial incarceration is clearly his or her loss of freedom, loss of income . . . and, it has been argued, an increased likelihood of being found guilty because the mere fact of being in jail can predispose judges or juries toward a guilty verdict." Thomas Bak, *Pretrial Release Behavior of Defendants Whom the U. S. Attorney Wished to Detain*, 30 AM. J. CRIM. L. 45, 65 (2002).

conduct of the accused."[2] Furthermore, these changes were perceived to curtail prosecutorial effectiveness as they increased defendants' bargaining power during the plea negotiation process.[3] Accordingly, courts and legislators that harbored a distrust of the Warren Court's procedural reforms viewed pretrial detention as a necessary means to ensure some form of punishment for the "guilty", even if it came before an adjudication of guilt.[4]

The second influence, which was arguably an outgrowth of the first, was the bail reform movement of the 1960s.[5] Although its immediate goal was to decrease the size of bail that was needed for defendants to secure their liberty pending trial, it ultimately led to the increased use of pretrial detention. Decreasing the amount of bail that had to be posted did limit the detention of some defendants. However, because courts and legislators were ultimately spurred to create express statutory grounds authorizing detention of criminal defendants thought to be dangerous notwithstanding their ability to post bail, these relatively broad exceptions provided prosecutors with wide latitude for securing the pretrial detention of such defendants.[6]

Statutory Development of Pretrial Detention for Dangerousness. From the 1960s onward, the use of pretrial detention to restrain potentially dangerous criminal defendants rapidly expanded throughout the United States. Authorization to detain criminal defendants on grounds of alleged dangerousness was virtually non-existent prior to the Federal Bail Reform Act of 1966.[7] Yet, by 1978, twenty-three states along with the District of Columbia had adopted legislation permitting detention of a defendant on grounds of alleged dangerousness.[8] A mere six years later that number had grown to thirty-four states, the District of Columbia, and the federal government.[9]

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[2] Marc Miller & Martin Guggenheim, *Pretrial Detention and Punishment*, 75 MINN. L. REV. 335, 341 (1990) (citing Miranda v. Arizona, 384 U.S. 436 (1966)).

[3] Peter Aranella, *Rethinking the Function of Criminal Procedure: The Warren and Burger Court's Competing Ideologies*, 72 GEO. L.J. 185, 229-230 (1983).

[4] Analogous to the use of pretrial detention as a means of circumventing enhanced procedural protections for criminal defendants at trial is the extensive use of plea-bargaining to ensure the ultimate conviction of felony arrestees. *See* Albert Altschuler, *Implementing the Criminal Defendant's Right to Trial: Alternatives to the Plea Bargaining System*, 50 U. CHI. L. REV. 931, 938 (1983).

[5] WAYNE H. THOMAS, BAIL REFORM IN AMERICA 223 (1976).

[6] Miller & Guggenheim, *supra* note 2, at 344.

[7] John S. Goldkamp, *Criminal Law: Danger and Detention: A Second Generation of Bail Reform*, 76 J. CRIM. L. & CRIMINOLOGY 1, 15 (1985). However, even the Federal Bail Reform Act of 1966 cabined considerations of dangerousness to a narrow class of defendants charged with capital offenses or requesting release pending appeal of their cases. *Id.* at 15 & n.53.

[8] *Id.* at 15.

[9] *Id.* These states include Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin. *Id.* This number has remained remarkably consistent in the subsequent two decades. As of 2002, the same 34 states along with the District of Columbia and the federal system require the judicial officer to assess (i) the risk that the defendant will fail to appear in court and (ii) whether a defendant will pose a risk to the safety of the community. *See* COUNCIL OF STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 95 n.26 (2002). *See also* John Clark & D. Alan Henry, *The Pretrial Release Decision*, 81 JUDICATURE 76 (Sept./Oct. 1997). The remaining states require the judicial officer to consider only the flight risk posed by the defendant. *Id.* In Virginia, the judicial officer is required to deny bail if "there is probable cause to believe that [the defendant] will constitute an unreasonable danger to himself or the public." VA. CODE ANN. § 19.2-120(A)(2) (2004).

The District of Columbia Bail Act of 1970. Typical of the initial wave of legislation is the statute governing bail practice enacted in 1970 by the District of Columbia.[10] The District of Columbia Bail Act of 1970 provides that "[t]he judicial officer shall order the detention of a person charged with an offense for a period of not more than 5 days . . . if the judicial officer determines that the person charged with an offense . . . [m]ay . . . pose a danger to any other person or the community."[11]

A judicial hearing is then held in cases involving a crime of violence or a dangerous crime, or where there is a serious risk that the defendant will flee or attempt to obstruct justice. At this hearing, a judge must "determine whether any condition or combination of conditions [of release] will reasonably assure the appearance of the person as required and the safety of any other person and the community."[12] If the judge finds that there is clear and convincing evidence that no such conditions exist, the defendant can be ordered detained until trial.[13] The judge is to take into account the nature and circumstance of the offense charged, the weight of the evidence, the history and characteristics of the defendant (including the defendant's mental condition), and the nature and seriousness of the danger posed by the defendant to any member of the community if released.[14] In addition, if the judicial officer finds by a substantial probability that the defendant poses a risk to the integrity of the judicial proceeding,[15] or has committed a violent crime or a dangerous crime while armed or while on release pending trial for another offense, then there is created "a rebuttable presumption that no condition or combination of conditions of release will reasonably assure the safety of any other person and the community."[16]

The District of Columbia enactment does provide defendants with substantial procedural protections. For example, the detention hearing must "be held immediately upon the person's first appearance before the judicial officer."[17] Defendants' interests are further protected by a statutory right to be represented by counsel and the right of indigent defendants to have counsel provided for them.[18] Defendants are also expressly afforded the opportunity to testify on their own behalf, as well as to present and cross-examine witnesses and introduce other evidence to counter the government's case for detention.[19] Lastly, defendants who are found to pose a danger to the community are placed on an expedited trial schedule during which they must be indicted within 90 days and have their trial commence within 100 days.[20]

In addition, the government is constrained by the fact that the burden of proof needed to support pretrial detention is a relatively high one—clear and convincing evidence.[21] Furthermore, the prosecution is required to present evidence that there is a "substantial probability" that the defendant committed the crime charged.[22] The defendant is further protected from prosecutorial over-reaching by the availability of appeal from a detention order.[23] This right of appeal is enhanced by a requirement that the judge, when ordering detention, "[i]nclude written findings of fact

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[10] D.C. CODE ANN. §§ 23-1321 to 1332 (2004).
[11] D.C. CODE ANN. § 23-1322(a)(2).
[12] *Id.* at (b)(1)(a)-(d).
[13] *Id.* at (b)(2).
[14] *Id.* at (e)(1)-(4).
[15] Such as threatening or intimidating "a law enforcement officer, an officer of the court, or a prospective witness or juror in any criminal investigation or judicial proceeding." *Id.* at (c)(2).
[16] *Id.* at (c)(1)-(4).
[17] *Id.* at (d)(1). Furthermore, "[e]xcept for good cause, a continuance on motion of the person shall not exceed 5 days, and a continuance on motion of the attorney for the government shall not exceed 3 days." *Id.*
[18] *Id.* at (d)(2).
[19] *Id.* at (d)(3)-(4).
[20] *Id.* at (h)(1).
[21] *Id.* at (b)(2).
[22] *Id.* at (b)(2)(c).
[23] D.C. CODE ANN. § 23-1324(a)-(b).

and a written statement of the reasons for the detention."[24]

The Federal Bail Reform Act of 1984. The District of Columbia Bail Act of 1970 is not only typical of state bail practices that emerged in the 1970s and 1980s, it also served as the model for what are arguably the most influential pretrial detention provisions today regarding the dangerousness of defendants: the Federal Bail Reform Act of 1984.[25] Indeed, the federal effort to give greater weight to considerations of defendant dangerousness in pretrial detention decisions was specifically intended to reflect the District of Columbia's bail practices.[26]

However, the Federal Bail Reform Act diverges from the District of Columbia Act model in that it expressly "makes protection of the public the pivotal factor in determining whether to release or detain federal defendants."[27] Release is not to be permitted if "release . . . will endanger the safety of any other person or the community."[28] Furthermore, unlike the District of Columbia Act, a rebuttable presumption in favor of detention does not address whether conditions of release can not reasonably assure the appearance of the defendant at future proceedings, but focuses exclusively on whether the conditions of release cannot "reasonably assure the safety of any other person and the community."[29]

The Federal Bail Reform Act also differs in that it does not provide procedural protections to defendants similar to those of its District of Columbia predecessor. Under the federal system, prosecutors at the pretrial hearings may offer hearsay evidence of the defendant's prior crimes and thus avoid cross-examination.[30] The class of defendants subject to pretrial detention is also more expansive. The Federal Bail Reform Act permits a prosecutor to seek pretrial detention of a defendant in cases involving a "crime of violence,"[31] which is defined as

> an offense that has [as] an element of the offense the use, attempted use, or threatened use of physical force against the person or property of another [or] any other offense that is a felony and that, by its nature, involves a substantial risk that physical force against the person or property of another may be used in the course of committing the offense.[32]

In addition, pretrial detention can be sought for any defendant charged with a felony who has been previously convicted of two or more federal or state "crimes of violence."[33]

The differences between the federal approach and that of the District of Columbia Act make clear that the Federal Bail Reform Act moves closer to a system of pure preventive detention. Indeed, unlike the District of Columbia, the federal system does not require evidence of a substantial probability of the defendant's guilt because this requirement was viewed as "one of the 'principle reasons' that the District of Columbia prosecutors had made such limited use of the [preventive] detention provisions."[34] However, predictions of dangerousness under the federal bail system uncomfortably rely on untested, intuitive, and largely unverifiable judgments of

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[24] D.C. CODE ANN. § 23-1322(g)(1).
[25] 18 U.S.C. §§ 3141-3156 (2004).
[26] S. Rep. No. 225, 98th Cong., 2d Sess., *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3182, 3205.
[27] Miller & Guggenheim, *supra* note 2, at 345.
[28] 18 U.S.C. § 3142(b).
[29] *Id.* at § 3142(e).
[30] *Id.* at § 3142(f).
[31] *Id.* at § 3142(f)(1).
[32] 18 U.S.C. § 3156(a)(4). The District of Columbia Act, by contrast, avoids a catchall definition and instead defines a "crime of violence" by referring to a series of specific criminal charges. *See* D.C. CODE ANN. § 23-1331(4)(A)-(Q) (2004).
[33] 18 U.S.C. § 3142(f)(1)(D). This can include one state and one federal crime of violence. *Id.*
[34] Miller & Guggenheim, *supra* note 2, at 348 (citing S. Rep. No. 225, 98th Cong., 2d Sess. 18, *reprinted in* 1984 U.S. CODE CONG. & ADMIN. NEWS 3201).

dangerousness by judges that are made in a vacuum, removed from proof of a defendant's particular dangerousness.[35] Nonetheless, preventive pretrial detention for "dangerous" defendants has survived constitutional scrutiny in a series of U.S. Supreme Court decisions.

Constitutional Challenges to Pretrial Detention Predictions of Dangerousness. Predictions of dangerousness have gained increasing credibility in the federal courts in a variety of contexts. These predictions permeate the criminal justice system,[36] and have been found constitutional even in extreme situations. In *Barefoot v. Estelle*, the U.S. Supreme Court held that clinical predictions of future violence or continuing danger to the community could be considered in deciding whether to sentence a defendant to death.[37] Under the Texas statute governing capital sentencing hearings, the government was permitted to produce evidence regarding the "probability that the defendant would [subsequently] commit criminal acts of violence that would constitute a continuing threat to society."[38] The Court concluded that:

> If the likelihood of a defendant's committing further crimes is a constitutionally acceptable criterion for imposing the death penalty, which it is, . . . and if it is not impossible for even a lay person sensibly to arrive at that conclusion, it makes little sense, if any, to submit that psychiatrists, out of the entire universe of persons who might have an opinion on the issue, would know so little about the subject that they should not be permitted to testify.[39]

This receptivity to predictions of dangerousness followed the acceptance of presumptions of continuing dangerousness by the Court only days earlier in *Jones v. United States*.[40] In *Jones*, the automatic confinement and involuntary hospitalization of a defendant acquitted on grounds of insanity was upheld even though the requisite dangerousness required for such a commitment was based on the defendant's criminal act, which may have occurred at a relatively remote time.[41] The Court asserted that "[t]he fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness. . . . Indeed, [this] evidence generally may be at least as persuasive as any predictions about dangerousness that might be made in a civil commitment proceeding."[42]

Although *Barefoot* and *Jones* permitted criminal dispositions to be shaped by predictions of future dangerousness, they are also examples of predictive efforts made only after the defendant has been found to have committed a criminal act. Such dispositions should be distinguished from the use of predictions of dangerousness to justify purely preventive detention, as occurs in bail decisions for defendants whose criminal behavior is only alleged and not yet adjudicated.[43]

Schall v. Martin. Preventive pretrial detention was put to the test a year after *Barefoot* and *Jones*, but it reached the U.S. Supreme Court in a relatively unexpected context—the preventive detention of juveniles by the juvenile justice system. In *Schall v. Martin*,[44] three juveniles had been detained prior to trial under a provision of the New York Family Court Act.[45] This Act permitted a judge to order the pretrial detention of a juvenile if "there is a serious risk that [the juvenile] may

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[35] Miller & Guggenheim, *supra* note 2, at 348. *See also* Albert Altschuler, *Preventive Pretrial Detention and the Failure of Interest-Balancing Approaches to Due Process*, 85 MICH. L. REV. 510, 513 (1986).
[36] *See* Jurek v. Texas, 428 U.S. 262, 275 (1976) (Stevens, J., plurality).
[37] 463 U.S. 880 (1983).
[38] TEXAS CODE CRIM. PROC. ANN. ART. § 37.071(b)(2) (Vernon 1981).
[39] 463 U.S. at 896-97 (citing Jurek v. Texas, 428 U.S. 262 (1976)).
[40] 463 U.S. 354 (1983).
[41] *Id.*
[42] *Id.* at 364.
[43] *See* Miller & Guggenheim, *supra* note 2, at 382.
[44] 467 U.S. 253 (1984).
[45] NEW YORK JUD. LAW § 320.5 (McKinney 1983).

before the return date commit an act which if committed by an adult would constitute a crime."[46] In evaluating the juveniles' due process challenge to these pretrial detention measures, the Court emphasized the state's *parens patriae* interest in promoting the welfare of juveniles as well as the limited liberty interests of juveniles.[47] In light of these considerations, the Court in *Schall* determined that in addition to ensuring a juvenile's presence at trial:

> The "legitimate and compelling state interest" in protecting the community from crime cannot be doubted. We have stressed before that crime prevention is "a weighty social objective," and this interest persists undiluted in the juvenile context. The harm suffered by the victim of a crime is not dependent upon the age of the perpetrator. And the harm to society generally may even be greater in this context given the high rate of recidivism among juveniles.[48]

The Court noted that juveniles have a substantial interest in freedom but found that interest qualified by the fact that juveniles "are always in some form of custody."[49] As a result, the Court concluded that, under certain circumstances, a juvenile's liberty interest may be subordinated to the State's interests.[50] The Court justified pretrial detention on the grounds of predicted dangerousness as a means of "protecting the juvenile from his own folly."[51] The Court added:

> Society has a legitimate interest in protecting a juvenile from the consequences of his criminal activity—both from potential physical injury which may be suffered when a victim fights back or a policeman attempts to make an arrest and from the downward spiral of criminal activity into which peer pressure may lead the child.[52]

For these reasons, the Court in *Schall* determined that pretrial detention of juveniles on the basis of predicted danger to the community properly promoted the interests of society and the juvenile and was compatible with the "fundamental fairness" demanded by the Due Process clause.[53] Because there was no indication that the pretrial detention measures were being used or intended as punishment,[54] the Court held that these provisions of the New York Family Court Act were not unconstitutional.[55]

United States v. Salerno. As the pretrial detention scheme upheld in *Schall* was linked to the juvenile justice system, some observers argued that a different outcome could be expected in conjunction with the adult criminal justice system. Indeed, compared to the pretrial detention of adult criminal defendants, the juvenile justice system is exceptional in almost every respect.[56] This prediction was put to the test three years after *Schall* when the danger-focused adult preventive detention scheme of the Federal Bail Reform Act of 1984 was subjected to a constitutional challenge. Yet in *United States v. Salerno,*[57] the same six justices who had written *Schall v. Martin* disengaged the reasoning of that opinion from its moorings in juvenile justice jurisprudence and extended it to the preventive pretrial detention of adult criminal defendants.

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[46] *Id.* at § 320.5(1)(b).
[47] 467 U.S. at 263.
[48] *Id.* at 264-65.
[49] *Id.* at 265.
[50] *Id.*
[51] *Id.*
[52] *Id.* at 266.
[53] *Id.* at 268.
[54] *Id.* at 269.
[55] *Id.* at 281.
[56] *See, e.g.,* Comment, *The Supreme Court and Pretrial Detention of Juveniles: A Principled Solution to a Due Process Dilemma*, 132 U. PA. L. REV. 95 (1983); Note, *Pretrial Detention of Juveniles: Denial of Equal Protection Masked by the Parens Patriae Doctrine*, 95 YALE L.J. 174 (1985).
[57] 481 U.S. 739 (1987).

In *Salerno*, two adult criminal defendants were charged with violating a host of federal laws, including violations of the Racketeer Influenced and Corrupt Organizations Act (RICO). They were detained pending trial under the Federal Bail Reform Act of 1984 because no condition of release would assure "the safety of any other person or the community."[58] The two defendants complained that their pretrial detention for predicted dangerousness violated the Due Process Clause of the Fifth Amendment, as well as the Eighth Amendment's proscription against excessive bail.[59]

The Court in *Salerno* rejected the contention that pretrial detention for dangerousness constituted an impermissible punishment before trial in violation of the Due Process Clause, determining that "the mere fact that a person is detained does not inexorably lead to the conclusion that the government has imposed punishment."[60] The Court concluded that the legislative history associated with the enactment of the Bail Reform Act indicated that pretrial detention was intended as a means to redress the "pressing societal problem" of federal defendants committing crimes while awaiting trial and thus was regulatory rather than punitive in nature.[61] And while it recognized that pretrial detention of dangerous defendants must not be excessive,[62] the Court reiterated the reasoning of *Schall* that "the Government's regulatory interest in community safety can, in appropriate circumstances, outweigh an individual's liberty interest."[63] The Court noted that the detention of individuals thought dangerous is acceptable during time of war or insurrection,[64] pending deportation of aliens,[65] for mentally unstable individuals presenting a danger to the community,[66] and, of course, for juveniles predicted to be dangerous pending adjudication.[67]

In light of these illustrations, the Court in *Salerno* found the government's interest in preventing crime by federal arrestees to be legitimate, stating that "[w]hile the Government's general interest in preventing crime is compelling, even this interest is heightened when the Government musters convincing proof that the arrestee . . . presents a demonstrable danger to the community."[68] Although acknowledging the liberty interests of criminal defendants, the Court determined that "[w]hen the Government proves by clear and convincing evidence that an arrestee presents an identified and articulable threat to . . . the community," a court may, consistent with the Due Process Clause, "disable the arrestee from executing that threat."[69] Accordingly, the Court held that the Federal Bail Reform Act's pretrial detention of dangerous defendants does not "offend[] some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental."[70]

The Eighth Amendment objection raised in *Salerno* was disposed of summarily. Relying on the venerable bail case of *Stack v. Boyle*,[71] the defendant asserted that the Eighth Amendment's prohibition of excessive bail grants all criminal defendants a right to bail calculated solely upon considerations of their individual flight risk—not the potential danger they may pose to the community.[72] The Court in *Salerno* responded that the Excessive Bail

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[58] *Id.* at 743.
[59] *Id.* at 746.
[60] *Id.*
[61] *Id.* at 747.
[62] *Id.*
[63] *Id.* at 748.
[64] *Id.* (citing Ludecke v. Watkins, 335 U.S. 160 (1948)).
[65] *Id.* (citing Carlson v. Landon, 342 U.S. 524 (1954)).
[66] *Id.* at 748-49 (citing Addington v. Texas, 441 U.S. 418 (1979)).
[67] *Id.* at 749 (citing Schall v. Martin, 467 U.S. 253 (1984)).
[68] *Id.* at 750.
[69] *Id.* at 751.
[70] *Id.* (citing Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)).
[71] 342 U.S. 1, 5 (1951) (holding that "bail set at a figure higher than an amount reasonably calculated [to ensure the defendant's presence at trial] is 'excessive' under the Eighth Amendment.").
[72] 481 U.S. at 752-53.

Clause of the Eighth Amendment does not "prohibit[] the government from pursuing other admittedly compelling interests through regulation of pretrial release"[73] nor establish that "all arrests must be bailable."[74]

The Court concluded that determinations of eligibility for bail are not limited to flight risk and can encompass defendant dangerousness and community safety.[75] As a result, the U.S. Supreme Court approved the use of predictions of defendant dangerousness in pretrial detention and cleared the constitutional path for something approaching pure preventive detention, at least in the context of a legislatively determined class of defendants awaiting trial for a set of crimes.

Pretrial Detention of Dangerous Defendants Following *Salerno*. The *Salerno* decision spurred a vast and predominantly critical literature.[76] Indeed, this criticism was present at the very birth of *Salerno*. In his dissenting opinion, Justice Marshall scolded the Court for a decision he characterized as "an ominous exercise in [constitutional] demolition. [It] is truly a decision which will go forth without authority, and come back without respect."[77] Notwithstanding Justice Marshall's remarks, at the time *Salerno* was decided every federal Court of Appeals but one that had considered the validity of the dangerousness-focused preventive detention provisions of the Bail Reform Act of 1984 had rejected constitutional challenges mounted against them.[78]

Nor has *Salerno* fulfilled Justice Marshall's Delphic prediction that it would soon return without respect. Far from being a prodigal son, *Salerno*'s approval of preventive detention on the basis of predicted danger has gained strength over the ensuing decade and a half. In the distinct but analogous area of involuntary civil commitment of sexual predators, the U.S. Supreme Court invoked *Salerno* for the proposition that non-punitive detention is constitutionally legitimate for such individuals thought to pose a risk to the community.

In *Kansas v. Hendricks,*[79] the Court examined the Kansas Sexually Violent Predator Act, which established procedures for the involuntary civil commitment of "sexually violent predators."[80] Under the statute, "any person who has been convicted of or charged with a sexually violent offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in the predatory acts of sexual violence"[81] is subject to civil commitment for care and treatment until they no longer pose such danger. The Court upheld the law against various constitutional challenges.[82] In doing so, the Court invoked *Salerno* in

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[73] *Id.*
[74] *Id.* at 754.
[75] *Id.* at 754-55.
[76] *See, e.g.,* Miller & Guggenheim, *supra* note 2; John A. Washington, *Preventive Detention: Dangerous Until Proven Innocent*, 38 CATH. U. L. REV. 271 (1988); Michael W. Youtt, *The Effect of Salerno v. United States on the Use of State Preventive Detention Legislation: A New Definition of Due Process*, 22 GA. L. REV. 805 (1988); Michael J. Eason, *Eighth Amendment - Pretrial Detention: What Will Become of the Innocent? United States v. Salerno, 107 S. Ct. 2095 (1987)*, 78 J. CRIM. L. & CRIMINOLOGY 1048 (1988).
[77] 481 U.S. at 767 (Marshall, J., dissenting).
[78] *See* United States v. Walker, 805 F.2d 1042 (11th Cir., 1986); United States v. Rodriguez, 803 F.2d 1102 (11th Cir., 1986); United States v. Simpkins, 801 F.2d 520 (D.C. Cir., 1986); United States v. Zannino, 798 F.2d 544 (1st Cir., 1986); United States v. Perry, 788 F.2d 100 (3d Cir., 1986); United States v. Delker, 757 F.2d 1390 (3d Cir., 1985).; United States v. Portes, 786 F.2d 758 (7th Cir., 1985). At the time *Salerno* was decided, only the Second Circuit Court of Appeals had found constitutional infirmities lurking within the Federal Bail Reform Act of 1984. *See* United States v. Salerno, 794 F.2d 64 (2d Cir., 1986); United States v. Melandez-Carrion, 790 F.2d 984 (2d Cir., 1986).
[79] 521 U.S. 346 (1997).
[80] KAN. STAT. ANN. § 59-29a01 *et seq.* (2003).
[81] *Id.* at § 59-29a02(a)-(c).
[82] 521 U.S. at 371.

affirming the constitutional propriety of civil commitment proceedings based on predictions of an individual's dangerousness to the community.[83] Because for some of these individuals there is no effective treatment, the Kansas law had the effect of authorizing lengthy detentions. Nevertheless, the Court upheld the law because of the danger such individuals posed to others.[84]

The degree of dangerousness required for the civil commitment of sexual predators was not expressly addressed in *Hendricks*, but was illuminated five years later in *Kansas v. Crane*.[85] Revisiting the same Kansas statute, the Court rejected a total or complete "lack-of-control" standard.[86] Instead, the Court recognized that "in cases where lack of control is at issue, 'inability to control behavior' will not be demonstrable with mathematical precision. It is enough to say that there must be proof of *serious difficulty* in controlling behavior."[87]

Because detention under *Hendricks* and *Crane* also requires a showing that the offender suffers from a mental abnormality or personality disorder that makes the person likely to engage in dangerous behavior consisting of predatory acts of sexual violence, these decisions are not directly applicable to the dangerousness-focused pretrial detention determinations exemplified by the Federal Bail Reform Act. Yet they do represent an affirmation of the view expressed in *Salerno*—that defendants deemed to pose a sufficient risk to the community may be constitutionally detained for reasons other than their conviction of a criminal offense. More specifically, they establish that preventive detention programs can be established to combat perceived social risks posed by certain categories of dangerous individuals.[88]

Such preventive detention of "dangerous" defendants merits a brief discussion. Judicial approval of the preventive detention set forth in the Federal Bail Reform Act and other legislation may strike some as Orwellian, but constitutional jurisprudence that authorizes such laws does not require state and federal legislators to act. It is ultimately the public, through its elected representatives, that fashions such legislative schemes. The legislative perceptions of dangerousness or lawlessness among defendants awaiting trial led them to enact laws that detain those individuals deemed to pose an unacceptable risk to the community. The merits of this policy can and perhaps should be debated. But absent a change in these perceptions, pretrial detention of dangerous defendants (or at least certain classes of dangerous defendants) is likely to remain a common feature of the legal landscape for the foreseeable feature. For this reason, attention should be given to improving the validity and reliability of predictions of this dangerousness, which will be the focus of the remainder of this article.

Predictions of Defendant Dangerousness and Detention Revisited

To improve predictions of pretrial dangerousness in criminal defendants under the Federal Bail Reform Act and similar state provisions, a base-line evaluation of current dangerousness assessments made by the judicial system is needed. Under the current federal regime, predictions of dangerousness in the context of pretrial detention emanate from the adversarial process associated with the detention hearing.[89] These are non-scientific predictions proposed by the

[83] *Id.* at 363 (citing Salerno, 481 U.S. at 746-49).
[84] 521 U.S. at 364-66.
[85] 534 U.S. 407 (2002).
[86] *Id.* at 412.
[87] 534 U.S. at 413.

[88] For example, the U.S. Congress passed the Federal Bail Reform Act of 1984 as a response to "the alarming problem of crimes committed by persons on release." S. Rep. No. 98-225, at 3 (1983).
[89] 18 U.S.C. § 3142(b).

prosecutor and ultimately made by the presiding judge. As a result, it is important to evaluate the relative capabilities of judges and prosecutors to predict defendant dangerousness.

Non-Scientific Predictions of Dangerousness in Federal and State Pretrial Detention Hearings. Assistant United States Attorneys ("AUSAs") are the legal agents that initiate pretrial detention proceedings under the federal bail procedures.[90] Because their requests for detention are approved by the court approximately five out of every six times,[91] an appraisal of their abilities to predict dangerousness is key to evaluating current pretrial detention procedures. A study of 64,164 federal defendants who had their first court appearance in 1996, found that 33,189 of them were granted bail and released.[92] Of these 33,189 defendants, 6,482 of them were released despite a request by the AUSA that they be detained pending trial.[93]

Those defendants released despite a request by the AUSA for pretrial detention did commit bail violations[94] at a substantially higher rate (22.5%) than those released without objection from the AUSA (13.7%).[95] Examining the types of violations committed, it was found that for defendants released over the objection of the AUSA, 0.9% had first violations and 0.2% had second violations that involved violence, while for defendants released without objection, 0.5% had first violations and 0.1% had second violations that involved violence.[96] The study determined that while an AUSA motion to deny bail is a statistically significant indicator of violations of bail, the large majority of defendants released over the objection of the AUSA do not commit violations. When the AUSA motion for pretrial detention was used as an independent variable in predicting violations of bail conditions, it was found to be a weaker predictor than several other variables and was found to be comparable to unemployment or previous drug use.[97] Moreover, when the prediction of *violent* behavior was considered, the results indicated AUSA motions for pretrial detention grossly overestimate defendants' propensity for dangerousness.

Judicial predictions of dangerousness fare slightly better, but still greatly inflate the degree of community risk posed by defendants awaiting trial. In the early 1980s, a unique opportunity presented itself for studying the effectiveness of judicial risk assessments. In the course of the litigation over the constitutionality of the New York Family Court Act's pretrial juvenile detention procedures that ultimately led to *Schall v. Martin*, a federal district court issued a writ of habeas corpus for all juveniles preventively detained under that statute in New York City.[98] During the following three years, New York Family Court judges identified juveniles that were released pursuant to the order but that would have been detained under the Family Court Act due to predicted dangerousness ("the *Schall* defendants").[99] A subsequent study investigated the effectiveness of judicial predictions of dangerousness by examining the arrest histories of the *Schall* defendants during their release pending trial.[100] In addition, a control group was constructed of juvenile offenders from the same time period

[90] 18 U.S.C. § 3142(f)(1).
[91] Bak, *supra* note 1, at 53.
[92] *Id.* Approximately half the 64,164 federal defendants were detained and never released, most on the request of the U.S. Attorney. *Id.*
[93] *Id.*
[94] *Id.* at 51-52 (defining "violation" as "(1) failure to appear at trial; (2) non-criminal violations of release conditions; and (3) criminal violations of release conditions.").
[95] *Id.* at 53.
[96] *Id.* at 54.
[97] *Id.* at 64.
[98] United States *ex rel.* Martin v. Strasburg, 513 F. Supp. 691, 717 (S.D.N.Y. 1981). The order was subsequently overturned in *Schall v. Martin*, 467 U.S. 253, 381 (1984).
[99] Jeffrey Fagan & Martin Guggenheim, *Preventive Detention and the Judicial Prediction of Dangerousness for Juveniles: A Natural Experiment*, 86 J. CRIM. L. & CRIMINOLOGY 415, 431-32 (1996).
[100] *Id.*

with the same characteristics (age, race, gender, committing offense, prior record, and census tract) as the *Schall* defendants but who had not been deemed dangerous, to provide an estimate of the gain in predictive efficiency from the judicial determination of dangerousness.[101]

The results showed that judicial predictions of law violation posed by the *Schall* defendants were more accurate than those of federal prosecutors described above. *Schall* defendants were almost three times as likely to be rearrested within ninety days of pretrial release, regardless of offense, than the control group.[102] When the focus was limited to violent behavior during release, judicial predictive accuracy was also more accurate than federal prosecutors. Of the *Schall* defendants, 18.8% were rearrested within ninety days for a violent offense, whereas only 7.8% of control group members were rearrested for similar offenses during the relevant time period.[103] However, even here the authors note:

> [T]he marginal gain in predictive efficiency for the *Schall* cases is tempered by the high rate of false prediction . . . . Nearly six-out-of-ten (59.4%) of the *Schall* defendants were not rearrested within the ninety day period . . . . When violent felony offenses are applied as the standard for evaluating preventive detention decisions, consistent with the [Federal] Bail Reform Act criteria for dangerousness, the false prediction rate for judicial decisions rises. More than eight-in-ten (81.2%) *Schall* defendants were not rearrested for violent offenses during the ninety-day period . . . . Accordingly, while predictions of subsequent crime within ninety days are effective, predictions of violence or danger are less accurate.[104]

This high rate of false prediction is troubling, especially in light of the fact that more than half of the *Schall* defendants were never convicted of the crime with which they were originally charged.[105] While the high false-positive rates of AUSA's in predicting dangerousness may be attributable to prosecutorial zeal or institutional pressures to over-detain, no such compulsion would appear evident in the judicial appraisals of the *Schall* defendants. Indeed, if a judge in the New York Family Courts was naturally inclined to over-detain juvenile defendants, the opportunity to do so was not present because of the constraints imposed by the federal habeas corpus order. One must accept the rates of accuracy for the *Schall* defendants to be a reasonable indication of the limitations on judicial capacity to predict dangerousness, opening the door to public debate over how pretrial preventive detention procedures can be improved. Such improvements are further needed because the Federal Bail Reform Act and comparable state legislation require the judge to order detention for dangerousness only upon "clear and convincing evidence."[106] As the high error rates of judicial and prosecutorial predictions suggest that this evidentiary threshold is frequently not being met, new and potentially more accurate measures of defendant risk should be considered.

The Use of Actuarial and Clinical Predictions to Determine Pretrial Detention or Release. If the best judicial predictions are capable of correctly identifying only one out of five dangerous defendants, then perhaps the use of actuarial or clinical predictions (or a combination thereof) can provide more accurate preventive pretrial detention choices.

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[101] *Id.* at 432-33.
[102] *Id.* at 437 ("Over 40% of the *Schall* defendants were rearrested within ninety days, compared to only 15.6% of the controls.").
[103] *Id.*
[104] *Id.* at 438.
[105] *Id.* at 448.
[106] *See* 18 U.S.C. § 3142(f); D.C. Code Ann. § 23-1322(b)(2).

This idea is not novel.[107] The U.S. Supreme Court has repeatedly expressed a positive view of forensic evaluations to inform criminal justice system decisions.[108] Furthermore, legislatively mandated use of actuarial instruments to gauge future dangerousness is already employed in conjunction with civil commitment proceedings for sexually violent predators.[109]

However, historically, studies of clinical evaluations of mental health patients have shown an ability to predict potential violent behavior that is only marginally better than chance.[110] One of the most widely cited studies of clinical predictive accuracy was contained in an article published in 1972.[111] The researchers conducted five-year follow-ups with nearly 600 males who had been convicted of violent offenses and placed in mental health facilities for evaluation and treatment. Nearly 400 of them were eventually determined by clinical evaluators to not pose a danger to the community and thus were released. Another 49 were released by judicial or parole authorities against the advice of the clinical evaluators, who had diagnosed them as still dangerous. At the end of the five-year follow-up period, only 34.7% of the patients diagnosed as dangerous but subsequently released were found to have actually committed an assaultive crime. In contrast, 8% percent of the patients diagnosed as non-dangerous were found to have committed an assaultive crime.[112]

Because the study showed that clinical predictions of future violence were wrong in two out of three evaluations, this study was used to deride the ability of mental health professionals to clinically predict dangerousness.[113] Yet accurately predicting one out of three cases is still a substantial improvement over the one-out-of-five rate of the New York Family Court judges with respect to the *Schall* defendants. And while the performance of mental health professionals in the 1972 article may not reach the level of "clear and convincing evidence," there are reasons to suspect that the study seriously underestimated the accuracy of forensic clinical evaluations. For example, one reason for the underestimate may be that only 20% of the crimes committed by the patients predicted to be violent were reported.[114] Second, the patients released

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[107] *See* Altschuler, *supra* note 35, at 534. *See also* JOSHUA DRESSLER & GEORGE C. THOMAS III, CRIMINAL PROCEDURE: PRINCIPLES, POLICIES AND PERSPECTIVES 793 (1999).

[108] *See* Estelle v. Smith, 451 U.S. 454, 473 (1981) (while holding that a psychiatrist's testimony at the penalty phase of a criminal trial violated the defendant's Fifth Amendment privilege against compelled self-incrimination, the Court stated that its holding should "in no sense [be seen as] disapproving the use of psychiatric testimony bearing on the issue of future dangerousness"). *See also* Barefoot v. Estelle, 463 U.S. 880, 896 (1983) (stating that psychiatrists should be permitted to testify at capital sentencing on the likelihood of a defendant committing further crimes).

[109] The Virginia statute governing sexually violent predators explicitly endorses the use of the Rapid Risk Assessment for Sexual Offender Recidivism instrument or "a comparable, scientifically validated instrument." *See* VA. CODE ANN. § 37.1-70.4(C) (2004).

[110] *See generally* ALLEN K. HESS & IRVING B. WEINER, THE HANDBOOK OF FORENSIC PSYCHOLOGY 172-81 (1999).

[111] H. L. Kozol et al., *The Diagnosis and Treatment of Dangerousness*, 19 CRIME & DELINQ. 371 (1972).

[112] *Id.*

[113] Justice Blackmun made much of this point in his dissent in *Barefoot v. Estelle*, 463 U.S. 880 (1983), when he stated that:

> A layman with access to relevant statistics can do at least as well and possibly better; psychiatric training is not relevant to the factors that validly can be employed to make such predictions, and psychiatrists consistently err on the side of overpredicting violence . . . . It is impossible to square admission of this purportedly scientific but actually baseless testimony with the Constitution's paramount concern for reliability in capital sentencing.

Id. at 922-23 (Blackmun, J., dissenting).

[114] *See* H. V. Hall, *Dangerous Predictions and the Maligned Forensic Professional: Suggestions for*

over the objections of clinical evaluators were presumably borderline cases and there is no way of telling how high the accuracy of the evaluations would have been if *all* patients predicted to be dangerous had been released.[115]

The suspicion that the rates for the accurate clinical identification of dangerous individuals may be higher than previously thought was supported by the results reported in a 1993 article,[116] cited at the time as "surely the most sophisticated study published on the clinical prediction of violence."[117] In this study, two groups of 357 patients were selected out of 1,948 patients recruited from the emergency room of a psychiatric hospital. The first group consisted of patients who clinical evaluators predicted to be violent, while the second consisted of matched comparison patients.[118] Subsequent patient violence was measured over the ensuing six months by reviewing official records and collateral reports and patient self-reports of incidents where the patient laid hands on or threatened another with a weapon. The study found that 53% of the patients predicted to be dangerous committed acts of violence within six months, compared to 36% in the comparison group.[119] While promising, the authors of the study concluded that clinical evaluations did add to predictive accuracy, but the overall accuracy was only modest.[120]

Perhaps the greatest advances in forensic predictions of an individual's dangerousness have come through recent developments in actuarial risk assessment. Such assessments rely on "previously demonstrated and validated associations [with] various specified, well-defined, and measurable predictor variables (e.g., age and history of arrests)."[121] In 1993, researchers attempted to create an actuarial scheme for assessing the future dangerousness of mentally disordered offenders.[122] Two groups of men were studied, the first consisting of 371 men admitted between 1965 and 1980 for treatment to a maximum-security psychiatric institution in Ontario, Canada. The second group was made up of 324 men who had been admitted for only a brief pretrial psychiatric assessment. Each individual in the first group was matched with a similar individual in the second to assure that the study results would be equally applicable to forensic psychiatric patients and serious offenders in general.[123] Subsequent incidences of violent behavior among the subject pool were tracked for an average 81.5 months. A wide variety of potential predictive variables for future violence were coded from institutional files, and twelve variables were identified for inclusion in the final prediction instrument—the Violence Risk Assessment Guide (VRAG).[124]

The resulting prediction instrument yielded a strikingly high degree of accuracy in predicting future violent behavior. For those subjects scoring in the 80th percentile or above, the percentage correctly identified as dangerous

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Detecting Distortions of True Basal Violence, 9 CRIM. J. & BEHAV. 3 (1982).

[115] *See* HESS & WEINER, *supra* note 110, at 176-77.

[116] Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 JAMA 1007 (1993).

[117] John Monahan, *Violence Prediction: The Past Twenty Years and the Next Twenty Years*, 23 CRIM. J. & BEHAV. 107, 111 (1996).

[118] Lidz *et al.*, *supra* note 116.

[119] *Id.*

[120] *Id.* This was especially so for female patients, for whom clinical predictions of violence were no more accurate than chance. *See also* Monahan, *supra* note 117, at 112.

[121] HESS & WEINER, *supra* note 110, at 173.

[122] Grant T. Harris et al., *Violent Recidivism of Mentally Disordered Offenders: The Development of a Statistical Prediction Instrument*, 20 CRIM. J. & BEHAV. 315 (1993).

[123] *Id.* at 317-19.

[124] The variables were (1) psychopathy checklist score, (2) separation from parents under age 16, (3) victim injury in index offense, (4) DSM-III schizophrenia, (5) never married, (6) elementary school maladjustment, (7) female victim in index offense, (8) failure on prior conditional release, (9) property offense history, (10) age at index offense, (11) alcohol abuse history, and (12) DSM-III personality disorder. *See id.* at 324.

by the VRAG was 74%.[125] The VRAG's predictive accuracy even for those individuals scoring in the 60th percentile was 70%.[126] The authors of the 1993 study thus concluded that:

> Clinical judgment *can* be improved . . . through the use of actuarial information . . . . In this approach to decision making about an individual, an actuarial estimate of risk is used to anchor clinical judgment. More specifically, clinicians can use dynamic (changeable) information such as progress in treatment, change in procriminal attitudes, and the amount and quality of supervision in the postrelease environment to adjust the risk level computed by the actuarial prediction instrument. If adjustments are made conservatively and only when a clinician believes, on good evidence, that a factor is related to the likelihood of violent recidivism in an individual case, predictive accuracy may be improved.[127]

The possibility that instruments such as the VRAG can significantly increase predictions of future violence is substantial. Yet even when available, it has been noted that "their application has been sufficiently cumbersome and time-consuming that actuarial input into the risk assessment of violence has been impractical in most real-world clinical settings."[128]

In response, researchers associated with The MacArthur Study of Mental Disorder and Violence developed what they believe is a clinically useful and accurate actuarial assessment tool—the Iterative Classification Tree (ICT).[129] In developing the tool, 134 risk factors for future violence were identified from four conceptual domains: dispositional or personal factors (e.g., age, gender, and head injury); historical or developmental factors (e.g., family, work, psychiatric hospitalization, and violence history); contextual or situational factors (e.g., social networks, social supports, and stress); and clinical or symptom factors (e.g., diagnoses, functioning, and substance abuse).[130] Over a thousand subjects were initially chosen from four acute psychiatric in-patient facilities in Pennsylvania, Missouri, and Massachusetts, where they were given a baseline interview in the hospital.[131] The subjects subsequently received follow-up interviews at ten-week intervals during their first year following discharge.[132] In addition, collateral informants were interviewed on the same schedule, and arrest and re-hospitalization records were also consulted.[133] The ICT was used to determine the interaction between the 134 risk factors and subsequent acts of violence in the community.

The classification tree method upon which the ICT is based was chosen because it permits an iterative model in which many different combinations of risk factors can be used to assess a person's risk of violence. The particular questions to be asked in generating an assessment grounded in this approach depend on the answers given to prior questions. Factors that are relevant to the risk assessment of one person may not be relevant to the risk assessment of another person. This contrasts with a regression approach in which a common set of questions is asked of everyone being assessed, and every answer is weighted to produce a score that can be used for purposes of categorization.[134]

The predictive ability of a tree-based approach alone is no more accurate than a standard main effects regression model. Researchers in the MacArthur study improved on the

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[125] *Id.* at 329.
[126] *Id.*
[127] *Id.* at 331.
[128] John Monahan et al., *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. OF PSYCHIATRY 312-19 (2000).
[129] JOHN MONAHAN ET AL., RETHINKING RISK ASSESSMENT (2001).
[130] *Id.* at 148, 158, 163-68.
[131] *Id.* at 148, 150.
[132] *Id.* at 148.
[133] *Id.* at 152-53.
[134] *Id.* at 10-11.

standard classification tree by introducing two novel aspects. The first was to avoid a dichotomous approach that classifies all subjects into either a high or low risk group. Rather, the researchers employed two cut-offs—one that identifies high-risk cases and one for low-risk cases. "By focusing actuarial attention on cases at the more extreme ends of the risk continuum, [the researchers] thought that [they] might increase predictive accuracy for the cases [they] designated as extreme."[135] The second innovation was to increase the predictive accuracy of the classification tree by pooling and reanalyzing all subjects that initially fell between the high- or low-risk thresholds. The logic of this innovation was that "the people who were not classified in the first iteration of the analysis might be different in some significant ways from the people who were classified and that the full set of risk factors should be available to generate a new classification tree specifically for the people who were not already classified as high or low risk."[136] The process of pooling and reanalyzing subjects was repeated until no additional groups of subjects could be classified into high or low risk categories. Thus, the classification tree used in the MacArthur study became an "iterative" one.

These two innovations resulted in substantially improved predictive accuracy, with the results of the ICT method significantly better than chance in predicting future violence. Even a truncated, clinically feasible ICT model succeeded in partitioning 72.6% percent of the subjects into either the high- or low-risk category for violent behavior within twenty weeks following hospital discharge.[137]

In addition to this high rate of classification, the predictive accuracy of high- and low-risk subjects within these classifications was impressive. The low-risk category consisted of groups of individuals whose rates of violence were no more than half the base rate of the total patient sample (i.e., $\leq$9% violent), whereas the high-risk category consisted of groups of individuals whose rates of violence were at least twice the base rate of the total patient sample (i.e., $\geq$37% violent).[138] Within these low- and high-risk categories, the observed rates of actual violence were 5% and 45%, respectively.[139] The prevalence of violence within the individual risk groups that comprised the low- and high-risk categories varied from 2.7% to 52.7%.[140]

Moreover, these results show that the improved accuracy of actuarial instruments such as a clinically feasible ICT can be applied without the unavailable or costly-to-gather information normally required by such tools. "[R]isk factors usually found in patient files, or capable of routine assessment, are all that are required for the ICT to function."[141]

This study illustrates that the ICT can be a viable candidate for use in the rough-and-ready world of pretrial detention hearings. Although the predictive accuracy of the ITC may still not be commensurate with the "clear and convincing evidence" requirement found in most pretrial detention statutes, ICT accuracy of over one-out-of-two correct predictions of future violence is a significant improvement over the one-out-of-five record found in judicial determinations of individual risk.

It is important to remember, however, that the ICT is a clinically useful actuarial approach only for assessing the risk of violence among acute psychiatric patients. It has not been

[135] *Id.* at 11.
[136] *Id.* at 12.
[137] *Id.* at 109. The clinically feasible ICT consists of 106 risk factors, as opposed to the 134 risk factors used in the empirically optimal ICT. *Id.* at 108. *See also* Monahan et al., *supra* note 128, for a full discussion of the clinically feasible ICT. This truncation does not, however, lead to a great decrease in accuracy. In addition, the 72.6% classification of the clinically feasible ICT far outstrips the 57.1% classification rate available through a standard main effects regression model. *Id.* at 106.
[138] *Id.* at 112.
[139] *See id.*
[140] *Id.*
[141] Monahan et al., *supra* note 128, at 319.

applied and tested among people with mental disorders in the general population, nor with the mixed (i.e., some of whom have a mental disorder and some who do not) population of criminal defendants appearing at bail hearings.[142] Simply put, the ITC results are encouraging, but the approach has not yet been demonstrated to be viable for pretrial predictions of dangerousness.

Some Objections to Preventive Pretrial Detention and a Final Conclusion

Even assuming that better means to assess the pretrial dangerousness of criminal defendants are developed, there still exists the well-worn adage that our criminal justice system would prefer to let ten guilty people go free rather than permit one innocent person to be convicted. But this adage is fundamentally inapplicable when the accuracy of dangerousness predictions rises above a certain threshold. When the issue is conviction for a crime, the harm has already occurred and should not be compounded by an additional injustice.[143] But when the goal is to prevent future harm, this calculus must change.

If we can accurately predict that six out of ten identified individuals will commit murder, the likelihood that four will unjustly lose their freedom for a limited period of time must be weighed against the likelihood that six individuals for whom guilt or innocence is not a question will lose their lives.[144] In such a scenario, it can be argued, preventive detention of the entire group of defendants may well be justified. Of course a prediction of dangerousness or even violence does not necessarily equate with a likelihood that a murder or other severe episode of violence will occur. But to the extent we become more certain in our predictions of violence, objections to the practice of pretrial detention will likely be muted. Indeed, if predictive accuracy increased sufficiently, the threshold findings required for such detention could even be lowered.

Another objection to the use of assessments of the likelihood of dangerousness in pretrial detention determinations is that the defendant is being incarcerated for crimes that have not yet been committed. However, the criminal law already punishes certain unconsummated transactions, including anticipatory crimes such as possession, or inchoate crimes like attempt or conspiracy. This reinforces the notion that, when a high degree of predictive accuracy has been established, pretrial preventive detention can be based on reasonably anticipated violent conduct.[145]

In general, predictions of future dangerousness are being made more accurately. The past three decades have seen an undeniable trend among mental health researchers, albeit at a slow and grudging pace, toward increasingly precise assessments of the risk of dangerousness posed by individuals. In addition, both clinical evaluations and actuarial tools intended to assess future dangerousness are markedly superior to assessments by the judiciary or prosecutors. This greater accuracy suggests an important role for clinical and actuarial assessments in pretrial decisions regarding defendant detention.

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[142] *See generally* MONAHAN ET AL., *supra* note 129, at 129-43.

[143] Michael L. Corrado, *Punishment and the Wild Beast of Prey: The Problem of Preventive Detention*, 86 J. CRIM. L. & CRIMINOLOGY 778, 793 (1996).

[144] *Id.* at 794.

[145] For an excellent discussion of preventive detention for dangerous individuals and the potential implications for criminal law in general, *see* Christopher Slobogin, *A Jurisprudence of Dangerousness*, 98 NW. U.L. REV. 1, 48-62 (2003).

Cases in the United States Supreme Court

Low IQ Score a Relevant Mitigating Factor at Capital Sentencing, Even If It Is Not Directly Connected to the Crime and No Other Evidence of Impairment Is Presented

In *Penry v. Lynaugh*, 492 U.S. 302 (1989), the U.S. Supreme Court established that a defendant's mental retardation is a potential mitigating factor at capital sentencing. Under Texas law, however, a finding of mental retardation was limited to where there is subaverage general intellectual functioning, concurrent deficits in adaptive behavior, and onset during the early development period.

During the penalty phase of a Texas capital murder trial, the only evidence admitted in defendant's favor was his low IQ score of 67. The jury, under Texas law, was instructed to consider the appropriate punishment by answering two "special issue" questions. The first question was whether defendant's conduct was committed deliberately and with the reasonable expectation that the death of the deceased would result. The second was whether there was a probability that the defendant would subsequently commit criminal acts of violence that would constitute a continuing threat to society. The jury answered both special issues in the affirmative and accordingly sentenced the defendant to death.

The Supreme Court determined that the defendant's low IQ was a potential mitigating factor and the two special issues were insufficient to permit the jury to give effect to the evidence pertaining to his IQ. The Court noted that it established in *Atkins v. Virginia*, 536 U.S. 304 (2002), that impaired intellectual functioning is inherently mitigating during capital sentencing, and that it has found IQs of 79 and 82 constituted mitigating evidence.

The Court held that evidence of impaired intellectual functioning based solely on an IQ score of 67 can be a mitigating factor at the penalty phase of a capital murder trial. The Court ruled that the jury instructions did not adequately permit the consideration of this evidence because impaired intellectual functioning has a mitigating dimension beyond the impact it has on the individual's ability to act deliberately, which was the focus of the Texas approach.

Furthermore, the Court ruled that the Fifth Circuit in reviewing this case had improperly required a connection between the defendant's impaired intellectual functioning and the crime before it could be considered as a mitigating factor. Tennard v. Dretke, 124 S. Ct. 2562 (2004).

Missouri Court Rules Individual Need Not Be Competent Before a Sexually Violent Predator Commitment Hearing Can Be Held; Supreme Court Declines Review

Many states in recent years have enacted laws that permit convicted sexual offenders to be civilly committed as a sexually violent predator upon the completion of their criminal sentence. It is well established that a criminal defendant must be competent to stand trial before the defendant can be convicted.

The question arose in Missouri whether a person facing commitment as a sexually violent predator must similarly be competent to understand the nature of the proceedings and to assist counsel in his defense. A Missouri Court of Appeals ruled that competence was not required. The U.S. Supreme Court declined to review this ruling.

The Missouri appellate court cited the U.S. Supreme Court's decision in *Kansas v. Crane*, 521 U.S. 346 (1997), that held that a similar sexually violent predator commitment scheme was civil in nature and not criminal. The Missouri court then determined that there is no requirement in general that a person for whom civil commitment is sought be competent to stand trial. The court asserted that the very nature of civil commitment is to

commit individuals for treatment who "are unable to comprehend reality or to respond to it rationally." The court also noted that the U.S. Supreme Court in *Jackson v. Indiana*, 406 U.S. 715 (1972), established that civil commitment is available for an individual who has been found incompetent to stand trial.

The court added that the person facing civil commitment as a sexually violent predator has been conferred by statute a number of other rights that provide sufficient due process protection. The court concluded that to block the proceedings because the individual is incompetent would thwart the state's interest in protecting the health and welfare of its citizens and jeopardize the individual's receipt of proper rehabilitating treatment. Missouri v. Kinder, 129 S.W.3d 5 (Mo. Ct. App. 2003), *cert. denied*, 125 S. Ct. 480 (2004).

Ruling That Dismissed Substantive Due Process Challenge to Sex Offender Registration and Notification Law Not Disturbed

Every state requires that various convicted sex offenders register with a state entity, typically a law enforcement agency, upon the completion of their prison term. This information is generally made available to the community by some means, which in many states, including Virginia, involves posting the information on an Internet website.

In 2003, the U.S. Supreme Court upheld such registration and notification laws in a pair of cases. In *Smith v. Doe*, 538 U.S. 84 (2003), the Court ruled that Alaska's registration requirements do not violate the federal constitution despite being imposed retroactively on defendants who were convicted prior to the enactment of the registration requirements because they did not constitute additional "punishment." In *Connecticut Dep't of Public Safety v. Doe*, 538 U.S. 1 (2003), the Court held that the Connecticut notification scheme did not violate procedural due process when it did not require a procedure to determine the current dangerousness of the individual because disclosure is based on the offender's prior criminal conviction, which he has already had a procedural opportunity to contest, and not the offender's current dangerousness.

The Supreme Court at the time did note that it was not addressing a possible substantive due process violation as the issue had not been raised on appeal. However, the Ninth Circuit subsequently reviewed such a claim, namely, that the registration and notification provisions constituted an infringement of sex offenders' fundamental interest in life, liberty, or property, which would have required the state to show a compelling reason for the provisions.

The Ninth Circuit determined that the U.S. Supreme Court has established that a "fundamental" right must be "deeply rooted in our history and traditions" or be "fundamental to our concept of constitutionally ordered liberty." Without discussion, the Ninth Circuit concluded that persons convicted of serious sex offenses do not have a fundamental right to be free from registration and notification provisions.

As a result, the state was only required to demonstrate a reasonable relation to a legitimate state interest to justify the action. The Ninth Circuit ruled that this requirement was met as the U.S. Supreme Court established in *Smith* that these provisions serve the legitimate purpose of "public safety" by alerting the public to the risk of sex offenders in their community. In addition, the court found that the broad categories of offenses that are included and the length of the reporting requirements are reasonably related to the danger of recidivism. Thus, although this scheme did infringe important liberty interests, the court concluded this infringement was not sufficient to strike it down as a violation of the Fourteenth Amendment right to substantive due process. The U.S. Supreme Court declined to review this decision. Doe v. Tandeske, 361 F.3d 594 (9th Cir. 2004), *cert. denied*, 125 S. Ct. 56 (2004).

Arkansas Court Finds That Nursing Home Negligence and Malpractice Warrants Significant Compensatory and Punitive Damages; Supreme Court Declines Review

A nursing home resident in Arkansas suffering from Alzheimer's Disease died from severe malnutrition and dehydration. There was considerable evidence that the resident did not receive proper care and suffered considerably; that the misconduct involved repeated actions; that the facility, part of a large chain of assisted living facilities, was short-staffed to maximize profits and this practice continued even after complaints by staff members, patients, and family members; and that efforts were made to conceal deficiencies, including bringing in extra employees on state-inspection days.

In the largest personal-injury verdict ever awarded in Arkansas, a jury awarded compensatory damages of $5 million for ordinary negligence and $10 million for medical malpractice, and $63 million in punitive damages. Given the egregious conduct of the nursing home, the Supreme Court of Arkansas upheld the jury findings, but did reduce as excessive the compensatory and punitive damages by two-thirds.

The U.S. Supreme Court declined to review this still substantial award, notwithstanding that the Court recently scrutinized the size of awards of punitive damages in *State Farm Mut. Ins. Co. v. Campbell*, 538 U.S. 408 (2003). Advocat, Inc. vs. Sauer, 111 S.W.3d 346 (Ark. 2003), *cert. denied*, 124 S. Ct. 532 (U.S. 2003).

Ruling That Dismissed Suit Against Therapist for Alleged Role in Conspiracy to Deny Child Custody to Mother Not Disturbed

Child custody disputes are frequently bitterly contested. Mental health professionals may be asked to play a pivotal role by formulating and submitting a report regarding who should be assigned custody. A disappointed party may subsequently file a lawsuit alleging improper behavior by the mental health professional in reaching his or her opinion. The U.S. Supreme Court declined to review a ruling by the Ninth Circuit that affirmed the dismissal of a lawsuit that alleged that a therapist had participated in a conspiracy to deprive a mother of the custody of her children.

The mother's complaint asserted that the therapist had joined with the fathers of her children and the social workers involved in the case in devising a plan to deprive her of the custody of her children. The mother claimed that the fathers of her children had made false claims of child abuse against her to punish her for leaving them and becoming involved with her ex-husband's brother, that the social workers had become involved to punish her for challenging their authority, and that the therapist's false report had been decisive in the judicial decision to deprive her of custody.

In dismissing the complaint, the Ninth Circuit ruled that the mother had to show more than that the therapist wrote reports upon which the social workers relied or that the therapist's actions ultimately resulted in the loss of custody. The court determined that there was no basis for inferring that the therapist was part of a conspiracy to violate the mother's constitutional rights. Elwood v. Morin, No. 02-56077, 2004 WL 26713 (9th Cir. 2004), *cert. denied* 125 S. Ct. 271 (2004).

Cases in Virginia State and Federal Courts

A Pair of Judicial Rulings Order Forcible Treatment of Non-Dangerous Criminal Defendants to Restore Competence to Stand Trial

In December of 2003, a federal district court in Virginia denied a request to forcibly medicate a criminal defendant to restore him to competence to stand trial. *United States v. Evans*, 293 F. Supp. 668 (W.D. Va. 2003). The court concluded that the government's interest in having the defendant treated over his objection was not sufficiently strong to outweigh the defendant's right to refuse such treatment. This case was noteworthy in that it was one of the first applications of the U.S. Supreme Court's decision in *Sell v. United States*, 539 U.S. 166 (2003), which permits, under certain circumstances, the medication over objection of criminal defendants even when the defendant is not a danger to self or others.

A month after the district court's initial ruling, a hearing was scheduled to determine whether the defendant should be civilly committed instead. Just before this hearing, however, the defendant was charged with threatening to murder the presiding magistrate. As a result, a hearing was conducted instead on whether the decision rejecting involuntary medication should be reconsidered in light of the new criminal charge.

The judge newly assigned to the case after the magistrate recused herself, ruled that involuntary treatment should be administered if the defendant continued to refuse to voluntarily take antipsychotic medicine prescribed for the purpose of restoring his competence. The court placed considerable weight on the fact that the defendant was now charged with a felony for which the maximum term of imprisonment is ten years. This new charge undercut one of the reasons given for initially refusing to order involuntary treatment, namely, that the defendant had already been confined longer than the possible imprisonment for the initially charged misdemeanor and therefore even if restored to competence and convicted he would not serve any time in jail.

The court also questioned another basis given for the initial ruling, namely, 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 risk of danger or flight that he might pose. The court noted it was uncertain that the defendant was sufficiently dangerous to permit long-term civil commitment.

The court also concluded that the other factors established by *Sell* supported an order of involuntary medication. In particular, the court found that (1) there was a substantial probability that the antipsychotic medicine would restore the defendant to competence within a reasonable time, (2) there were not less intrusive forms of therapy likely to restore the defendant to competence, (3) the administration of the medicine was not substantially likely to cause any serious side effects that would interfere with the defendant's ability to assist in his defense, (4) the medicine was medically appropriate, and (5) the government had important interests at stake in the restoration of defendant's competence.

The court noted the government intended to rely largely on the testimony of informants in prosecuting the latest charge and therefore the government had an interest in a prompt prosecution before memories fade. The court rejected the concern of the defendant's expert that the side effects of the medication would be enhanced because the defendant was seventy-five years old. The court also dismissed as "ironic" the likelihood that the defendant's delusional beliefs of persecution were likely to be enhanced by his lengthy incarceration without trial and the

government's efforts to involuntarily medicate him. United States v. Evans, No. 102CR00136, 104M00014, 2004 WL 533473 (W.D. Va. Mar. 18, 2004).

In a similar case decided within the same federal district court but by a different judge, involuntary treatment was ordered for another defendant who had been found incompetent to stand trial. The defendant, charged with possession of stolen firearms, testified that he believed that medicine was poison, that it could cause him substantial bodily harm, and that he would refuse medication even if ordered by the court to take it.

Relying on the testimony of two mental health professionals who examined the defendant, the court acknowledged that the defendant did not pose a risk of danger to himself or others. The court concluded, however, that involuntary medication was necessary to further the government's important interests in bringing the defendant to trial and assuring a fair and timely trial.

The court determined that with appropriate medication there was a substantial likelihood that the defendant could be restored to competence within a reasonable time. The court further determined that the proposed medication was not substantially likely to cause any serious side effects or any side effects that could interfere significantly with the defendant's ability to assist in his defense, although the court did note that there was a small probability that such side effects could occur. The court also found that the proposed medications were medically appropriate, and that less intrusive means of treatment, such as group or individual therapy, were unlikely to restore the defendant to competence. United States v. Mackie, No. 7:03CR00007, 2004 WL 368477 (W.D. Va. Feb. 26, 2004).

All Defendants Sentenced to Death Entitled to Have a Jury Determine Non-Frivolous Claims That They Are Mentally Retarded

In response to the U.S. Supreme Court ruling in *Atkins v. Virginia* (2002) that bans sentencing a mentally retarded individual to death, the Virginia General Assembly in 2003 established procedures for determining mental retardation in capital murder trials. This legislation established separate procedures for defendants whose trials occurred after the effective date of this legislation (i.e., new trials) and for defendants whose trials had previously been concluded. For new trials, it is clear that this legislation allows a jury to decide whether a capital murder defendant is mentally retarded. For defendants whose trials were completed prior to the effective date of the legislation, it was unclear whether those who raise a non-frivolous claim are entitled to have a jury decide the issue.

The Supreme Court of Virginia held that all defendants convicted of capital murder and sentenced to death are entitled to have a jury determine whether they are mentally retarded. The court determined that affording some defendants a right to have a jury decide the question and not others would violate the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution. Burns v. Warden of Sussex I State Prison, 597 S.E.2d 195 (Va. 2004).

Paraphiliac Pedophile's Acceptance of Responsibility for the Sexual Exploitation of Children Is Grounds for Sentence Reduction

The future of the federal sentencing guidelines is somewhat in doubt following the U.S. Supreme Court's recent ruling in *Blakely v. Washington*, 124 S. Ct. 2531 (2004). Under the guidelines as they currently exist, however, a trial judge in the federal system is to consider a number of factors in deciding whether to enhance or reduce a convicted defendant's sentence. The Fourth Circuit Court of Appeals held that a defendant who admitted to and attempted to remedy his mental disorder should be granted a sentence reduction.

A 63-old pedophile pled guilty to two counts of sexual exploitation of children, admitted to having sex with several hundred children

throughout his lifetime, and acknowledged his condition as a mental illness. Under the federal guidelines, a defendant is entitled to a reduction when the defendant "clearly demonstrates acceptance of responsibility." The trial court refused to grant this reduction because during sentencing the defendant indicated he believed that a child at age ten has the ability to consent to having sex with an adult. The Fourth Circuit reversed, noting that our legal system should not punish defendants for seeking the counseling and rehabilitation that they require.

The Fourth Circuit acknowledged that a guilty plea alone does not automatically entitle a defendant to a reduction for acceptance of responsibility. Rather, the defendant must prove by a preponderance of the evidence that he has clearly recognized and affirmatively accepted personal responsibility for his criminal conduct.

In assessing this defendant's acceptance of responsibility, the Fourth Circuit looked beyond his statement about children's ability to consent, which it characterized as a manifestation and acknowledgement of his disorder and consonant with the thought process of someone with a pedophilic paraphilia. The court added that, notwithstanding his statement, the defendant understood that a child cannot legally consent to such behavior, that the children he had interacted with had been harmed by his behavior, and that he should not engage in this behavior.

The court instead emphasized the defendant's willingness to speak voluntarily and in detail with authorities about crimes beyond those with which he had been charged, his admission to a life history as a sexual predator, his efforts to fight the disorder and obtain treatment, and his repeated expressions of guilt and remorse. While stating that the defendant's conduct was "of the most abhorrent type society knows," the court concluded that the rejection of a downward adjustment in his sentence would inappropriately establish a categorical bar that would deny the acceptance of responsibility reduction to individuals who suffer from and are not yet cured of mental disorders. Furthermore, the court reasoned, it would punish them for answering questions honestly and undermine their first steps toward rehabilitation. United States v. Kise, 369 F.3d 766 (4th Cir. 2004).

Downward Departure in Sentencing Under Federal Sentencing Guidelines for Defendant with Diminished Mental Capacity Prohibited When Possibility Exists That Defendant May Discontinue Medication

Under the federal sentencing guidelines as they currently exist, a federal judge can reduce a sentence below the applicable guideline range "if the defendant committed the offense while suffering from a significantly reduced mental capacity." However, this reduction may not occur if (1) the reduced mental capacity was caused by the voluntary use of drugs or other intoxicants, (2) "the facts and circumstances of the defendant's offense indicate a need to protect the public because the offense involved actual violence," or (3) the defendant's criminal history indicates a need to incarcerate the defendant to protect the public.

A Maryland man had pled guilty to possession of a firearm, his second conviction of a crime punishable by imprisonment. During a traffic stop, the police officer noted the man was clutching the side of his jacket and ordered the man to remove his hands from the jacket. The man refused to do so and, after back-up officers arrived, was subsequently found to have a .22 revolver in the jacket. The man suffers from paranoid schizophrenia and, unless medicated, experiences auditory hallucinations and feelings of paranoia. At the time of the arrest, the man had stopped taking his medication, was hallucinating, believed he was an undercover police officer, and thought people were trying to "hurt" him.

At sentencing, the trial court granted the defendant a downward departure under the

sentencing guidelines based on his diminished mental capacity and sentenced him to three years' probation. The Fourth Circuit Court of Appeals, however, ruled that the defendant was not eligible for the departure because the offense involved a serious threat of violence and indicated a need to protect the public. The court reasoned that the defendant's clutching his jacket while refusing to comply with an officer's order to remove his hands from the jacket where the gun was located created a "highly volatile situation that could have erupted in violence." The court added that because the defendant thought he was an undercover police officer and that people were trying to hurt him, the defendant apparently was prepared to use the gun, exposing the officers and the public to potential harm.

In addition, the Fourth Circuit cited the defendant's failure in the past to take his medication as establishing a "need to protect the public." Notwithstanding his current treatment compliance, the court determined that inadequate assurances had been provided that he would continue to do so. The court noted that he could refuse to visit his doctor or take his oral medication, and the discontinuation of his medication could "easily lead to a recurrence of symptoms" whereby his actions would pose "a serious threat of violence" and endanger the public.

A dissenting opinion criticized the majority for overly relying on speculation. The dissent asserted that whether an offense involved a serious threat of violence should depend on what actually happened, not what could have happened, and there was nothing "volatile" about this arrest. The dissent noted the defendant had neither moved nor spoken during the initial encounter with the officer, was already holding his jacket when the officer approached him, was clutching the jacket and not his firearm, and complied without incident when other officers arrived.

Similarly, the dissent criticized the majority's conclusion that a downward departure in sentencing was not justified because the defendant *might*, at some future time, decide not to take his medication. The dissent pointed out that the defendant had been treatment compliant for almost two years, was receiving daily reminders to take his medication from his mother, had expressed an intent to take his medication that his consulting clinical psychologist believed, and was now receiving injections of medication that ensured he would remain medicated for a month even if he forgot or refused to take his pills. The dissent emphasized that the offense had occurred two or three days after he failed to take his oral medication and the addition of the injections of medication to his treatment regime diminished the likelihood that such a relapse would occur again. The dissent added that the defendant's prior offense had occurred before any psychiatric treatment had been provided. United States v. Riggs, 370 F.3d 382 (4th Cir. 2004).

Physician at Virginia Mental Health Facility Ordered Reinstated

Ending a long-standing employment dispute at Western State Hospital, the Virginia Supreme Court ordered the reinstatement of a physician who had worked for six years as an internist at the state-run facility. The physician had been fired on May 15, 2001. He claimed he was fired for complaining publicly about the quality of psychiatric care at the hospital, while the state asserted he was fired for failure to follow a supervisor's instructions and for violating state policy regarding the disclosure of personnel records.

Under the grievance procedure that existed at the time, the physician contested his dismissal to his immediate supervisor, another physician, who reversed the termination and ordered his reinstatement. However, management took the matter to a "second-step" and a "third-step" review, provided by the facility's Medical Director and Hospital Director, respectively, and subsequently to a hearing officer and the Department of Human Resource Management, all of whom upheld the initial termination. The Virginia Code at that time read "[e]ach level of management

review shall have authority to provide the employee with a remedy."

The Virginia Supreme Court held that this provision permitted the physician to accept the ruling of his immediate supervisor and to preclude any subsequent review. Otherwise, the court asserted, the first-stage of the process would be reduced to a mere recommendation that could be followed or ignored. It added that giving the immediate supervisor the ability to preempt review by higher authorities was not unfair because the state had established this process and it was not absurd to afford an employee a remedy at the first stage of review.

The court acknowledged the Virginia General Assembly had amended this procedure in 2003, in direct response to this suit, to make each level of management review "subject to the agency head's approval," but concluded that only supported its view that such was not the case before this change occurred. Horner v. Dep't Mental Health, 597 S.E.2d 202 (Va. 2004); *Court Orders Reinstatement of Doctor Critical of Care*, 19 Virginia Lawyers Weekly 58 (June 21, 2004).

Employee Who Was Sexually Assaulted at a Correctional Facility for Inmates with Psychiatric Problems Can Only Turn to Workers' Compensation for Recovery

In general, when employees are injured in the course of work, they must turn to a state-run workers' compensation plan for recovery. These plans are intended to ensure compensation in a quick and reliable manner and do not require employees to show that the employer was at fault in connection with the injury. At the same time, the worker's compensation plan also places limitations on the size of the damages that can be recovered.

However, when the injury is outside the realm of expected activities for a particular business, employees typically have the option of filing claims through the tort system where they may recover more if they can show the employer was at fault. One such common exception involves sexual assaults that occur on the job because they involve an activity that is outside the norm for most businesses.

A female medical records technician at Marion Correctional Treatment Center, a facility for inmates with psychiatric problems operated by the Virginia Department of Corrections, asserted that this exception applied when she was subjected to an attempted forcible sodomy by an inmate while at work, and filed a tort claim for recovery.

The Smith County Circuit Court of Virginia, however, held that her exclusive remedy is workers' compensation. The court ruled that under the Virginia scheme, employees are limited to workers' compensation when the nature of the employment substantially increased the risk of sexual assault. The court cited the nature of the prisoners housed at the facility, the presence of rules and policies designed to keep such inmates from attacking the employees, and the fact that the inmate waited for a lapse in the security system before attacking as establishing the increased risk of this job. Gilbert v. Commonwealth, No. 03-199 (Va. Cir. Ct. June 3, 2004); 19 Virginia Lawyers Weekly 356 (Sept. 6, 2004).

Physician Employed as a "Physician Extender" by a State Psychiatric Facility Is Not Protected by Sovereign Immunity and Thus May Be Sued for Malpractice

Unless waived, the state is protected by the doctrine of sovereign immunity from malpractice claims. Employees of the state may be similarly protected. In Virginia, the greater the control of an employee's actions by the Commonwealth, the greater the likelihood of immunity. However, state-employed physicians may not be entitled to this immunity because they must exercise their professional skill and judgment when treating patients and thus tend not to be subject to the control and direction of others. *James v. Jane*, 282 S.E.2d 864 (Va. 1980).

The Virginia Supreme Court has ruled that a "physician extender" was not entitled to the protection of sovereign immunity when he was sued for malpractice following the death of a psychiatric patient. The physician was a resident in psychiatry at the University of Virginia and was on duty for weekend shifts at Western State Hospital to respond to emergent non-psychiatric medical needs. The patient, who suffered from a bipolar disorder, had "experienced a violent assault, likely through his rectum" within three days after having been involuntarily committed. The physician failed to diagnose the presence of free air in the patient's abdominal cavity and ordered treatment that exacerbated the patient's condition.

The court acknowledged that the facility did exercise some control over which patients the physician would see because the physician was expected to see patients that the nurses requested him to see. However, it concluded that the defendant was otherwise free to exercise his judgment and discretion about seeing patients and was not under anyone's supervision. As a result, the Commonwealth's control over the physician was, at best, slight, and the physician was not entitled to the protection afforded by the doctrine of sovereign immunity. McCloskey v. Kane, 604 S.E.2d 59 (Va. 2004).

Out-of-State Physician Can Provide Expert Testimony About Virginia Standard of Care

The Virginia Supreme Court reversed a trial court decision to exclude an out-of-state physician from providing expert testimony regarding the Virginia standard of care in a medical malpractice case. The trial court had ruled that the New York physician, although familiar with the national standard of care, was not sufficiently familiar with the Virginia standard of care and thus was not qualified to testify as an expert witness under § 8.01-581.20 of the Virginia Code.

In rejecting this ruling, the Virginia Supreme Court found that the physician was sufficiently familiar with the Virginia standard of care after having attended seminars and meetings in Virginia and having discussed this standard with Virginia physicians. In addition, the court noted the physician maintained an active clinical practice and was familiar with the medical specialty in question. Christian v. Surgical Specialists, 596 S.E.2d 522 (Va. 2004).

Sufficient Facts Alleged Regarding Suicide of Detainee to Permit "Deliberate Indifference" Lawsuit Targeting Jail Staff to Continue

Suicides and suicide attempts by jail and prison inmates with a mental disorder are unfortunately not a rare event. Following an inmate suicide, a lawsuit may be filed that asserts that correctional officials did not take adequate steps to prevent the suicide. The United States Supreme Court in *Farmer v. Brennan*, 511 U.S. 825, 848 (1994), established that a prison official may be held liable under federal law if the official "knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." Such a complaint is widely referred to as a "deliberate indifference" claim.

Such a complaint was filed in the Western District of the U.S. District Court of Virginia by the wife of a detainee who committed suicide at the Warren County jail. As a preliminary matter, the deputy sheriffs at the jail responded that the facts that the wife alleged, even if taken to be true, were not sufficient to support a deliberate indifference claim. The court disagreed and allowed the lawsuit to continue.

The court noted that a judge or jury can conclude that a prison official knew of a substantial risk if the risk was obvious. The court determined that the complaint alleged that the arresting officer had told the deputies that the detainee was drunk and threatening suicide, that the deputies failed to follow jail procedures for suicidal inmates (which included placing the inmate on suicide watch), that the deputies failed to provide adequate

treatment, evaluation, and protection (which included a failure to order a mental health evaluation), that the deputies had watched surveillance cameras trained on the detainee during this time, and that the detainee had engaged in suspicious activity for thirty minutes before he hung himself in full view of the cameras (which included multiple tests of the noose he crafted from his shoelaces). The complaint also alleged that despite the fact that the detainee's actions were observable on jail monitors and inmates in adjacent cells repeatedly tried to get the deputies' attention, the detainee's body was not cut down until approximately an hour and 40 minutes after his suicide. Thus, the court concluded, the detainee's wife had sufficiently alleged a "deliberate indifference" claim and was entitled to an opportunity to prove these assertions at trial. Short v. McEathron, No. Civ.A.5:04 CV 00043, 2004 WL 2475561 (W.D. Va. 2004).

Jury Verdicts Split on Medical Malpractice Claims of Negligent Administration of Pain-Relief Medicine by Psychiatrists

The family of a woman who died of an overdose of a strong pain-relief medicine given to her by a psychiatrist was awarded $1.4 million by a Virginia jury. The woman, who suffered from menstrual cramping and endometriosis, obtained four Fentanyl patches from the psychiatrist, allegedly without proper instructions, warning, medical exam, or a prescription. At the time she obtained the patches, the woman was an administrative clerk at the psychiatrist's clinic and in the process of obtaining a divorce from him. The woman was apparently unaware of the strength and potency of Fentanyl, a Schedule II drug, and applied all four patches simultaneously plus a heating pad, which increased the circulation of the medication. Criminal charges were subsequently brought against the psychiatrist and he was found guilty of prescribing a Schedule II narcotic without a written prescription.

During the civil trial, the presiding judge found that the psychiatrist and his psychiatric group breached the standard of care owed to the woman and thus were negligent as a matter of law. The jury was charged with determining whether the claim should be denied because of contributory negligence on the part of the woman. The defendants asserted that a reasonable and prudent person, such as the woman, who was intelligent and reasonably knowledgeable about the medication, would not have acted as the woman did and thus the claim should be defeated because the woman had also been negligent. The jury rejected this argument. Estate of Feury v. Member (Spotsylvania Co. Circ. Ct. 2004); *Deceased Woman's Family Wins $1.4 Million Against Psychiatrist*, 1 Virginia Medical Law Report 34 (July 2004).

In another case, a jury rejected a medical malpractice claim against a psychiatrist for the alleged negligent administration of pain medication. The psychiatrist had treated a woman for approximately a year for mental health issues. During this time, the woman sought treatment for chronic pain. The psychiatrist provided some pain medications but told the woman she needed to find another physician to provide long-term pain management.

Some time later, in the course of an emergency appointment, the woman and her husband told the psychiatrist that no other physician would provide treatment to the woman and they asked the psychiatrist to provide pain medication. The psychiatrist, although concerned about drug seeking behavior, concluded that this was a crisis situation based on what she had been told, and gave the woman a prescription for two weeks of Methadone. Five days later, the woman was found dead. An autopsy revealed a high level of Methadone, as well as the presence of two others drugs, including Elavil.

The woman's family claimed that the psychiatrist was negligent when she prescribed Methadone to this patient. The psychiatrist responded that the prescription of Methadone was within the standard of care and that the woman suffered a sudden cardiac

death due to her ingestion of Elavil, which is known to cause cardiac arrhythmias. The jury found for the psychiatrist. Estate of Marlow v. Slam, No. LR-1470-3 (Richmond Circ. Ct. 2004); *Wrongful Death Suit Nets Defense Verdict*, 19 Virginia Lawyers Weekly 103 (June 28, 2004).

A Court Can Not Impose Care and Discharge Obligations on a Hospital Beyond the Period of Time for Which the Individual Was Involuntarily Committed

An individual was involuntarily committed to a Virginia hospital for a period of 180 days and discharged by the hospital about two-and-a-half months later. A circuit court judge that affirmed the individual's initial commitment subsequently held a number of hearings and entered various orders relating to the individual's involuntary commitment, including an order that the hospital had an obligation to care for the individual and to advise the local county department of human development if it chose to discharge the patient. This order was entered over 10 months after the circuit court affirmed the commitment and over 11 months after the initial commitment order.

The hospital asserted that it had properly discharged the patient, that it was not responsible for the care of the individual after discharge, and that the circuit court did not have jurisdiction to enter its order. The Virginia Supreme Court agreed that the circuit court could not impose these requirements because the court's jurisdiction over the involuntary commitment ended 180 days after the commitment order was entered. Inova Health Sys. v. Grandis, 603 S.E.2d 876 (Va. 2004).

Termination of Parental Rights of Woman Who Suffered from Situational Anxiety Disorder Rejected

The Virginia Court of Appeals refused to terminate a woman's parental rights after concluding that there was sufficient evidence to establish that the woman had made substantial efforts to remedy the conditions that led to the placement of her son in foster care. The court cited the woman's attendance at recommended programs and services, her independently obtaining one-on-one sessions with the director of community violence services, and her participation in individual counseling, even after an initial ruling terminated her parental rights.

The court also noted an assessment of the mother by a psychologist who testified that the woman had learned a lot from her parenting classes. The psychologist found the mother suffered from situational anxiety disorder, making her less likely to stand up to her boyfriend, but determined that this condition would likely lessen over time. The court ruled that termination was premature and that the department of social services had failed to make reasonable and appropriate efforts to assist the woman to remedy the circumstances that led to the placement of her child in foster care. Richmond Dep't of Soc. Servs. v. Enriquez, No. 1650-03-2 (Va. Ct. App. July 13, 2004).

Parental Rights Terminated for Failure to Remedy Mental Health, Substance Abuse, and Domestic Violence Issues That Adversely Affected Ability to Properly Parent Children

It is not unusual for mental illness and substance abuse to figure prominently in a decision to remove a child from the custody of a parent, as well as in a decision to ultimately terminate parental rights. In a recent case, the Virginia Court of Appeals ruled that a mother's failure to remedy issues associated with mental health, substance abuse, and domestic violence that adversely affected her ability to properly parent her children provided a sufficient basis for terminating the mother's parental rights. The court indicated that its focus is not whether steps have been taken to remedy these issues, but what has been achieved as the results of these steps.

The court noted that it had been three years since the occurrence of the conditions that necessitated placing the children in foster

care, that the mother failed to establish that she had benefited from the services she had sought or had remedied the conditions that necessitated the children's removal from her care, and that it was the opinion of the professional that had conducted a psychological evaluation of her parenting ability that she still required long-term therapy to remedy her parental deficiencies. As a result, the court concluded that there was sufficient evidence that the mother was either unable or unwilling to substantially remedy within a reasonable time the conditions that resulted in foster care placement and further opportunities were not required.

Relying on similar grounds, the court also upheld the termination of the parental rights of the father. Carr v. James City County Div. of Soc. Servs., Nos. 0339-04-1, 0499-04-1, 2004 WL 1822374 (Va. Ct. App. 2004).

Cases in Other Federal Courts & Federal Legislation

Third Circuit

Medicaid-Eligible Adults Who Are Mentally Retarded Can Sue State for Failure to Provide Community-Based Intermediate Care Facilities

The Medicaid Act furnishes funds to the states to help them provide medical assistance to eligible low-income individuals. Although states are not required to participate in such programs, if they accept federal funding they must comply with the Medicaid Act and related federal regulations.

In Pennsylvania, Medicaid-eligible, mentally retarded adults needed medical services from an intermediate care facility, but were kept on a waiting list for years. Although they qualified for these services under Pennsylvania's medical assistance plan, the Commonwealth claimed it lacked the funds to provide this assistance and that, in any event, the sole remedy for non-compliance with the Medicaid Act is the suspension or revocation of funding from Congress.

The Third Circuit rejected this latter assertion and held that these individuals were entitled to file a lawsuit to seek enforcement of their right to these services. The court agreed that the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action but action by the federal government to terminate funds to the state. However, under the Supreme Court's decision in *Gonzaga University v. Doe,* 536 U.S. 273 (2002), the court determined plaintiffs can pursue such a cause of action if they can show that Congress unambiguously conferred rights that may be vindicated by individual suits.

Reviewing the relevant portions of the Medicaid Act, the court found "rights-creating language" that clearly conferred specific entitlements on eligible individuals to be provided these services with "reasonable promptness," and that Congress had not indicated its intention to preclude individual suits.

As a result, the court held that individual actions to obtain these services could be pursued against the Commonwealth, notwithstanding that the federal government might also sanction Pennsylvania for failure to comply with its own medical assistance plan. Sabree v. Richman, 367 F.3d 180 (3d Cir. 2004).

Seventh Circuit

Life-Time Ban from City Parks Can Be Imposed on Past Sex Offender Who Has Molestation Fantasies While "Cruising"

States and communities across the country have crafted numerous mechanisms to limit the activities of repeat sexual offenders. The City of Lafayette, Indiana, banned one such offender from all of its public parks.

In 2003, a three-judge panel of the Seventh Circuit of the U.S. Court of Appeals struck down this ban as a violation of the First Amendment. Doe v. Lafayette, Ind., 334 F.3d 606 (7th Cir. 2003). Reviewing this case en banc, the Seventh Circuit reinstated the ban and ruled that it did not violate the federal constitution.

John Doe had convictions between 1978 and 1991 for child molestation, voyeurism, exhibitionism, and window peeping, most of which involved children. Since 1986 he has been receiving psychological treatment. In 2000, an anonymous call to Doe's probation officer reported that Doe "had been 'cruising' public parks and watching young children." In response to the call, the City of Lafayette imposed a lifetime ban that prohibited Doe from entering all city park property.

Doe later admitted that he had watched three or four children in their early to mid teens for

15-30 minutes on his way home from work and had thought about having sexual contact with them. He said that he left after telling himself that "I've got to get out of here before I do something" and asserted these were just thoughts because it was not realistic to approach a group of children in such a wide open area.

Doe's psychologist, who saw him on a weekly basis, stated that, like any other addict, Doe does not have control over his thoughts and will always have such thoughts. However, she believed that in the past 10 years Doe had learned how to resist these inappropriate urges. Nevertheless, she conceded that she could not guarantee that Doe would not relapse and that sexual addicts do sometimes relapse.

The Seventh Circuit sitting en banc upheld the city's ban, finding that the ban was a measure reasonably designed to serve the city's compelling interest in protecting children. The court acknowledged that under the First Amendment an individual cannot be punished for "pure thought," but concluded that this was a regulation of conduct, which was permissible notwithstanding its incidental effect on thought. The city was not banning Doe from having sexual fantasies about children, the court determined, but rather barring him from parks because he was on "the brink of committing child molestation."

The court added the city was not required to wait until Doe attempted child molestation before it could act. The court also emphasized that Doe, as an admitted pedophile who continues to have difficulty controlling his urges, belongs to a group of persons who are more susceptible to having sexual desires and to acting on those desires and, although society cannot exile, harass, or marginalize such individuals, it can act to protect vulnerable children.

The court also rejected Doe's claim that this ban violated the Due Process Clause of the Fourteenth Amendment. The court responded that such claims are successful only if the individual can establish that the government's action has infringed upon a fundamental right that is "deeply rooted in the Nation's history and tradition." While noting the range of fundamental rights that have been recognized, including the right to marital privacy, the Seventh Circuit concluded that Doe did not have a fundamental right to enter public parks to "loiter." Further, the court noted that Doe had not entered a park in the previous ten years and was not simply wandering, loitering, or pursuing other innocent activities on this occasion. The court emphasized the city's compelling interest in protecting its youth and concluded that Doe's ban was rationally related to this interest.

A dissenting opinion characterized this ban as a regulation of a person's thoughts. The dissent argued that the mere fear that a person may act upon his or her thoughts is not a sufficient basis for curbing protected thinking, regardless of the content of the thoughts, and asserted that there must be actual harm before such steps can be taken. The dissent also criticized the absence of an assessment of whether Doe was actually unable to control his urges.

Further, the dissent emphasized the importance of therapy for former sex offenders and contended that they should be supported in their efforts to control their urges rather than penalized. Doe had related the incident to his sexual addict anonymous support group. The dissent believed that the possibility that an individual can be banned from public spaces after communicating one's thoughts to others may have a chilling effect on efforts to obtain help. Doe v. Lafayette, Ind., 377 F.3d 757 (7th Cir. 2004).

Eighth Circuit

N.D. Iowa

Law Enforcement Officials as Part of Their "Community Caretaking" Function Are Entitled to Detain and Transport an Individual Who Is Not Suspected of a Crime to a Hospital for the Purpose of

Providing Him with Medical or Psychological Assistance; But Medical Staff May Be Liable for Forcibly Administering Tests Without the Individual's Consent Absent the Showing of an Emergency

Law enforcement officials are often the first to respond to emergent mental health crises and health care providers at hospital emergency rooms are often the first to treat an individual in the midst of a mental health crisis, frequently after a law enforcement official has brought the individual to the emergency room. Questions have arisen about their respective abilities to respond to and treat individuals who do not desire their assistance. A federal court in Iowa afforded relatively wide latitude to the law enforcement officials, but less so to emergency room health care providers.

In January 2001, sheriff's deputies in Iowa detained a man after he was found walking on a highway without a coat. The man's pickup truck had run out of gas and he had initially walked to a nearby farmhouse. Although the deputies were responding to a call of a reported burglary; a subsequent investigation determined that a burglary had not occurred.

Finding the man relatively uncooperative and uncommunicative, the deputies concluded the man was intoxicated from alcohol or a controlled substance and for his own safety and the safety of others could not remain at large. He was handcuffed and placed in the front seat of a patrol car and taken to a nearby hospital's emergency room. After arrival, the man was turned over to the care of the hospital staff but the deputies remained at the hospital to provide security.

Still handcuffed, the man was first seen by an emergency room nurse, who found him in an agitated state pacing about the room. The man would not answer the nurse's questions but she was able to take his pulse, respiration, temperature, and blood pressure. A physician then arrived and also observed the man in an agitated state. The physician concluded that although the man was medically stable, his mental state was not normal or stable and he was most likely under the influence of drugs, alcohol, or both. A urine test was ordered to determine the proper course of treatment and to ascertain whether the man could be treated at the hospital or needed to be transferred to another hospital that was better equipped to treat patients with a psychiatric disorder.

However, the man was unable to urinate and a decision was made to insert a catheter. The man was not asked if he wanted to be catheterized and his consent was not obtained. His pants were removed, his arms were handcuffed, and he was restrained on a cart by the deputies. After completing the test and consulting with a staff psychiatrist, the decision was made to transfer the man to a psychiatric facility. The man asserted the actions by the sheriff's deputies and the emergency room staff violated his rights and brought a lawsuit.

The U.S. District Court for the Northern District of Iowa, in reviewing the deputies' actions, focused on whether these actions were justified as part of their "community caretaking" function. This doctrine authorizes law enforcement actions unrelated to the detection or investigation of crime. However, courts have split on whether its scope is limited to searches and impoundments of motor vehicles, which have been characterized as being associated with lesser expectations of privacy, or whether it has a broader scope.

The Iowa federal court ruled that the "community caretaking" function did apply in this case and justified the deputies' detention and transportation of the man to the hospital and their assisting in his involuntary catheterization. The court determined that the deputies would have been remiss to have left the man along the road in his condition. It further found that the transportation to the hospital was properly provided for the non-investigatory purpose of supplying him with medical and/or psychological assistance.

As for their actions at the hospital, the court

noted the deputies had no input into the decisions made by the medical staff, were there only to maintain the peace and to provide protection to the hospital staff, and would have been "derelict in their duties" if they had merely transported the man to the hospital and "foisted him, an individual with possible psychological difficulties, upon the staff of a small town hospital." The court characterized the deputies' actions as reasonable and in keeping with their community caretaking functions.

As for the claims against the medical staff, the staff acknowledged that they did not obtain consent for the tests they administered, but claimed they were obligated under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) to provide a medical screening examination to ascertain whether the man had an emergency medical condition. The court ruled that EMTALA does not preempt the usual requirement to obtain informed consent for a medical procedure. Because the hospital defendants had not thus far established the existence of an emergency situation that would have eliminated the need to obtain the man's consent before catheterizing him, the court concluded the man could proceed with his claims against the hospital and its staff. Tinius v. Carroll County Sheriff Dep't, 321 F. Supp. 2d 1064 (N.D. Iowa 2004).

Federal Legislation

On October 21, 2004, President George W. Bush signed into law the Garrett Lee Smith Memorial Act (PL 108-355). The law authorizes $82 million in grants over three years to address the problems of students that may lead to suicide. Suicide is the third leading cause of death both for youth between the ages of 10 and 24 and for college-age students. Although money for the grants has not been fully appropriated, these competitive grants to states, Indian tribes, colleges, and universities are intended to help develop early intervention and prevention strategies and to help promote the delivery of mental and behavioral health services on school campuses.

On October 30, 2004, President Bush signed into law the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (PL 108-414). The law authorizes federal funding to expand access to mental health treatment for offenders with a mental illness during and after incarceration; to support pretrial jail diversion programs, mental health courts, and sentencing programs; and to provide specialized training to criminal or juvenile justice officers and mental health personnel who work with offenders who have mental health disorders. Money for these grants, however, was not appropriated in the omnibus funding bill for fiscal year 2005.

Cases in Other State Courts

California

Psychotherapist Alerted by a Patient's Immediate Family of a Threat by the Patient Can Be Held Liable for Failing to Warn the Patient's Victim; Expert Testimony Not Required to Establish Liability

Tarasoff v. Regents of Univ. of California, 551 P.2d 334 (1976), the first judicial opinion to rule that a psychotherapist may have a legal duty to take reasonable steps to protect a third party who has been threatened by the psychotherapist's patient, reverberated across the country. A number of states, including California and Virginia, enacted legislation to specify more clearly when this duty arises.

The California legislature established that this duty only exists when "the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim." A California Court of Appeals ruled that this duty is not limited to when the patient has communicated a threat, but is also invoked when a member of the patient's immediate family conveys the threat to the psychotherapist for the purpose of facilitating and furthering the patient's treatment.

In this case, a police officer with a history of emotional problems killed a man who had begun dating the officer's ex-girlfriend. The officer then killed himself. The assailant had been taken to a hospital two days earlier by his father and treated by a licensed clinical social worker employed by the hospital. The father told the social worker that his son had just punched him for the first time in his life and had threatened to kill the man his ex-girlfriend was now seeing. He also stated that he believed his son was likely to carry out the threat.

The social worker perceived the son as angry, upset, and hostile, and because he feared for his own safety, requested assistance from the hospital's security guards during the intake interview. The social worker believed the son met the criteria for involuntary hospitalization but because an involuntary hospitalization would hurt his career as a police officer, the social worker persuaded him to instead voluntarily admit himself to the hospital.

The son was discharged the next day. The parents of the murdered man filed a lawsuit that asserted that the psychotherapist's failure to warn their son constituted professional negligence.

The California Court of Appeals ruled that it did not matter that the threat had not been communicated by the patient because the pivotal question was whether the psychotherapist actually believed or predicted a patient posed a risk of inflicting serious physical harm upon a reasonably identifiable person.

In a companion case, *Ewing v. Goldstein*, 15 Cal. Rptr. 3d 864 (Cal. Ct. App. 2004), the court reasoned that a literal reading of the statute was not justified because the statute reflected a determination by the legislature that the need to preserve the confidentiality of patient communications must yield when disclosure is necessary to avert serious physical harm to another and that another statutory provision established that a communication between a patient's family members and the patient's therapist, made in conjunction with the diagnosis and treatment of the patient, is a confidential patient communication.

In addition to this arguably broad reading of the duty to protect statute, the court also ruled that the plaintiffs in the lawsuit were not required to introduce supporting expert testimony to establish liability. The court noted that the California legislature had established that psychotherapists could only be held liable if the therapist actually believed or predicted a patient posed a risk of harm to

another person, and not just because they should have known of this risk pursuant to professional standards, as the duty had been originally formulated in *Tarasoff*. Because a review of professional standards and the professional standard of care was not required, the court reasoned that expert testimony was not required.

The court added that its ruling fell within the "common knowledge" exception typically employed in medical malpractice cases in which an improper act that is sufficiently obvious as to fall within the common knowledge of laypersons does not necessitate expert testimony. Although the court discussed at considerable length the legislature's intent to limit psychotherapists' liability in these cases, the effect of this ruling is to remove in California a second potential barrier to such lawsuits.

Finally, the court determined that the facts were sufficient for a jury to determine that the social worker actually believed or predicted that his patient would fulfill his threat to kill the man who was dating his patient's ex-girlfriend. The court noted that the patient was a police officer, and well-trained in the use of guns and with ready access to them. In addition, it observed that the patient had been in therapy for years, had recently become increasingly despondent upon learning his longtime love was romantically involved with another man, had just struck his father for the first time in his life, and had insisted his father get him to a hospital to obtain help.

Also, it noted the father, a former police officer himself, had told the social worker about the threat, that the father believed his son was fully capable of carrying out the threat, and that he was likely to do so. Finally, the court found the evidence indicated the social worker perceived the son as angry, upset, and hostile, believed the father's statements, asked the son whether he intended to hurt or kill his ex-girlfriend's new boyfriend, intended to involuntarily commit the son if he did not agree to a voluntary admission, and was sufficiently concerned for his own safety that he insisted upon the presence of security staff. Ewing v. Northridge Hosp. Med. Ctr., 16 Cal. Rptr. 3d 591 (Cal. Ct. App. 2004).

Mentally Disabled Son Can Recover Damages for Wrongful Death of His Father, Even Though He Believes His Father Is Still Alive

A California man died four days after a surgical procedure. The man's family asserted that the death was the result of professional medical negligence during the surgery and filed a wrongful death action. One of the man's sons is mentally disabled due to a head injury and as a result believes his father is still alive. Nevertheless, through his guardian ad litem, this son joined in the lawsuit. In response, the defendant argued that because this son believed his father was alive, he had suffered no damages from his father's death and thus was not entitled to pursue this claim.

A California Court of Appeals rejected the defendant's argument. It noted that children of a decedent in a successful wrongful death action are entitled to compensation "for the loss of love, companionship, comfort, affection, society, solace, or moral support suffered as a result of the death." It also noted that mental retardation does not necessarily render a person less able to suffer damages associated with loss of companionship or limit the capacity to appreciate parental comfort and support.

The court concluded that even though this son lacked knowledge of his father's death, it appeared the son's guardian would be able to show that the son suffered from the loss of his father's love and companionship and thus a wrongful death action could be pursued on his behalf. Knowles v. Superior Court of San Diego County, 13 Cal. Rptr. 3d 700 (Ct. App. 2004).

Connecticut

Psychiatrist and Psychologist Not Liable for Traffic Accident That Occurred When Patient Fell Asleep While Driving After Taking Prescription Medication

In 1997, a registered nurse fell asleep at the wheel and struck another vehicle head on, killing the driver of that vehicle. Initially, a wrongful death action was brought against the nurse.

However, during a deposition the nurse disclosed that she was being treated at the time of the accident by a psychiatrist and a psychologist and had been prescribed medication that caused her to fall asleep during the day. It was also discovered that the psychologist had followed the nurse's vehicle in her own vehicle to determine the nurse's ability to drive and had concluded the nurse could not keep her vehicle within recognized lanes of traffic. A wrongful death action was then filed that targeted the psychiatrist and psychologist, claiming they had breached their duty of care in failing to warn the nurse not to operate a vehicle after taking her prescribed medication.

The Appellate Court of Connecticut ruled that the defendants were not liable for the accident. The court determined that the proximate (i.e., legal) cause of the death was the nurse operating her vehicle on the highway even though she knew that her ability to do so was impaired, not a failure by the defendants to warn the nurse not to operate her motor vehicle.

The court reasoned that, as a nurse, she knew, without the benefit of a warning from the defendants, that the medication caused her to fall asleep while driving and that her driving was impaired. In addition, she had asked the psychologist about her ability to drive and been told that she had not operated her vehicle appropriately. As a result, the court concluded, she was aware of the substance of any warning the defendants might have given her. Weigold v. Patel, 840 A.2d 19 (Conn. App. Ct. 2004), *cert den.* 847 A.2d 314 (Conn. 2004).

District of Columbia

Patient Confidentiality Not Violated When Physicians in Same Medical Office Communicated About Patient's HIV Status

The District of Columbia, where this case arose, has recognized the tort of breach of the confidential physician-patient relationship. A patient, who was HIV positive, brought a lawsuit against a physician and his medical office, claiming such a breach. The claim arose when one of the patient's doctors sent a memorandum to another doctor within the medical office regarding a claim by the patient that the second doctor had sexually molested him. The memo disclosed that the patient's HIV status had recently deteriorated.

The District of Columbia Court of Appeals noted that this confidentiality tort was established to encourage candor by patients and confidentiality by physicians, but added that there is an expectation that related health care personnel will interact, that the reality of medical practice is that many individuals may work in concert, and that doctors within the same office should be allowed to work together with some latitude of freedom of communication.

The court acknowledged that in this case the communication was not made in connection with the immediate on-going treatment of a common patient. However, it ruled that such communications were not limited to when treatment of a patient was involved, but were also permitted in response to patient administrative requests and, as here, to patient complaints.

Moreover, the court considered the fact that both doctors already knew of the patient's HIV-positive status as a result of their previous treatment of the patient. Even though the recipient of the memo may have been unaware of the decline in the patient's condition, the court determined that, as long

as the challenged statement was medical information acquired as part of the firm's practice, it was unwilling to hinder the free flow of information within that practice, which ultimately might work to the detriment of the medical care of the patients of the firm as a whole.

Because the communication "related to important practice-related concerns that a patient of the medical practice had voiced," the court held that this was not "unconsented, unprivileged communication with a third party" as required to establish the tort. Suesbury v. Caceres, 840 A.2d 1285 (D.C. 2004).

Georgia

Mental Health Care Provider Not Liable for Negligent Hiring of Employee Who Later Raped Patient at Residential Treatment Facility

In part because relatively low wages are typically offered, it can be a challenge to find qualified staff to provide care to individuals with a mental disorder. When a staff member abuses these individuals, the question may arise whether the employer can be liable for having hired the person in the first place.

The Supreme Court of Georgia ruled that a mental health care provider was not liable for the rape of a patient in a residential treatment facility by a mental health assistant when it relied on a professional investigation service to perform a background check on the staff person, had no reason to question the accuracy or thoroughness of the information provided, and the investigation indicated that the staff person had no record of criminal activity.

The court noted that an employer may be liable for hiring or retaining an employee the employer knew or should have known was not suited for the particular employment involved. In addition, employers who fill positions in relatively sensitive businesses without performing an affirmative background or criminal search on job applicants may be liable as a result even if the legislature has not specifically required them to do so.

However, the court added, there must be a causal connection between the employee's particular incompetence and the injury sustained. Furthermore, the employer is liable only when the evidence establishes that the employer reasonably knew or should have known of an employee's "tendencies" to engage in certain behavior relevant to the injuries incurred.

In this case, the court concluded, the mental health care provider could be liable only if it knew or in the exercise of ordinary care should have known that the employee it hired to perform duties involving personal contact with medicated, vulnerable patients was unsuitable for that position because he posed a reasonably foreseeable risk of personal harm to such patients.

Here, the employer had conducted a background search. Even though the search did reveal some problems, namely, that inaccurate or incomplete employment and education information was provided in the employee's application, the court determined that these problems did not involve any accusations of criminal activities or violent behavior, nor otherwise indicate that the employee posed a risk of personal harm to others.

Thus, the mental health care provider did not breach its duty to avoid hiring an employee who posed a reasonably foreseeable risk of inflicting personal harm on others. Munroe v. Universal Health Servs., Inc., 596 S.E.2d 604 (Ga. 2004).

New Mexico

New Mexico Permits Defendant to Assert at Pretrial Hearing That Mental Retardation Precludes Death Penalty; If Not Established at This Hearing, Defendant Can Still Introduce Related Evidence During Sentencing Phase and Jury Must Unanimously Determine That Defendant

Not Mentally Retarded Before Turning to Possible Aggravating Factors

State courts continue to wrestle with the implementation of the U.S. Supreme Court's ruling in *Atkins v. Virginia*, 536 U.S. 304 (2002), which established that a mentally retarded defendant cannot receive the death penalty under the Constitution.

These courts are also required to take into account the U.S. Supreme Court's ruling in *Ring v. Arizona*, 536 U.S. 584 (2002), which held that a jury and not a judge must determine the existence of any aggravating factors during capital sentencing that might result in the imposition of the death penalty, and apply the beyond a reasonable doubt standard in reaching its decision.

The New Mexico Supreme Court held that because mental retardation is a potential mitigating factor that may reduce rather than increase the maximum punishment, the prosecution was not required to convince a jury that a defendant was not mentally retarded beyond a reasonable doubt. As a result, it was permissible for a judge to determine by a preponderance of the evidence whether a capital defendant has a mental retardation. The court noted the Fifth Circuit, the Georgia Supreme Court, and the Texas Court of Criminal Appeals have reached similar decisions.

In addition, the court held that under New Mexico's statutory scheme the determination of whether the defendant was mentally retarded did not have to wait until the sentencing phase of the trial but could be determined at a pretrial hearing. The court reasoned that because a capital trial consumes significantly more resources than a noncapital trial, it would be beneficial to all parties to resolve the question whether the defendant is ineligible for the death penalty as early in the proceedings as possible. The court also cited concerns about the reliability and fairness of a capital trial for defendants with mental retardation.

Finally, the court ruled that even if a judge determines that the defendant is not mentally retarded at the pretrial hearing, if the death penalty is being considered (which must be decided by a jury), the defendant must still be allowed to introduce evidence of mental retardation during the sentencing phase. Further, when such evidence has been introduced, the jury must first resolve the issue of mental retardation before it can proceed to consider aggravating and other mitigating factors. In addition, the jury must unanimously decide that mental retardation does not exist before addressing other factors, and it must specify via a special verdict its finding. State v. Flores, 93 P.3d 1264 (2004).

New York

New York Antidiscrimination Insurance Law Does Not Require Parity in Coverage for Physical and Mental Disabilities

Efforts have been launched across the country to enhance the benefits available to individuals with a mental illness under employer-provided health care plans. Such plans often include long-term disability insurance coverage that provides income or other benefits for an employee that becomes disabled. For a physical disability, this coverage may last as long as the disability continues or until the age of 65 when Social Security and Medicare benefits become available. For a mental disability, however, this coverage may be limited to a given period of time, such as two years, notwithstanding that the mental disability may be chronic and leaves the individual unable to work.

This lack of parity has been the focus of lawsuits, including one in New York. In New York, as in many states, a law exists that prohibits insurers from refusing to provide insurance to an individual with a mental disability or from limiting the scope of that insurance without an actuarial basis for that restriction.

The high court of New York, however, held that the state's insurance law and its

antidiscrimination provisions do not require that an employer's long-term disability plan offer the same benefits for both physical and mental disabilities. The court ruled that the New York law does not prevent an insurer from providing different benefits for different disabilities and ailments as long as the plan itself was equally available to both disabled and non-disabled individuals. The court emphasized that such limitations precede the occurrence of the disability and thus there is no discrimination against an employee with a mental disability because such employees were eligible for the same long-term disability coverage at the same premium as all other employees participating in the employer's group plan.

The court noted that courts in several other states, including Maine and Texas, where similar antidiscrimination statutes exist, have also generally declined to interpret these statutes to require equivalent coverage for mental and physical disabilities. The court added that eight federal courts of appeal have ruled that the federal Americans with Disabilities Act, which has similar antidiscrimination provisions, does not mandate equivalent benefits for physical and mental disabilities. The court stressed that to rule otherwise would require a "radical change" in the way the insurance industry does business and such a change requires direct legislative action. *In re* Polan v. New York Ins. Dep't, 814 N.E.2d 789 (NY 2004).

Washington

Defendant Who Received Direct Command from God to Murder Is Unsuccessful in Raising Deific Decree Defense Because the Command Did Not Overcome His Cognitive Ability to Tell Right from Wrong

Most states offer an insanity defense to defendants accused of committing a crime, although the nature of that defense varies somewhat from state to state. The State of Washington has adopted the *M'Naghten* test and will find a defendant legally insane if the defendant can establish that as a result of mental disease or defect the defendant was unable to perceive the nature and quality of the act or was unable to tell the difference between right and wrong with respect to the particular act charged.

In addition, Washington has recognized what is known as a "deific decree" exception, which allows a defendant to establish insanity if the defendant knew the criminal act was wrong but believed, as a result of mental defect, that God commanded the act.

An individual, who organized a religious group known as "the Gatekeepers" and claims he regularly receives messages from God, killed a former member of the group after he allegedly was told by God to kill the man. In preparation for the murder, he and another member of the group obtained camouflage clothing, wiped fingerprints off shell casings they planned to use, and drove from California to Washington. The victim was shot when he responded to a knock on the door of his home. The defendant confessed to the crime but asserted the insanity defense, arguing that God commanded him to murder the man. A jury rejected the defense and convicted him of first degree murder.

On appeal, the defendant argued that the jury instructions had improperly stated the deific decree defense because they did not define wrongfulness in terms of a moral wrong as opposed to a legal wrong. The Washington Court of Appeals dismissed this argument, citing *State v. Applin*, 67 P.3d 1152 (Wash. 2003), which held that a definition of wrongfulness should not be given to a jury. The court ruled that the trial court instructions were proper because they were neutral with regard to this definition, which in turn allowed both parties to argue their theories of whether a defendant who understood that an act was legally wrong could still qualify for the insanity defense because the defendant failed to understand that it was morally wrong.

The defendant next challenged a jury instruction that required that the delusional belief of a direct command from God must

have "destroyed the defendant's free will and his ability to distinguish right from wrong." The defendant argued that the "free will" language should not have been included. The court agreed that the Washington standard was a cognitive rather than a volitional test, but rejected the notion that the reference to "free will" was improper. The court determined that the reference to "free will" was not related to the defendant's volitional ability to control his behavior but rather his cognitive ability to tell right from wrong, and thus did not establish that the defendant must show a loss of volitional control or an irresistible impulse. The court did note that the instruction would have been more appropriate if it instead required the jury to find that the direct command from God had destroyed the defendant's free will to distinguish between right and wrong.

The court also commented that it was awkward to apply the insanity defense in this case because the defendant was not insane in the traditional sense in that he did not suffer from a mental disease. State v. Turgeon, 120 Wash. App. 1050 (2004).

Submission Guidelines

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Juvenile Sex Offenders and the Virginia Transfer Statute: Let Treatment Fit the Crime

"Mankind seems to be averse to the science of government."
John Adams in a letter to George Wythe, 1776

By Jessie M. Kokrda*

Abstract. When crafting transfer statutes, legislative decisions should be based on empirical research, not catchy but unsubstantiated assertions of a need to "get tough on juvenile crime." Although the research on juvenile sex offenders is limited, lawmakers should use the research that is available to design transfer laws that will minimize the future recidivism of juvenile sex offenders. For example, because research shows juvenile sex offenders respond well to treatment, and much more extensive treatment is available in the Virginia juvenile justice system than in the adult system, most juvenile sex offenders in Virginia should not be transferred to adult court.

Also in this issue:

Introduction

In response to public perception that violent juvenile crime is on the rise,[1] nearly all state legislatures have broadened the reach of their transfer statutes,[2] thereby making more juveniles eligible to be tried as adults. These

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[1] Ironically, the growth in juvenile violent crime that began in the late 1980s peaked in 1994, with the arrest rate declining 47% from 1994 through 2002. Howard N. Snyder, *Juvenile Arrests 2002*, OFF. JUV. JUST. & DELINQ. PREV. 1 (Sept. 2004).

[2] Between 1992 and 1997, 44 states and the District of Columbia passed laws making it easier for juveniles to be tried as adults. *OJJDP Statistical Briefing Book, available at* http://ojjdp.ncjrs.org/ojstatbb/html/qa135.html (last visited June 14, 2005) [hereinafter OJJDP Study].

"get tough" measures may have an emotional appeal, but they deny children needed treatment and the rehabilitative features of the juvenile justice system, making them more likely to recidivate.[3]

In the case of juvenile sex offenders, this problem is especially acute. Because juvenile sex offenders are more amenable to treatment than their adult counterparts,[4] special consideration should be given to the possibility of treating them rather than transferring them to the adult system. Rehabilitation in the juvenile system may be the best means of protecting communities from these sex crimes.

Although rehabilitation may not be the exclusive focus of the juvenile justice system today, public opinion still supports this goal.[5] Transfer and its potentially dire consequences should be imposed primarily when the danger that a juvenile poses to society outweighs the potential for rehabilitation. Unfortunately, these transfer statutes as they apply to juvenile sex offenders tend not to take this potential for rehabilitation into account.

Portrait of a Juvenile Sex Offender

Because male adolescents are charged with 20% of the sex offenses in this country[6] and half of adult sex offenders say they began offending during their teenage years,[7] the problem of sexually abusive youth is a significant one. The median age of juveniles

[3] *See* Donna M. Bishop et al., *The Transfer to Criminal Court: Does It Make a Difference?* 42 CRIME & DELINQ. 171, 183 (Apr. 1996).
[4] *See* Howard E. Barbaree et al., *Sexual Assault in Society: The Role of the Juvenile Offender, in* THE JUVENILE SEX OFFENDER 1, 11 (Howard E. Barbaree et al. eds., 1993).
[5] VIRGINIA COMMISSION ON YOUTH, THE STUDY OF JUVENILE JUSTICE SYSTEM REFORM, H. 37 at 59 (1996) (reporting that 68% of Virginia respondents said government should focus on prevention or rehabilitation, rather than enforcement or punishment, and 63% thought the main purpose of the juvenile court system should be to rehabilitate).
[6] OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUSTICE, MANAGING SEX OFFENDERS IN THE COMMUNITY: A NATIONAL OVERVIEW 34 (2003).
[7] Howard E. Barbaree & Franca A. Cortoni, *Treatment of the Juvenile Sex Offender Within the Criminal Justice and Mental Health Systems, in* THE JUVENILE SEX OFFENDER 243, 243 (Howard E. Barbaree et al. eds., 1993).

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adjudicated for a sex offense is 14.[8] These offenders generally are male adolescents, but there is a growing number of prepubescent youth and females being identified as juvenile sex offenders.[9] The population of juvenile sexual offenders is quite heterogeneous and its composition reflects the greater racial, religious, and socioeconomic population of the United States.[10] Consequently, efforts to develop a typical profile of a sexually abusive youth have had little success.[11]

However, a number of risk factors have been identified to explain why sex offenses in juveniles occur. The two most prominent factors are prior experiences of abuse and exposure to aggressive role models.[12] A prior history of maltreatment and abuse is a common feature among sexually abusive youth. A history of physical abuse is found in 20-50% of juvenile sex offenders, while 40-80% have suffered sexual abuse.[13] Exposure to pornography and substance abuse may also be risk factors, although they are more likely disinhibitors than causal factors.[14]

Other commonly shared traits include high rates of learning disabilities and academic dysfunction (up to 30-60%), the presence of other behavioral health problems such as substance abuse and conduct disorders, difficulties with impulse control and judgment, and a diagnosable psychiatric disorder (as high as 80%).[15] Juvenile sex offenders also tend to lack knowledge about sex and, more specifically, consensual sex, with distorted opinions and attitudes concerning sexuality.[16]

Although juvenile sex offenders resist categorization, some professionals find it helpful to distinguish among them on the basis of various traits. For example, sexually abusive youth, much like sexually abusive adults, can be characterized by the age of their victims: peers and adults as opposed to younger children. Those who offend against peers or adults are more likely to engage in delinquent behavior, to have a conduct disorder and a history of criminal activity, and to use violence in the commission of their sex offenses.[17] Juveniles who offend against children are more likely to target males and family members and to rely on guile and opportunity rather than force.[18]

Juvenile sex offenders can also be distinguished by the type of crime they commit. One group consists of "sexual status offenders" — juveniles whose behavior is criminal only because the age of their sexual partner falls below the legal limit prescribed by law. It is unknown what percentage of arrests falls into this category.[19] The second, and by far the largest, group is that of first-time offenders involved in abusive conduct. These juveniles are arrested because they are much older than their victims or because coercion was involved.[20] The last group, comprising 4-8% of the juveniles arrested for sex crimes, is the repeat offender involved in abusive

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[8] Gail Ryan, *Sexually Abusive Youth: Defining the Population*, *in* JUVENILE SEX OFFENDING 3, 6 (Gail Ryan & Sandy Lane eds. 1997).

[9] JOHN A. HUNTER, INSTITUTE OF LAW, PSYCHIATRY & PUBLIC POLICY, UNIVERSITY OF VIRGINIA, UNDERSTANDING JUVENILE SEX OFFENDERS: RESEARCH FINDINGS AND GUIDELINES FOR EFFECTIVE MANAGEMENT AND TREATMENT 1 (2000).

[10] CENTER FOR SEX OFFENDER MANAGEMENT, U.S. DEP'T OF JUSTICE, UNDERSTANDING JUVENILE SEXUAL OFFENDING BEHAVIOR: EMERGING APPROACHES AND MANAGEMENT PRACTICES (Dec. 1999), *available at* www.csom.org/pubs/juvbrf10.html (last visited June 10, 2005) [hereinafter CSOM REPORT].

[11] *See* Alexis O. Miranda & Colette L. Corcoran, *Comparison of Perpetration Characteristics Between Male Juvenile and Adult Sexual Offenders: Preliminary Results*, 12 SEXUAL ABUSE: J. RES. & TREATMENT 179, 181 (2000).

[12] HUNTER, *supra* note 9, at 2.

[13] CSOM REPORT, *supra* note 10.

[14] *Id.*

[15] *Id.*

[16] *See* VIRGINIA COMMISSION ON YOUTH, THE STUDY OF THE FEASIBILITY OF MANDATORY MONITORING OF JUVENILE SEX OFFENDERS FOR TEN YEARS, H. 73 at 6 (1994) [hereinafter FEASIBILITY STUDY].

[17] HUNTER, *supra* note 9, at 2.

[18] *Id.* at 3.

[19] FRANKLIN E. ZIMRING, AN AMERICAN TRAVESTY 67 (2004).

[20] *Id.*

conduct.[21] It is not possible to predict, based on existing studies, whether these repeat offenders are more likely to continue their sex offenses into adulthood.[22]

The victims of sexually abusive juveniles are predominantly female and their median age is seven.[23] Victims are often substantially younger than the offender.[24] Typically, a family member or acquaintance is the victim; 90% of juvenile sex offenses are committed against someone known to the abuser.[25]

The portrait of juvenile sex offenses in Virginia is similar to the nationwide one. In Virginia, juveniles perpetrate 10-13% of reported sexual assaults.[26] These crimes vary from misdemeanors such as indecent exposure to serious felonies such as aggravated sexual battery.[27] Almost 10% of the male population committed to the Department of Juvenile Justice (DJJ) have been identified as sex offenders.[28] In FY 2004, 84 newly committed juveniles were placed in DJJ's mandatory sex offender treatment program, with roughly two-thirds of them expected to remain with DJJ for a period greater than 24 months.[29] However, perhaps as many as 85% of charged juvenile sex offenders in Virginia receive services in the community from a Community Services Board (CSB).[30]

Juvenile sex offenses were once considered to be mere horseplay or the product of normal adolescent sexual experimentation.[31] Juvenile sexual offenses, however, may in some respects be more serious than adult offenses. According to one study, juvenile sex offenders are more likely than their adult counterparts to engage in more invasive forms of contact with their victims, such as intercourse, and to threaten their victims with weapons.[32]

Despite the seriousness of these actions, juvenile sex offenders, on average, engage in less serious and aggressive behaviors,[33] have fewer victims,[34] and are less likely to use physical violence while committing a sexual crime than adult offenders.[35] Juvenile sex offenders are also less likely to engage in more extreme forms of sexual fantasy and compulsivity than adult offenders, suggesting they may be more amenable to treatment.[36]

Recidivism Rates

Despite the disturbing figures recited above, the recidivism rates among adolescent sex offenders, particularly those who receive treatment, provide reason for optimism. The

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[21] *Id.*
[22] *Id.* at 68.
[23] Victor I. Veith, *When the Child Abuser Is a Child: Investigating, Prosecuting, and Treating Juvenile Sex Offenders in the New Millenium*, 25 HAMLINE L. REV. 47, 50-51 (2001); Tom Leversee & Christy Pearson, *Responding to Juvenile Delinquency: Eliminating the Pendulum Effect: A Balanced Approach to the Assessment, Treatment, and Management of Sexually Abusive Youth*, 3 J. CENTER CHILD. & CTS. 45, 47 (2001).
[24] SUE RIGHTHAND & CARLANN WELCH, U.S. DEP'T OF JUSTICE, JUVENILES WHO HAVE SEXUALLY OFFENDED: A REVIEW OF THE PROFESSIONAL LITERATURE 4 (2001).
[25] Veith, *supra* note 23, at 50.
[26] FEASIBILITY STUDY, *supra* note 16, at 7.
[27] *Id.*
[28] VA. DEP'T OF JUVENILE JUSTICE, VIRGINIA IS A LEADER IN TREATING JUVENILE SEX OFFENDERS, DJJ SPOTLIGHTS, *at* http://www.djj.state.va.us/index_information/treatment_sex_offenders.php (last visited June 10, 2005) [hereinafter DJJ SPOTLIGHTS].
[29] VA. DEP'T OF JUVENILE JUSTICE, OFFENDER POPULATION FORECASTS, FY 2005 40-41 (2004).
[30] FEASIBILITY STUDY, *supra* note 16, at 26.
[31] Leversee & Pearson, *supra* note 23, at 45. *See generally* NATIONAL ADOLESCENT PERPETRATOR NETWORK, THE REVISED REPORT FROM THE NATIONAL TASK FORCE ON JUVENILE SEXUAL OFFENDING, 44(4) JUV. & FAM. CT. J. 5 (1993) [hereinafter NAPN REPORT].
[32] Veith, *supra* note 23, at 51.
[33] Miranda & Corcoran, *supra* note 11, at 179-88.
[34] *Id.*
[35] RIGHTHAND & WELCH, *supra* note 24, at 4.
[36] *See* ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS (ATSA), THE EFFECTIVE LEGAL MANAGEMENT OF JUVENILE SEX OFFENDERS (Mar. 11, 2000), *at* www.atsa.com/ppjuvenile.html.

recidivism rate for juvenile offenders committing another sex offense is low — around 8% if measured by self-report and 14% if measured by reconviction.[37] Across a series of studies that employed various follow-up periods and definitions of recidivism, the rate of treated juvenile sex offenders recidivating is consistently below 15%.[38] For untreated juvenile sex offenders with follow-ups of two to ten years the rate was somewhat higher — 17.8% were charged with another sexual offense.[39] These statistics challenge the commonly held belief that juvenile sex offenders will continue to offend into adulthood and the axiom that "once a sex offender, always a sex offender."

For recidivism of non-violent non-sexual offenses, however, the re-arrest rates rise to 20.7% for treated juvenile sexual offenders and 50% for untreated juvenile sexual offenders over a two to ten year period.[40] These higher rates may suggest that juvenile sex offenders are generally delinquent, rather than sexually deviant.[41]

It should be noted that recidivism studies are typically based on re-arrest rates; however, many sexual offenses likely go unreported. Therefore, reported recidivism rates may be substantially lower than the actual number of offenses being committed.[42] Also, recidivism studies vary widely as to follow-up periods and as to types of treatment offered to the juveniles. Furthermore, much of the research performed has been on small samples. Because of these various factors and limitations, it is difficult to generalize from the current available research. Nonetheless, the figures do suggest that juvenile sex offenders are more likely to recommit a nonsexual offense than a sexual one.

Additionally, the rates of sex offense recidivism appear to be lower among juvenile sex offenders than adult sex offenders. One review of adult sexual offender recidivism studies found that rapists' recidivism rates ranged from 7-35%, child molesters with female victims ranged from 10-29%, child molesters with male victims ranged from 13-40%, and exhibitionists ranged from 41-71%.[43] The likelihood that juvenile sex offenders recidivate less than adult offenders, especially when provided treatment, further supports the use of a juvenile justice regime that provides treatment for juvenile sex offenders.

Treatment

Because juvenile sex offenders' low recidivism rates are correlated with treatment, treatment appears to be a better option for most sexually abusive youth than transfer. Indeed, in recent years the resources for treatment have greatly expanded. In 1982, there were a scant 20 juvenile sex offender programs, but by 1993 the number of treatment programs had skyrocketed to over 800.[44] With this increased pool of resources, debate has turned to who should receive this treatment and how those in need of treatment should be identified.

In a recent book, Professor Franklin E. Zimring critically examines the landmark 1993 report of the National Adolescent Perpetrator Network (NAPN) and its focus on a "tough love" approach.[45] The NAPN report advocates that all juveniles who engage in illegal sexual conduct be adjudicated and screened for possible mandatory treatment as part of the

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[37] James R. Worling & Tracey Curwen, *Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction*, 24 CHILD ABUSE AND NEGLECT 965, 967 (2000).
[38] *Id.* at 966.
[39] *Id.* at 965.
[40] *Id.*
[41] Telephone interview with Edward Wieckowski, Program Supervisor, Sex Offender Treatment Program, Department of Juvenile Justice (Va.) (Dec. 6, 2004) [hereinafter Wieckowski interview].
[42] Leversee & Pearson, *supra* note 23, at 49.
[43] CENTER FOR SEX OFFENDER MANAGEMENT, OFFICE OF JUSTICE PROGRAMS, U.S. DEPARTMENT OF JUSTICE, RECIDIVISM OF SEX OFFENDERS (May 2001), *available at* http://www.csom.org/pubs/recidsexof.html (last visited July 3, 2005).
[44] NAPN REPORT, *supra* note 31, at 5.
[45] ZIMRING, *supra* note 19, at 81.

disposition.[46] The report strongly discourages the use of pre-adjudication diversion and early return to the community based largely on an unstated assumption that all law violators are sexually deviant and thus dangerous.[47]

Zimring challenges this assumption and analogizes juvenile sex offenders to juveniles who violate drug, alcohol, and tobacco prohibitions.[48] He argues that every juvenile who commits a crime involving drugs or alcohol is not assumed to have a substance abuse problem and to need treatment.[49]

One of NAPN's reasons for rejecting diversion is to ensure that offenders are held accountable.[50] Zimring counters, however, that considerable discretion is exercised by social workers, police, and prosecutors in choosing which juveniles to pursue criminally and thus the mere filing of charges against juvenile offenders is not an inherently reliable indicator of sexual deviancy and dangerousness.[51]

In essence, Zimring argues that the NAPN approach casts too wide a net and fails to identify those few juvenile sex offenders who are truly dangerous and deviant. But because researchers have not been able to identify with confidence which juvenile sex offenders are sexually deviant versus those who have simply committed an isolated crime,[52] Zimring's analysis provides little guidance as to who to retain for placement and mandatory treatment.

A possible means for resolving this dilemma is to routinely mandate a predisposition treatment assessment for juvenile sex offenders who have been found to have committed a sexual offense.[53] The assessor should provide the court a recommendation on whether treatment is needed and appropriate, and, if so, where treatment should be provided (community-based or residential) based on the dangerousness of the youth, the severity of his psychiatric and psychosexual disturbance, and the youth's amenability to treatment.

Most juvenile sex offenders pose a low enough risk that they can be treated on an outpatient basis in a community setting.[54] As for the type of treatment the youth should receive, there are several different treatment models available. Many treatment programs integrate different aspects of these models into their approach. These treatment models can be divided into three general categories.

Biological. A biological model involves the use of medications, usually antiandrogens, to decrease the level of male hormones and thus the sexual arousal of male sex offenders.[55] This "chemical castration" is rarely prescribed for juvenile sex offenders because of issues of informed consent, medical supervision, and the fluctuation of juvenile hormones.[56]

Cognitive Behavioral/Social Learning. The focus of a cognitive model is on individual and group therapy, and can include sex education and value clarification that are especially geared for juvenile sex offenders.[57] This model assumes that sexual misbehavior has been learned, observed, or experienced by the juvenile and that the behavior can be changed by developing new responses to distressing emotions.[58] The use of this approach is very

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[46] NAPN REPORT, *supra* note 31, at 18-21. Many clinicians agree that adjudication and ensuing supervision are helpful means of ensuring client accountability and compliance with treatment. HUNTER, *supra* note 9, at 6.
[47] ZIMRING, *supra* note 19, at 81.
[48] *Id.* at 82-83.
[49] *Id.* at 83.
[50] NAPN REPORT, *supra* note 31, at 19.
[51] ZIMRING, *supra* note 19, at 83.
[52] RIGHTHAND & WELCH, *supra* note 24, at 34-35.
[53] *Id.* at 37.
[54] Mark Chaffin et al., *What Research Shows about Adolescent Sex Offenders*, 5(2) AMERICAN PROSECUTORS RESEARCH INSTITUTE NEWSLETTER 2 (2002).
[55] Earl F. Martin & Marsha Kline Pruett, *The Juvenile Sex Offender and the Juvenile Justice System*, 35 AM. CRIM. L. REV. 279, 306 (1998).
[56] Veith, *supra* note 23, at 73.
[57] *Id.* at 74.
[58] Martin & Pruett, *supra* note 55, at 307.

widespread and appears in 95% of sex offender treatment programs.[59]

Relapse Prevention. Originally developed for substance abusers, the use of a relapse prevention model has become an increasingly common means of treating juvenile sex offenders. This treatment modality encourages sex offenders to identify factors associated with an increased risk of sex offending and to develop strategies to either avoid these situations or to use coping mechanisms to address them as they arise.[60] With these skills, juvenile sex offenders are better able to control deviant urges.[61]

In Virginia, the DJJ has combined elements of the cognitive and relapse prevention models to create its Sex Offender Treatment Program for juveniles. The program provides individual psychotherapy, group psychotherapy, family therapy, and treatment team meetings.[62] It has grown from 14 beds at its inception in 1990 to a capacity of 150 youths today.[63] The juveniles live together in the same unit and all staff members are trained in sex offender rehabilitation techniques.[64]

The program has been very successful, with five-year follow-up recidivism rates for sexual offenses at 4.7% and ten-year rates rising only to 6.9%.[65] In FY2003, of 92 juveniles committed to a DJJ juvenile correctional center (JCC) who received sex offender treatment services (although not all of them completed treatment) and were released, 29% were re-arrested (for any offense) within 12 months. In contrast, the re-arrest rate for all juveniles released from a JCC in FY2003 was 49%.[66]

[59] Veith, *supra* note 23, at 74.
[60] RIGHTHAND & WELCH, *supra* note 24, at 41-42.
[61] Veith, *supra* note 23, at 74-75.
[62] DJJ SPOTLIGHTS, *supra* note 28.
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] VA. DEP'T OF JUVENILE JUSTICE, JUVENILE RECIDIVISM IN VIRGINIA, DJJ RESEARCH QUARTERLY 4, 6 (April 2005), *at* http://www.djj.state.va.us/about/recidivism_RQ.pdf (last visited June 26, 2005).

Juvenile Transfer Statutes

"The objectives [of the juvenile justice system] are to provide measures of guidance and rehabilitation for the child and protection for society, not to fix criminal responsibility, guilt, and punishment." — United State Supreme Court Justice Abe Fortas, writing in *Kent v. United States*[67]

A series of highly publicized media accounts of violent juvenile crime coupled with rising violent juvenile crime rates in the 1980s and early 1990s[68] led to a sea change in the way juvenile justice operates in America. The system's basic doctrine that children are "wards in need of care" and not "responsible moral agents subject to the condemnation of the community"[69] is being replaced by a "demonization of youth as young thugs and predators, with a consequent disregard for their special needs."[70]

As this tide rolled across the country, nearly all states expanded their transfer statutes.[71] As a result of these legislative changes, judicial transfers increased nationwide by 68% from 1988 to 1992.[72]

Virginia was no exception. Although Virginia ranked eighth in terms of the per capita number of juveniles transferred and convicted in adult court from 1988 through 1990, and first among states where the minimum age for

[67] 383 U.S. 541, 554 (1966).
[68] In the U.S., serious violent victimizations committed by juveniles peaked in 1993 at 4.2 million, the highest level since 1973. OJJDP Study, *supra* note 2. However, this rate dropped 27% between 1993 and 1997. *Id.*
[69] Martin & Pruett, *supra* note 55, at 280.
[70] Robert E. Shepherd, Jr., *Legal Issues Involving Children*, 30 U. RICH. L. REV. 1467, 1506-07 (1996).
[71] Also known as "waiver" statutes. *See* Martin & Pruett, *supra* note 55, at 325.
[72] Richard E. Redding, *Juveniles Transferred to Criminal Court: Legal Reform Proposals Based on Social Science Research*, 1997 UTAH L. REV. 709, 715 (1997).

transfer was 15,[73] Virginia state legislators in the 1990s broadened the transfer statute further to expose even more juveniles to prosecution in adult court.

Before discussing the specific modifications made to the Virginia transfer statute and the accompanying political process, a brief overview of the types of transfer statutes is in order. There are a number of different types of transfer mechanisms, and many states have hybrid approaches incorporating two or more of these variations.

Perhaps the most controversial form of transfer is the *legislative waiver.*[74] Under this approach, the legislature places certain offenses outside the jurisdiction of the juvenile court. Although usually only the most serious crimes are excluded, they divest the juvenile court judge of the ability to retain jurisdiction over juveniles charged with these crimes even if a juvenile has no prior record, acted uncharacteristically in committing the crime, or is a good candidate for rehabilitation.[75]

Another controversial transfer mechanism is the *prosecutorial waiver.*[76] Under prosecutorial waiver, the juvenile and adult courts have concurrent jurisdiction for certain offenses, and discretion is vested in the prosecutor to file the case in the court she deems most appropriate.[77] States vary in the degree of discretion given to the prosecutor, and some require that the prosecutor consider certain factors before filing in adult court.[78] Also, in some states these decisions are subject to review; however, "the deference traditionally afforded those decisions makes reversal unlikely."[79]

A third transfer vehicle is the *reverse transfer.* This approach allows the adult court to hold a hearing to consider whether to waive its jurisdiction back to the juvenile court.[80] Although the court typically is required to consider a variety of factors in its decision, a rebuttable presumption against juvenile court adjudication generally exists.[81] The benefits of reverse waiver are that it can offset the over-inclusiveness and other defects of the automatic transfer process.[82] However, the juvenile court judge, who is most aware of the characteristics and special needs of juveniles, would arguably be better equipped to make these decisions than the adult court judge.

Finally, the traditional method for making transfer decisions is the *judicial waiver* process, although it has greatly diminished in prominence in recent years. Where judicial waiver is employed, the juvenile is entitled to an evidentiary hearing in juvenile court before a transfer decision is made.[83] Typically, the court will consider a variety of statutorily mandated factors in making its decision.[84] This case-by-case inquiry is the most faithful to the rehabilitative spirit of the juvenile justice

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[73] VIRGINIA COMMISSION ON YOUTH, THE STUDY OF SERIOUS JUVENILE OFFENDERS, H. 81 at 4 (1994) [hereinafter SJO STUDY].

[74] This mechanism is also called "automatic transfer" or "offense exclusion." Martin & Pruett, *supra* note 55, at 326.

[75] *See* Joshua T. Rose, *Innocence Lost: The Detrimental Effect of Automatic Waiver Statutes on Juvenile Justice*, 41 BRANDEIS L.J. 977, 979 (2003). Furthermore, legislative waiver is typically unnecessary because "the most serious juvenile offenders and repeat offenders, such as the Columbine shooters and juvenile gangbangers, would most likely be transferred to adult court via judicial waiver in the absence of an automatic waiver statute." *Id* at 978.

[76] This is sometimes referred to as the "direct file" method. Martin & Pruett, *supra* note 55, at 327.

[77] *Id.*

[78] *Id.*

[79] *Id.*

[80] Marisa Slaten, *Juvenile Transfers to Criminal Court: Whose Right Is It Anyway?* 55 RUTGERS L. REV. 821, 838-39 (2003).

[81] *Id.*

[82] *Id.*

[83] *Id.* at 832.

[84] *Id.* Many states have adopted with little or no modification eight criteria promoted by the U.S. Supreme Court in *United States v. Kent*, a case that defined the due process requirements for transfer hearings. Redding, *supra* note 72, at 718-19.

system,[85] but it is denied to many youth as the nation wages its battle against juvenile crime.

The Virginia Transfer Statute

In Virginia, the battle to revamp the juvenile justice system reached its pinnacle in the years 1994 through 1996. These efforts were spearheaded by two ideologically opposed groups, the Virginia Commission on Youth (VCOY) and the Governor's Commission on Juvenile Justice Reform (Governor's Commission). The former advocated for a preventative and rehabilitative model, the latter a more punitive one. The resulting legislation largely reflected the agenda of the Governor's Commission.

Discussion of substantial revisions began in earnest in 1995 when Governor George Allen commissioned three studies to examine the procedures for dealing with youth in the juvenile justice system.[86] Allen appointed the Governor's Commission, which was co-chaired by Attorney General James Gilmore and Secretary of Public Safety Jerry Kilgore. In its final report, the Governor's Commission recommended expanding the means by which juveniles could be transferred to adult court, as well as opening up both juvenile trials and juvenile records to the public.[87]

A report issued by a task force established by the VCOY followed shortly thereafter. This task force, chaired by Delegate Jerrauld C. Jones, recommended prevention and early intervention, with less of an emphasis on court procedures.[88] In addition, the Joint Legislative Audit and Review Commission (JLARC) issued a third report that described the operation of the juvenile justice system in the state.[89]

As stated above, the Governor's Commission and VCOY propounded conflicting revisions, with the JLARC study largely supporting VCOY.[90] Two sets of bills were introduced into each house of the Virginia legislature, but on the eve of the bills' consideration by the Senate's Courts of Justice Committee, the leaders of the conflicting studies reached a compromise, which ultimately led to the enactment of amendments to the juvenile justice system.[91]

Of the revisions made, the most significant were changes to the juvenile transfer process.[92] Prior to 1996, transfers to adult court were judicial waivers,[93] but with the passage of this legislation a three-tiered system was instituted.

Under the first tier, the circuit (i.e., adult) court has jurisdiction over juveniles age 14 or older at the time of offense if they are charged with capital murder, first or second degree murder, murder by lynching, or aggravated malicious wounding.[94] Before this legislative waiver can occur, a juvenile court judge must hold a preliminary hearing and certify that there is probable cause that the juvenile committed the charged offense, the juvenile was 14 or older at the time of the alleged offense, proper notice was given, and the juvenile is competent to stand trial.[95]

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[85] *See generally* Rose, *supra* note 75.
[86] Shepherd, *supra* note 70, at 1467-68.
[87] *Id.* at 1468.
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *See* VA. CODE ANN. § 16.1-269.1 (2005). These changes followed earlier modifications enacted in 1994, which, among other things, lowered the minimum age for transfer from 15 to 14. Robert E. Shepherd, Jr., *Legal Issues Involving Children*, 28 U. RICH. L. REV. 1075, 1077 (1994).
[93] If the juvenile was charged with armed robbery, rape, or murder, or if the juvenile had been previously tried as an adult and convicted of a felony and was presently charged with an act that would be a felony if committed by an adult, the court could transfer the juvenile without making the findings otherwise required, such as the juvenile was not amenable to treatment or rehabilitation as a juvenile. VA. CODE ANN. § 16.1-269(A)(3)(b) (1993).
[94] VA. CODE ANN. § 16.1-269.1(B) (2005).
[95] *Id.* § 16.1-269.1(D).

A second tier involves prosecutorial waiver, under which the Commonwealth's Attorney can initiate transfer to adult court by giving seven day's written notice for any juvenile charged with one of a variety of violent offenses, including rape, forcible sodomy, and object sexual penetration.[96] As for legislative waivers, a juvenile court judge must first hold a preliminary hearing and certify that probable cause exists, that the juvenile was 14 or older at the time of the alleged offense, proper notice was given, and the juvenile is competent to stand trial.[97]

Finally, a third tier authorizes judicial waiver for all other felonies.[98] The legislation establishes specific factors that the court must consider in deciding whether a juvenile is "a proper person to remain within the jurisdiction of the court."[99] These factors include, but are not limited to, the juvenile's age, the seriousness and number of alleged offenses, the juvenile's competence to stand trial, the juvenile's record and previous history, the juvenile's mental and emotional maturity, the juvenile's physical condition and maturity, the mental retardation or mental illness of the juvenile, if any, the juvenile's school record and education, the availability of services and dispositional alternatives, and whether the juvenile can be retained in the juvenile justice system long enough for treatment and rehabilitation to be effective.[100] However, although the legislation directs the court to consider these factors, the court cannot be reversed for failing to consider any of them.[101]

Along with the expansion of the transfer statute, a number of other legislative changes in the 1994 and 1996 sessions underscored the shift in the juvenile justice system from a rehabilitative focus to a more punitive one. Most notably, changes in the serious offender statute in 1994 authorized juvenile court judges to commit youths 14 years of age or older who qualify as a serious offender to a JCC for a determinate period as long as seven years or until the age of 21, whichever comes first.[102] Previously, judges were empowered to commit juveniles for a maximum of one year. Although this change could lead to longer periods of commitment for youth, it may provide a viable means of both protecting society and facilitating the rehabilitation of the juvenile within the juvenile system and thereby diminish the need to transfer juveniles to the adult system where little, if any, treatment will be provided. Indeed, VCOY recommended this change to the serious offender statute, emphasizing that it is "a viable alternative to encourage the Commonwealth to keep juveniles in the juvenile justice system, rather than . . . increasing [the] number of transfers to adult court."[103]

Other legislative changes such as the use of the term "juvenile" rather than "child" in many sections[104] and the renaming of "learning centers" as "juvenile correctional centers"[105] altered the tenor of the juvenile justice system and placed an emphasis on accountability and punishment rather than rehabilitation. Indeed, the legislature changed the "purpose and intent" section so that the "paramount concerns" of the law were expanded from a focus on "the welfare of the child and the family" to also include "the safety of the community and the protection of the rights of victims" and holding "offenders accountable for their behavior."[106] This modification plays a key role as appellate courts are guided by this language when interpreting other sections of the juvenile code.[107]

A Blueprint for Reform

These legislative changes to the juvenile justice system may have paved the way for

[96] *Id.* § 16.1-269.1(C).
[97] *Id.* § 16.1-269.1(D).
[98] *Id.* § 16.1-269.1(A).
[99] *Id.* § 16.1-269.1(A)(4).
[100] *Id.*
[101] *Id.*
[102] *Id.* § 16.1-285.1(C).
[103] SJO STUDY, *supra* note 73, at 27.
[104] *See, e.g.*, VA. CODE ANN. § 16.1-248.1 (2005).
[105] *See, e.g.*, *id.* § 18.2-473; §29.1-317.
[106] *Id.* § 16.1-227.
[107] Shepherd, *supra* note 70, at 1470.

future political triumphs by many of the key players in this process,[108] but the value of this legislation is questionable. For example, research has not shown that increasing the transfer of juvenile offenders to adult court has had a general deterrent effect on juvenile crime.[109] Furthermore, although there is no disputing the virtue of keeping the community safe, locking children up in prison is at best a doubtful means of promoting this goal. This is especially true for juvenile sex offenders. As discussed, sexually abusive youth when treated rarely recidivate and are more amenable to treatment than adults, suggesting emphasis should be given to their rehabilitation rather than their punishment.

For these reasons, society should not forgo an opportunity to treat a juvenile sex offender through its juvenile justice system before the behavior becomes ingrained.[110] The Virginia DJJ Sex Offender Treatment Program is comprehensive and tailored to identify and address specific treatment goals for each juvenile.[111] Also, upon reentry into the community the Virginia juvenile justice system continues to provide, when available, sex offender therapy to these youth on an out-patient basis. This targeted treatment and rehabilitation is simply not available in the Virginia adult correctional system.[112] Although sex offender treatment services are provided to correctional inmates, this program does not address the special needs of youth.[113] In addition, it is generally inappropriate to mix juvenile and adult sex offenders in a treatment program.[114]

Therefore, every effort should be made to ensure that appropriate treatment options are made available to sexually abusive youth through the juvenile justice system. This approach requires that politicians abandon or at least deemphasize retribution as the goal in addressing this population, and focus instead on rehabilitation and the prevention of repeat offenses. Politicians and community members will likely be hesitant to embrace less stringent measures for these offenders. However, using available research, legislators can craft a transfer statute that better implements *both* worthy goals of protecting the community and rehabilitating its children.[115]

This research supports the following recommendations.[116]

First-Time Sex Crimes Should Not Be Subject to Legislative or Prosecutorial Waiver. The transfer of first-time, juvenile sex offenders should typically only occur pursuant

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[108] James Gilmore was elected governor of Virginia in 1997. Jerry Kilgore was elected Attorney General of Virginia in 2001. Jerrauld C. Jones was appointed Director of the Department of Juvenile Justice by Virginia Governor Mark Warner on July 1, 2002.

[109] There have been two studies on the general deterrent effect of transfer, neither of which found notable evidence of general deterrence from legislation that expanded the availability of juvenile transfers. The studies conducted in New York and Idaho in 1978 and 1981, respectively, compared arrest rates for a number of years before and after transfer statutes were passed in those states. Jill Ward, *Deterrence's Difficulty Magnified: The Importance of Adolescent Development in Assessing the Deterrence Value of Transferring Juveniles to Adult Court*, 7 U.C. DAVIS J. JUV. L. & POL'Y 253, 261-62 (2003).

[110] Barbaree et al., *supra* note 4, at 11.

[111] Wieckowski interview, *supra* note 41.

[112] VIRGINIA STATE CRIME COMMISSION, SEX OFFENDER TREATMENT SERVICES IN VIRGINIA, S. 20 at 6 (1996).

[113] E-mail from Mario J.P. Dennis, Clinical Director, Virginia Center for Behavioral Rehabilitation (Dec. 1, 2004, 11:38 EST) (on file with author).

[114] *Id.*

[115] Where the research is spotty or nonexistent, state resources should be mobilized to support the research needed to give legislators the tools they need to make sound legislation. Surely, some of the enormous budget used to incarcerate juveniles could be diverted to research that shows how to keep kids out of jail and in our communities. For example, the total operating expenditures for the Virginia DJJ during fiscal year 2003 were $181.4 million. VIRGINIA DEPARTMENT OF JUVENILE JUSTICE, DATA RESOURCE GUIDE FY 2003, 10 [hereinafter DJJ DATA RESOURCE GUIDE].

[116] *See generally* Redding, *supra* note 72.

to a judicial waiver where the juvenile's amenability to treatment and rehabilitation can be taken into account.[117] Rape, forcible sodomy, and object sexual penetration are subject to prosecutorial waiver under the current Virginia transfer statute.[118] Because treated juvenile sex offenders have very low recidivism rates and juvenile treatment programs are widely available, public safety concerns associated with these juveniles are minimized. The juvenile court system is still at least in part based on a rehabilitative model, and it contravenes the tenets of the system to transfer a first-time juvenile sex offender to adult court without a judicial hearing when the opportunities for rehabilitation are so great.

Another justification for removing these offenses from the list of those eligible for legislative or prosecutorial waiver is that the offense committed may be mislabeled in the course of apprehension and adjudication. Edward Wieckowski, Program Supervisor of the Sex Offender Treatment Program at the Virginia DJJ, reports that often in the course of treatment it is found that the offense charged does not reflect what occurred.[119] For example, rape may have been charged even though there was a legitimate dispute over whether there was consensual intercourse between two adolescents.[120]

Judicial waivers have the advantage of ensuring that a case-by-case determination is undertaken before transfer is ordered. In addition, for judicial waivers a clinical assessment of the juvenile may be ordered to guide the court's determination.[121] Because children may not speak freely about the nature of their offense outside of a clinical setting,[122] such assessments can help ensure that the court is provided a full picture of the events that transpired and can make the most appropriate decision regarding the proposed transfer.

Juvenile sex offenders should ordinarily remain within the juvenile justice system where they can receive the treatment programs that will best enhance their rehabilitation.[123] Also, treatment within the juvenile justice system may be particularly needed and appropriate when the sexual conduct was the result of an emotional or behavioral disorder.[124]

Focus on Amenability to Treatment. Prior to legislative revisions in 1994, transfer decisions in Virginia focused on the juvenile's amenability to treatment.[125] Such a standard was subject to criticism because its relative vagueness permitted inconsistency among judges. However, the court was required to consider specific identified factors in reaching

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[117] The transfer mechanism employed is generally dictated by the most serious offense with which the juvenile is charged. When a sex offense has occurred in conjunction with another offense (e.g., aggravated malicious wounding) that is subject to legislative or prosecutorial waiver, this other offense should take precedence over the sex offense in dictating the applicable transfer mechanism.

[118] VA. CODE ANN. § 16.1-269.1(C) (2005). Any other charged sexual offense that would be a felony if committed by an adult is subject to judicial waiver. *Id.* § 16.1-269.1(A).

[119] Wieckowski Interview, *supra* note 41.

[120] Barbaree et al., *supra* note 4, at 15.

[121] VA. CODE ANN. § 16.1-269.2(B) (2005).

[122] Wieckowski Interview, *supra* note 41.

[123] In cases where commitment to the juvenile justice system is ordered, the period of time that a juvenile is detained should be subject to adjustment if it is discovered in the course of treatment that the offense did not occur or that the offense was not as severe as originally determined.

[124] It is estimated that at least 20% of the youth in contact with the juvenile justice system have a serious emotional disturbance and it is asserted that "most youth in the juvenile justice system have a diagnosable mental illness and could benefit from some services." Joseph J. Cocozza & Kathleen R. Skowyra, *Youth with Mental Health Disorders: Issues and Emerging Responses*, 7(1) JUV. JUST. 3, 6 (2001).

[125] VA. CODE ANN. § 16.1-269(A) (1993) ("Any transfer . . . shall be subject to the following conditions: . . . 3. The court finds: . . . b. The child is not, in the opinion of the court, amenable to treatment or rehabilitation as a juvenile through available facilities.").

its determination.[126] This test and the identified factors had the virtue of focusing the court's attention on whether treatment was available and whether the juvenile was likely to benefit from this treatment and be rehabilitated.

In 1994, the Virginia General Assembly replaced the amenability to treatment standard used by juvenile court judges considering judicial waiver with a "proper person" test.[127] Although one of the factors that must be considered under the proper person test is the appropriateness and availability of the services in the juvenile justice system for dealing with the juvenile's problems,[128] it is given no more weight than a number of other factors, including the seriousness of the alleged offense and the juvenile's record.[129]

Notwithstanding the research that indicates that juvenile sex offenders can be successfully treated and their recidivism rates diminished to relatively low levels, there is a serious risk under the current iteration of the judicial waiver statute that scant attention will be given to the juvenile's amenability to treatment in light of the emotionally charged context in which these charges are typically brought. Because research indicates that most juvenile sex offenders can be rehabilitated, legislators should reestablish the priority of the amenability to treatment criteria in making transfer determinations for these juveniles.

Raise the Minimum Age for Transfer to 15. The minimum age for a juvenile to be transferred should be no less than 15 years of age.[130] A juvenile under 15 is unlikely to have sufficient psychological maturity to meet adult standards of criminal culpability.[131]

Research indicates that children do not develop adult-like decision-making skills until age 15, while "younger adolescents are less able to identify risks and benefits, foresee consequences, and assess the credibility of information."[132] While it might be countered that a lower age limit should be utilized because juvenile offenders are relatively sophisticated and streetwise, research indicates that, on the contrary, juvenile delinquents tend to have lower IQs, a higher incidence of learning disabilities and mental illness, lower levels of moral development, and fewer social problem-solving skills than non-delinquent juveniles.[133] As noted, until the legislative revision of 1994, juveniles had to be at least 15 years of age at the time of the alleged offense to be subject to transfer in Virginia.[134]

Correctly Identify Chronic Offenders. Like other juvenile delinquents, juvenile sex offenders have been shown to perform poorly in school, to have chronic learning problems and deficiencies in social competence, and to have psychiatric symptoms comparable to other juvenile delinquents.[135] Juvenile sex offenders also struggle with impulse control and lack decision-making skills.[136] Some juvenile sex offenders, like juvenile offenders in general, will be chronic offenders and concerns for public safety may dictate that they be more subject to transfer.
It is, however, important to correctly identify chronic juvenile sex offenders for whom transfer may be more appropriate. The number of contacts with the juvenile system is considered to be a far better predictor of recidivism than the seriousness of a single

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[126] *Id.* § 16.1-269(A)(3)(b) (The court must "consider[ ] the nature of the present offense or such factors as the nature of the child's prior delinquency record, the nature of past treatment efforts and the nature of the child's response to past treatment efforts.").
[127] It should be noted that this test and its related factors are not employed when a legislative or prosecutorial waiver is sought. *See* VA. CODE ANN. § 16.1-269.1(B), (C) (2005).
[128] *Id.* § 16.1-269.1(A)(4)(d).
[129] *Id.* § 16.1-269.1(A)(4)(b),(e).
[130] Redding, *supra* note 72, at 747-48.
[131] *Id.* at 748.
[132] *Id.* at 724.
[133] *Id.* at 725-26.
[134] VA. CODE ANN. § 16.1-269(A)(1) (1993).
[135] Barbaree et al., *supra* note 4, at 14-15.
[136] Wieckowski interview, *supra* note 41.

offense.[137] Although it is unclear that even several instances of juvenile sex offending are predictive of future sex offending,[138] a single offense, as discussed, rarely warrants transfer to the adult court and is best handled by treatment available through the juvenile justice system.[139] Repeat offenders, however, are potentially more appropriate candidates for transfer.

Policymakers and judges face difficult choices in deciding how to best handle such sex offenders because research has not developed a typology for identifying the future dangerousness of juvenile sex offenders.[140] Because the number of juvenile sex offenders that will develop into adult sex offenders is low and difficult to predict, the transfer of these offenders should be limited. However, research may ultimately show that there is a cadre of repeat offenders for whom judicial transfer should be routinely granted or for whom legislative or prosecutorial transfer is appropriate.

Extend the Jurisdiction of Juvenile Courts over Sex Offenders to the Age of 25. Lawmakers should consider extending the jurisdiction of the juvenile court to the age of 25 for more serious sex offenses such as rape, forcible sodomy, and object sexual penetration.[141] Giving juvenile court judges the ability to maintain supervision over such offenders for this extended period should reduce public safety concerns that they will enjoy an early return to the community before their treatment is successful.

At the same time, because treatment may be successful before juvenile offenders reach the age of 25 and the need for further detention obviated, periodic judicial review of the need for this continued detention should be afforded.[142] This approach would allow juvenile court judges to impose an extended commitment for chronic sex offenders, but allow for early release if in the course of treatment it becomes clear that the juvenile is rehabilitated and is of minimal danger to society.[143]

Base Transfer Decisions on Actuarial Predictions of Recidivism Risk. Actuarial predictions of recidivism risk, when available, should be used to determine whether a juvenile sex offender remains in juvenile court.[144] Actuarial (i.e., statistically-based) predictions are in general more valid and reliable than case-by-case clinical judgments about the likelihood of recidivism and a juvenile's amenability to treatment, given that

[137] Redding, *supra* note 72, at 733-34.
[138] ZIMRING, *supra* note 19, at 68.
[139] *Id.* at 129.
[140] *Id.* at 68.
[141] Virginia data from 1992, before legislative revisions made these offenses subject to prosecutorial waiver, showed that these were the sex offenses for which juveniles were most likely to be committed to the juvenile justice system. FEASIBILITY STUDY, *supra* note 16, at 9.

[142] In Virginia, youth subjected to this extended jurisdiction would likely be detained pursuant to the serious offender statute, under which they would be eligible for review for early release after two years and then every year thereafter. VA. CODE ANN. § 16.1-285.1(F) (2005). This application, however, would require an amendment to the serious offender statute as it currently only permits juveniles to be committed for a period of 7 years or the juvenile's 21st birthday, whichever occurs first. *Id.* § 16.1-285.1(C).
[143] One consideration that may weigh against the expansion of juvenile court jurisdiction in Virginia to age 25 is the DJJ requirement that individuals over 18 be sight and sound separated from juveniles under that age. DEPARTMENT OF JUVENILE JUSTICE, JUVENILE CORRECTION CENTER UTILIZATION REPORT, Special Session, 445C at 1 (2004). This requirement could make a jurisdictional expansion fiscally unrealistic. However, if, as discussed in the previous note, the serious offender statute was amended to permit all serious offenders to be detained for this period of time, a sufficiently large number of juvenile offenders might be detained to make this program fiscally viable. Advocates for juvenile offenders might support such an extension as a better means of responding to the treatment needs of these juveniles than transfer to the adult criminal justice system.
[144] *Id.* at 745.

clinical judgments are subject to the personal biases of the evaluator or judge.[145] Unfortunately, there have been no comprehensive studies identifying recidivism rates for various subtypes of juvenile sex offenders.[146] In addition, the actuarial model for recidivism needs to be tailored to the specific jurisdiction because different factors may be predictive in different locales.[147]

Nor has there been a valid actuarial risk instrument developed for the juvenile sex offender. Two promising juvenile specific risk-assessment instruments are under development—the J-SOAP-II and ERASOR-II—but they are still in the early stages of development and must be used with caution.[148]

Despite these research gaps, policymakers should be guided by statistical information rather than visceral reactions to sex crimes and transfer legislation should be guided by the overall low recidivism risk of treated juvenile sex offenders.

Conclusion

Members of the community have every right to be concerned about protecting themselves from the crimes of juvenile sex offenders. However, because treated offenders rarely recidivate and are not as dangerous to society as is often assumed, policymakers should resist the knee-jerk reaction to classify them as adult sex offenders, thereby making retribution and incapacitation the judicial system's primary foci. Juvenile sex offenders have a wide array of characteristics, backgrounds, and motivations, which are generally overlooked in a statutory scheme favoring transfer to the adult criminal justice system rather than individualized assessment and treatment within the juvenile justice system.[149] Although research is still limited, policymakers should use the research that is available in tailoring transfer statutes so as to maximize the opportunities for rehabilitation while still protecting society. Perhaps now that violent juvenile crime has been steadily declining for a number of years, legislators can apply a more balanced approach rather than allow political rhetoric to guide the response to these children.

[145] *Id.* at 746.
[146] ZIMRING, *supra* note 19, at 63.
[147] Redding, *supra* note 72, at 750.
[148] John A. Hunter & Mark Chaffin, *Ethical Issues in the Assessment and Treatment of Adolescent Sex Offenders* 1 (April 2005), *available at* http://www.ncsby.org/pages/publications/Ethical%20Issues%20in%20the%20treatment%20of%20ASO%20042505.pdf.

[149] ZIMRING, *supra* note 19, at xiv ("Assumptions about adolescent sex offenders in current legislation and debates are often based only on the presumed motives and proclivities of nonadolescent offenders.").

UPCOMING ILPPP MENTAL HEALTH AND LAW PROGRAMS

8/22-26: *Forensic Evaluation [Adult]*, Charlottesville, VA

9/16: *Confidentiality of Medical Records*, Staunton, VA

10/7: *Risk Assessment*, Charlottesville, VA

10/27-28: *Civil Commitment*, Fairfax, VA

11/3-4: *Sex Offender Evaluation*, Charlottesville, VA

12/2: *Juvenile Risk Assessment*, Charlottesville, VA

12/16: *Insanity Acquittee Evaluation*, Petersburg, VA

1/19-20: *Advanced Forensic Evaluation*, Charlottesville, VA

2/24: *Rational Understanding & Assessing Juvenile Competence*, Charlottesville, VA

3/16-17: *Juvenile Evaluation Update*, Charlottesville, VA

3/24: *Jail Diversion: Innovative Practices That Work*, Charlottesville, VA
featuring Fred Osher, M.D., Director, Center of Behavioral Health, Justice, and Public Policy, University of Maryland School of Medicine

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The Sacrifice Wrought by a Costly and Fragmented Mental Health Care System: Parents Forced to Relinquish Custody to Obtain Care for Their Children

By Adria N. Bullock*

Introduction

The Supreme Court has repeatedly held that parents[1] have a fundamental constitutional right to direct the upbringing of their children. However, thousands of parents are forced to sacrifice this right and relinquish custody of their children so they can obtain desperately needed mental health services. Although legislation is being introduced to address this mental health services crisis, greater efforts are needed to redress this American tragedy.

Scope and Nature of the Problem

A study conducted by the United States General Accounting Office (GAO) estimated that in fiscal year 2001, parents relinquished custody of at least 12,700 children because they could find no other way for their children to access mental health care.[2] The report stressed that this number underestimated the magnitude of the problem because officials in the District of Columbia and 31 states, including five states with the largest populations of children, did not provide data for the study.

Another study found that 23% of families of children with a serious mental illness were told they had to relinquish custody of their children to obtain much needed mental health services, and 20% said they did so to get this care.[3] The GAO study identified several reasons why parents relinquish custody, including the financial strain of paying for needed services, an inability to access suitable treatment, and the emotional strain of the child's mental illness on the family.[4]

Financial Strain. Key factors that compel parents of children with a mental disorder to relinquish custody are the high cost of mental health care, limits on the coverage provided by their health insurance plan or a lack of insurance, ineligibility for publicly funded services, and parents' inability to personally finance treatment.

The ability to finance a child's mental health care is essential for accessing treatment. A single outpatient therapy session can cost more than $100, while it can cost up to $250,000 a year for a child to live in a residential treatment facility.[5] Private insurance, when available, often runs out relatively quickly, leaving many parents unable to afford the intensive treatment and care their children require.

While stays in residential treatment are generally limited due to the emphasis given rapid stabilization and discharge in the managed care era, residential care remains an often-needed but expensive therapeutic intervention that few insurance policies cover fully or for any extended period. Moreover, treatment costs increase for children with a

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[1] In this article the term "parents" is used in its generic sense to encompass those adults who bring up and care for and have legal custody of children living in the community.

[2] *Child Welfare and Juvenile Justice: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services: Hearing Before the Senate Comm. on Governmental Affairs* 2, 10-11 (GAO-03-865T) (Apr. 2003) (statement of Cornelia M. Ashby, Director, Education, Workforce, and Income Security Issues), *available at* http://www.gao.gov/new.items/d03865t.pdf [hereinafter GAO Report].

[3] NATIONAL ALLIANCE FOR THE MENTALLY ILL, FAMILIES ON THE BRINK: THE IMPACT OF IGNORING CHILDREN WITH SERIOUS MENTAL ILLNESS 10-1 (July 1999), *at* http://web.nami.org/youth/ brink.html [hereinafter NAMI Report].

[4] GAO Report, *supra* note 2, at 3.

[5] *Id.* at 7.

serious, difficult-to-treat mental disorder or for children who have a disorder that makes them prone to criminal or destructive behavior such as drug addiction, sex offenses, fire-setting, or other violent behavior.[6] Expenses can grow to more than $1,000 a day, reflecting treatment, medication, and room and board costs.[7]

These expenses make it imperative for parents to find means of financing their child's mental health care. About 68% of the children in the United States are covered by private health insurance plans (i.e., employer-sponsored or individually purchased insurance), 19% are covered by public health insurance programs (e.g., Medicaid and the State Children's Health Insurance Program (SCHIP)), and 13% have no coverage.[8]

Private sector insurance is dominated by managed care organizations (MCOs) that try to provide cost-effective health care by imposing various coverage limitations.[9] MCOs place many restrictions on mental health care coverage. High co-payments, benefit limits, and diagnostic exclusions and service limitations serve as substantial barriers to needed mental health care.[10]

High co-payments increase out-of-pocket costs for parents and, particularly for parents of children with serious, long-term mental disorders, ultimately make mental health care unaffordable. Benefit limits can take the form of annual or lifetime limitations on the amount that will be expended on inpatient and outpatient care by an insurance provider. Alternatively, benefit limits may restrict the number of inpatient days or outpatient visits that will be covered.[11] When these limits are surpassed, the daunting task of personally paying for additional needed care again arises. Diagnostic exclusions and service limitations are also a substantial obstacle for parents seeking insurance coverage as they deny coverage for certain psychiatric disorders and mental health treatments.[12]

One study identified the most common benefit limits and diagnostic and service exclusions in 128 managed behavioral health plans.[13] More than half the plans contained benefit limits of 12 to 60 outpatient sessions per year, and 65% of the plans only covered 20 to 60 days of inpatient care per year, with a median of 30 days.[14] Among the diagnostic conditions consistently excluded were mental retardation, impulse control disorders, autism, and childhood psychosis. Services consistently excluded were custodial and respite care, psychoanalysis, psychosurgery, and experimental or investigational therapies.

These restrictions have important implications for parents of children with a mental disorder. Children suffering from serious mental disorders often require long-term treatment that exceeds the limit on inpatient days or outpatient sessions imposed by most managed care insurance policies, or results in cumulative co-payments or out-of-pocket expenses that exhaust family resources.

The limitations on experimental or investigational therapies, in addition to

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[6] *See* BAZELON CENTER FOR MENTAL HEALTH LAW, AVOIDING CRUEL CHOICES: A GUIDE FOR POLICY-MAKERS AND FAMILY ORGANIZATIONS ON MEDICAID'S ROLE IN PREVENTING CUSTODY RELINQUISHMENT 1-3 (Nov. 2002), *available at* http://www.bazelon.org/issues/children/publications/TEFRA/avoidingcruelchoices.pdf [hereinafter CRUEL CHOICES].

[7] Debra Jasper & Spencer Hunt, *Parents Without Hope Are Giving Up Custody: Some Say Mental Health System Is Broken,* ADVOCATE, April 4, 2004, at 8A.

[8] GAO Report, *supra* note 2, at 7-8.

[9] *See* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM 57 (4th ed. 2004) (177 million Americans are enrolled in some type of managed behavioral care, representing 80% of all individuals with either private or public insurance).

[10] Pamela B. Peele et al., *Exclusions and Limitations in Children's Behavioral Health Care Coverage*, 53 PSYCHIATRIC SERVICES 591 (May 2002).

[11] *Id.* at 592.

[12] *Id.* at 591.

[13] *Id. See also* Jeffrey A. Buck et al., *Behavioral Health Benefits in Employer-Sponsored Health Plans, 1997*, 18(2) HEALTH AFFAIRS 66 (1999).

[14] Peele et al., *supra* note 10, at 592.

constraining access to innovative therapies, may also add to the family's financial burden. The health plan may not clarify the criteria for when a treatment is considered investigational or experimental. As a result, parents operating under the mistaken belief that their health plan covered a treatment may subsequently learn that it is not covered and that they are fully responsible for payment.[15]

Insurance policy limitations can leave even gainfully employed parents hard-pressed to find means of paying uncovered treatment expenses and make them feel compelled to relinquish custody of their children so they can receive the services provided by the foster care or juvenile justice systems.[16]

If the parents' income is sufficiently low, these children may qualify for services provided through various public sector programs, such as Medicaid and SCHIPS. Because these programs are generally only available to low-income families, their strict financial eligibility rules keep most families from qualifying for these programs.[17]

Finally, many families today have neither health insurance to help pay for their children's mental health treatment nor access to public sector programs because their income level disqualifies them from receiving services under these programs. These parents, not surprisingly, can find it extremely difficult to afford the services needed for their children.

Barriers to Accessing Treatment. Parents of children with a mental disorder who can afford mental health treatment still face substantial barriers in their pursuit of appropriate care due to national and regional shortages of needed services.[18] For example, a survey of 756 family members who have a child with a serious mental illness found that 43% said the types of treatments most helpful to their children were not available.[19]

Shortages in national and regional services are often attributed to the low reimbursement rates of insurance providers, particularly MCOs.[20] Low reimbursement rates fail to adequately cover the costs of mental health care practitioners, forcing practitioners to either cut back on the services they offer or to disenroll from provider networks.[21] The exit of practitioners from these networks constrains the availability of treatment options within the community in which the family lives.[22]

When MCOs first began to penetrate the private insurance market in the early 1990s, they negotiated payment contracts with mental health practitioners and facilities that were below the prevailing rate of payment.[23] For example, in Massachusetts negotiated reimbursement rates were 30-50% below the prevailing rate of payment. Practitioners and

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[15] Parents may also be reluctant to enroll their child in such a program for fear that they will be personally responsible for paying for the treatment.

[16] CRUEL CHOICES, *supra* note 6. Ironically, foster parents are able to draw on Medicaid funds to obtain the mental health services required by these children even though the child's parents were ineligible to participate in Medicaid. GAO Report, *supra* note 2, at 21.

[17] *Id.* Managed care has also begun to penetrate the public health sector. One study found 55% of Medicaid beneficiaries enrolled in managed care and, although care was successful at reducing inpatient service use for children and total costs, there was often a subsequent increase in outpatient care, most likely because of relapses due to inadequate initial treatment. Angela Blair Hutchinson & Michael Foster, *The Effect of Medicaid Managed Care on Mental Health Care for Children: A Review of the Literature*, 5 MENTAL HEALTH SERVICES RES. 39, 50 (Mar. 2003).

[18] *See* Dennis E. Cichon, *Encouraging a Culture of Caring for Children with Disabilities: A Cooperative Approach*, 25 J. LEGAL MED. 39, 53-55 (2004) (citing Surgeon General's Report and explaining how nation's lack of a unified approach to mentally ill children results in coverage gaps that ultimately leads to their being removed from their families).

[19] NAMI Report, *supra* note 3, at 9-1.

[20] Paul S. Appelbaum, *The 'Quiet' Crisis in Mental Health Services*, 22(5) HEALTH AFF. 110, 112 (2003).

[21] *Id.* at 112, 115.

[22] *Id.* at 110.

[23] *Id.* at 112.

facilities felt compelled to accept this low rate out of concern that failure to participate in the provider networks being established would result in a sizeable loss of the number of patients under their care.

Since then, the expenses of mental health practitioners have grown but the minor increases in the reimbursement rates of MCOs have failed to keep pace, thereby further reducing the insufficient compensation that mental health care practitioners receive for their services. Furthermore, participation in managed care networks added additional clerical and administrative expenses to perform mandated tasks such as obtaining advance authorizations, monitoring the number of authorized sessions, and providing increased billing documentation.[24]

As a result, practitioners and facilities have been forced to either substantially cut back their services or to withdraw from provider networks, leaving a demand for mental health care that far exceeds the supply.[25] The situation is particularly dire for children with emotional and behavioral disorders as their treatment is more costly for practitioners. Practitioners often must spend time meeting with parents, teachers, and others—costs often not reimbursed by insurance providers.[26]

Similarly, low fees associated with participation in Medicaid have led many practitioners to limit their participation or to deny services altogether to children enrolled in Medicaid programs.[27]

As practitioners and facilities limit their services to children, the children are placed on increasingly longer waiting lists to obtain needed treatment. For example, in California some children have had to wait eight months for a residential placement.[28]

Children with emotional and behavioral disorders who are forced to endure excessive waiting times for treatment often deteriorate and require emergency treatment in over-crowded emergency rooms.[29] Parents of children with a mental illness often have to drive across the state in which they live and sometimes leave their state to procure the mental health services their children require.[30]

Children with a mental illness in rural areas have particularly experienced the impact of the mental health care shortage. Rural areas in Arkansas, California, Kansas, Maryland, and Minnesota, for example, consistently have either very limited child mental health services or none at all.[31] In rural and poor counties there are often long waiting lists and few well-trained practitioners, and often children are not referred for help until they are suicidal.[32]

Children with emotional and behavioral disorders who have a history of engaging in arson or sexual assault have even fewer treatment options because very few residential facilities are willing to accept them.[33] In contrast, children who are in the child welfare or juvenile justice systems are given preference for mental health services, often because services are court-ordered. This preference can cause parents of children with this particular type of history to transfer custody of their children to these systems so they can receive priority for these services.

Public sector eligibility requirements for mental health care also hinder the ability of parents of children with a mental illness to access mental health services. As noted,

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[24] *Id.*
[25] *Id.* at 113.
[26] *Id.*
[27] GAO Report, *supra* note 2, at 18.
[28] *Id.* at 19.

[29] Appelbaum, *supra* note 20, at 113 (stating that in a one-year period the number of mentally ill children coming to an emergency room in Massachusetts rose by 30%).
[30] *See* GAO Report, *supra* note 2, at 19; *This Is Wrong, Parents Shouldn't Have to Give Up Custody to Get Mental-health Care for Their Children*, DES MOINES REG., Apr. 26, 2004, at 8A.
[31] *See* GAO Report, *supra* note 2, at 19.
[32] Jasper & Hunt, *supra* note 7, at 8A.
[33] GAO Report, *supra* note 2, at 19.

public sector programs are generally limited to indigent families whose income can not exceed a relatively low amount. Completing enrollment requirements can itself be a relatively formidable task. Also, children who have qualified for Medicaid or SCHIP funded services at one point can lose their coverage if their family's income increases beyond the maximum permitted for participation in these programs.[34] Continuity in mental health care, which can be vital to successful treatment, can be lost as families move in and out of eligibility due to fluctuating income.[35]

Confusion among public officials regarding state and federal legislation authorizing mental health services may also result in the erroneous denial of care or substantial delays in treatment for children with a mental illness.[36] For example, the Katie Beckett option allows states to provide Medicaid coverage for children with a mental illness regardless of family income.[37] States choosing this option provide Medicaid coverage for children under age 19 if they meet certain standards for disability, would be eligible for Medicaid if they were in an institution, and are receiving medical care at home that would be provided in an institution.[38] However, some public officials are still largely unaware of this legislation.[39] As a result, families eligible for Medicaid under this option are often erroneously denied coverage or forced to endure unnecessary delays in obtaining treatment for their children.

Similar confusion over eligibility and erroneous denial of needed treatment are associated with services guaranteed under the federal Individuals with Disabilities Education Act (IDEA).[40] States receiving federal funds for education are required to provide schoolchildren with a disability a "free appropriate public education." To meet this requirement, educational instruction must be specially designed to meet the unique needs of these children, supported by such services as are necessary to permit the child to benefit from the instruction.[41]

Eligible children include those who have an emotional or behavioral disorder.[42] Some of the services provided for children suffering from an emotional or behavioral disorder under IDEA include counseling, day treatment, and residential care.[43]

However, these services are limited to those that will enable a child to benefit from special education. School districts often use this restriction as a basis for denying payment for services such as room-and-board costs for residential treatment, respite care, and evening and weekend crisis services.[44]

School districts also often under-identify, misidentify, or are slow to identify children with an emotional or behavioral disorder who should qualify for services under the IDEA.[45]

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[34] *Id.* at 21.
[35] *Id.*
[36] *Id.* at 23. *See* Jasper & Hunt, *supra* note 7, at 8A (reporting that the two state agencies that oversee all of the county agencies providing mental health services for children do not share information, and as many as five separate agencies may be in charge of different aspects of one child's care).
[37] The "Katie Beckett" option is also known as the TEFRA 134 option because it was enacted under section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). BAZELON CENTER FOR MENTAL HEALTH LAW, TEAMING UP: USING THE IDEA AND MEDICAID TO SECURE COMPREHENSIVE MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH 22, n.13 (Aug. 2003), *at* http://www.bazelon.org/issues/children/publications/teamingup/report.pdf [hereinafter TEAMING UP].
[38] GAO Report, *supra* note 2, at 9. Although family income is not considered in determining eligibility, states can require families to contribute to the cost of the program. *Id.*
[39] *Id.* at 23.
[40] *Id.* at 20-21, 23.
[41] *See* 20 U.S.C. § 1400(c) (2005).
[42] TEAMING UP, *supra* note 37, at 2.
[43] *Id.* at 3.
[44] *Id.*
[45] BAZELON CENTER FOR MENTAL HEALTH LAW, FAILING TO QUALIFY: THE FIRST STEP TO FAILURE IN SCHOOL? 3-5 (Jan. 2003), *at* http://www.bazelon.

One study reported that 46% of families of children with a serious mental illness believe that schools resisted identifying children with serious mental illnesses and only 16% believe the school system quickly evaluated their children and placed them in an appropriate special education class.[46] Another study concluded that schools may be failing to correctly identify 80% of IDEA-qualified children with a mental or emotional disorder.[47]

In addition to being reluctant to evaluate children to determine their eligibility because they will then be required to provide them with services, school systems often fail to supply the specialized services they are expected to provide.[48] Often parents must file a lawsuit to get assistance from the school system.[49]

If the school district determines that the child has a behavior problem, not a mental disorder, the child will be denied needed education services. Children with emotional and behavioral disorders often exhibit behaviors that disrupt the classroom and some school officials would rather remove them from the school than offer them services. Another reason for under identification is that school officials are concerned that labeling a child as mentally ill or emotionally disturbed will stigmatize the child.[50]

Further, children with emotional and behavioral disorders are often misidentified as having a learning disability. This leads school systems to provide services and supports that fail to adequately address the child's needs.[51]

Children with emotional and behavioral disorders on average are not identified by schools until the child is 10 years old. Such delays have been characterized as "typical," even though parents and professionals recognize these disorders in children at a very young age, often well before the child starts school. Effective prevention of mental health problems depends on early recognition and provision of services, while delayed recognition often necessitates placements in more restrictive settings and less mainstreaming of the child when identification does occur.[52]

Strain on the Family. Parents of children with emotional or behavioral disorders must endure the challenging and oftentimes overwhelming task of raising and providing care for their children. There is incalculable sorrow associated with watching these children struggle with a mental disorder.

Enormous efforts also must be expended to respond to their children's needs. A survey of family members who have a child with a serious mental illness found that 59% said that caring for their children often felt as if it was pushing them to their breaking point and 70% said their marriages had been severely stressed by the experience of caring for their child.[53]

In addition, parents often experience a myriad of emotions while coming to terms with the knowledge that their child has an emotional or behavioral disorder. Many parents experience a profound sense of grief as they come to a realization that many of the hopes and dreams they had for their child will go unfulfilled.[54]

The inability to pinpoint a cause for most mental illnesses often leaves parents with the sense that they are responsible for their child's mental disorder and failed their child in some way.[55] Indeed, parents seeking help or services for their children are often told that

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org/issues/ education/publications/failingtoqualify/ failingtoqualify.pdf [hereinafter FAILING TO QUALIFY].

[46] NAMI Report, *supra* note 3, at 11-1.

[47] FAILING TO QUALIFY, *supra* note 45, at 4.

[48] GAO Report, *supra* note 2, at 20-21, 23.

[49] NAMI Report, *supra* note 3, at 11-1 (16% of families had to file a lawsuit to get assistance).

[50] FAILING TO QUALIFY, *supra* note 45, at 4.

[51] *Id.* at 4-5.

[52] *Id. at 5.*

[53] NAMI Report, *supra* note 3, at 13-1.

[54] KATHARIN A. KELLER, TAKING CHARGE: A HANDBOOK FOR PARENTS WHOSE CHILDREN HAVE EMOTIONAL DISORDERS 5-6 (1994).

[55] *Id.* at 6.

the child's behavior and inability to make progress are their fault, which adds to their burden.[56] The survey of family members who have a child with a serious mental illness determined that 50% of them felt that others blamed them for their children's condition.[57]

Parents' task is made even more daunting by the stigma and shame that all too often attaches to mental illness and that may reduce the support systems ordinarily available to parents.[58] The survey of family members who have a child with a serious mental illness found that 46% of them felt shunned by friends and neighbors because of the illness and most believed that limited social support reduced their family's overall quality of life.[59]

Furthermore, parents of children with mental disorders often instinctively withdraw from their friends out of fear of what they will think or say about them or their children.[60] In addition, many parents find it difficult to engage in normal family activities outside of the home due to the unpredictable behavioral manifestations of their child's mental illness. Finding babysitters that are equipped to manage their child's special needs also poses a substantial challenge and many parents are forced to quit or change their jobs and assume full time care-giving duties.[61]

As parents navigate the mental health system, they also are often inundated with conflicting diagnoses and advice from mental health practitioners regarding how to control the behavioral manifestations of their child's disorder.[62] Parents may also experience anger and frustration as they face what seems to be an endless array of barriers to obtaining the mental health care their children require. These emotions are often exacerbated by the sense that there is nothing they can do to help their children wrestle with their emotional or behavioral disorder.

Parents are not the only ones who feel the strain of living with a child who has an emotional or behavioral disorder. The brothers or sisters of these children with a mental disorder are also deeply affected by their sibling's disorder. They often become angry or frightened when their sibling lashes out in a destructive or aggressive manner, while others feel embarrassed when their sibling engages in strange or abnormal behavior or become envious as more and more of their parents' attention is diverted to managing their sibling's mental illness.[63] The survey of family members discovered that 80% said the experience of having a sibling with a serious mental illness had been extremely stressful for the child's brothers and sisters, and 64% said they felt they could not care for their other children as they wanted because of the caregiving demands required by the child with the mental disorder.[64]

Children with emotional or behavioral disorders that exhibit escalating degrees of violence may also place at risk the safety of themselves or family members. Parents are more inclined to relinquish the custody of children with a mental disorder who engage in violent or aggressive behaviors or who are perceived as posing a threat to themselves or family members.[65] The GAO study revealed that 65% of the children whose custody was relinquished were male and 67% were

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[56] *See* Cichon, *supra* note 18, at 40; GAO Report, *supra* note 2, at 22.
[57] NAMI Report, *supra* note 3, at 13-1.
[58] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 188 (1999), *at* http://www.surgeon general.gov/library/mentalhealth/home.html.
[59] NAMI Report, *supra* note 3, at 13-1.
[60] KELLER, *supra* note 54, at 5-6.
[61] *Id.* at 6.
[62] Kathleen R. Delaney & Barbara Engels-Scianna, *Parents Perception of Their Child's Emotional Illness and Psychiatric Treatment Needs*, 9 J. CHILD & ADOLESCENT PSYCHIATRY 1, 4 (Oct.-Dec. 1996).
[63] KELLER, *supra* note 54, at 8.
[64] NAMI Report, *supra* note 3, at 13-1.
[65] GAO Report, *supra* note 2, at 15.

between the ages of 13 and 18,[66] suggesting that parents are more likely to relinquish children who are more physically capable of uncontrollable outbursts (i.e., older, male children).

Decisions to Relinquish. Parents who are unable to pay for needed mental health services for their children, who have been unable to access needed treatment, or who are overwhelmed by the emotional impact of the child's illness on the family, may feel they have no choice but to surrender the custody of their children so that needed mental health treatment can be provided by a state or local agency through the child welfare or juvenile justice systems. Ironically, neither of these systems is well-equipped to care for children solely because of their mental health needs[67] and these placements may expose the children to other risks.[68]

This relinquishment of custody may be temporary or permanent in nature. If relinquishment is permanent, parental rights will be terminated and the child will be made available for adoption.

Temporary relinquishment to the child welfare system is typically initiated pursuant to a state's child abuse and neglect statute, which authorizes a child protective services agency (CPS) to receive allegations of abuse or neglect and investigate these reports. Some parents have told CPS workers that they would physically abuse their child in the CPS workers' presence to force them to place the child in their system if they could not get help for their child any other way.[69]

If the allegations are found to have merit, the agency is expected to work with the parents to resolve the problems and to commence court action if the parents are uncooperative. A juvenile or family court will then hear the allegations of abuse or neglect and determine whether the child should be removed from the home. If the child is removed, the agency must develop a reunification plan, hold periodic review hearings, make efforts to reunify the parents and the child, and, if reunification is found to not be possible, terminate parental rights and make the child available for adoption.[70]

Alternatively, custody can be temporarily relinquished as the result of a finding by a juvenile court judge that a child has committed a delinquent act or a status offense. Following such a finding, custody may be assigned to the juvenile justice system and the child placed in a juvenile justice facility. Arrests and juvenile court proceedings are sometimes initiated by a parent seeking to obtain the mental health services available through the juvenile justice system who reports that the child has committed a violent or some other form of delinquent act or is wayward and out-of-control (e.g., truant, violating curfews).[71]

Temporary relinquishment may provide respite and a short-term solution to the family's needs. It is unlikely, however, to remedy long-term needs that are likely to arise

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[66] *Id.* at 14.

[67] GAO Report, *supra* note 2, at 1; Cichon, *supra* note 18, at 40, 53 (facilities associated with these systems are far more restrictive environments than needed for children with a mental illness, but without such facilities some children would not be able to access any care at all); Swanee Hunt, *Keeping Families Together*, SCRIPPS HOWARD NEWS SERVICE, May 25, 2004 ("[S]urrendering custody doesn't guarantee the best care. Child welfare and justice systems are designed for kids who have been neglected, abused or accused of crimes, not those with mental-health problems.").

[68] THE PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 34 (2003) ("when parents cede their rights . . . , they may also be inadvertently placing their children at risk for abuse or neglect").

[69] GAO Report, *supra* note 2, at 21.

[70] Elizabeth A. Varney, *Trading Custody for Care: Why Parents Are Forced to Choose Between the Two and Why the Government Must Support the Keeping Families Together Act*, 39 NEW ENG. L. REV. 755, 766-67 (2005).

[71] GAO Report, *supra* note 2, at 21.

if the child's mental disorder is extended in duration or chronic. For example, although children may receive Medicaid-funded services while in foster care, they are likely to lose their access to these services if the family regains custody and is not Medicaid-eligible. Similarly, children in juvenile justice correctional or detention facilities lose Medicaid eligibility when released from the facility and their families have to reapply to resume coverage.[72]

In addition, even temporary relinquishment has its costs. Besides further fragmenting the bonds between these children and their families, the placements themselves have certain risks. A study of family members with a child with a serious mental illness found that 15% said their child was physically or sexually abused during their stay in a hospital or residential treatment center and 13% said their child was physically or sexually abused while in jail.[73]

Parents also complain that they are often seen as a "nuisance" by the agency that has assumed custody of the child or treated as if the placement was the result of their having abused or neglected their children.[74] They may also be afforded limited visiting privileges and rarely be consulted about their child's treatment,[75] even though they may have valuable knowledge to share regarding prior treatment efforts. In general, not only do they lose physical custody, but they lose the ability to fulfill their parental roles.[76]

An Infringement of the Fundamental Right to Family Integrity and Association?

The United States Supreme Court has held in a series of rulings that parents have what has been characterized as a fundamental constitutional right to "family integrity" or "family association."[77] Because parents are essentially forced to sacrifice this fundamental right when they relinquish custody of their children so they can obtain appropriate mental health services for their children, class action lawsuits have been filed on their behalf asserting that this requirement violates their constitutional right. A pair of federal court rulings, however, have rejected this claim.

Joyner v. Dumpson. In a New York case, plaintiffs, acting on behalf of a class of approximately 5,000 New York children in need of special residential services whose parents could not afford the cost of such out-of-home treatment, argued that New York law implicitly required parents to relinquish custody of their mentally ill children to the state if they wanted residential treatment for their children at the state's expense and that this infringed their substantive due process right to family integrity under the Fourteenth Amendment to the United States Constitution.[78] The plaintiffs asserted that while New York law did not explicitly require relinquishment of custody, it had that effect if parents wanted to access these services.

New York law required that the parents and a local social services official enter into a voluntary placement agreement (VPA) that transferred care and custody of the child from the parent to an authorized child welfare agency.[79] Parents were allowed to designate a date in the VPA when the child would be returned to them, but this could be overridden by a court order extending the placement.

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[72] *Id.* at 21-22.
[73] NAMI Report, *supra* note 3, at 12-1.
[74] Varney, *supra* note 70, at 756.
[75] *Id.* at 776.
[76] Gwen Goodman, *Accessing Mental Health Care for Children: Relinquishing Custody to Save the Child*, 67 ALB. L. REV. 301, 305 (2003).

[77] *See* Santosky v. Kramer, 455 U.S. 745 (1982); Quilloin v. Walcott, 434 U.S. 246 (1978); Smith v. Org. of Foster Families for Equality & Reform, 431 U.S. 816 (1977); Stanley v. Illinois, 405 U.S. 645 (1972); Prince v. Massachusetts, 321 U.S. 158 (1944); Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).
[78] Joyner v. Dumpson, 712 F.2d 770, 771-72 (2d Cir. 1983).
[79] *Id.* at 773. If the agency expected that the child would remain in its custody for more than 30 days, judicial approval of the VPA was required. *Id.*

Also, although parents could request an early return of their child, the agency to which the child was relinquished was empowered to reject this request, subject to judicial review.

A federal district court ruled that requiring parents who wished to obtain state-subsidized residential mental health treatment for their children to transfer temporary custody of their children to the state was unconstitutional.[80] The Second Circuit of the U.S. Court of Appeals reversed this ruling.[81]

The Second Circuit employed a three-step substantive due process analysis to address the plaintiffs' claim that this law infringed upon the fundamental right to family integrity. As a first step, the court acknowledged that there is a fundamental, constitutionally-protected right to family integrity under the Fourteenth Amendment.[82]

The second step of this analysis required the court to determine whether the state action significantly infringed this fundamental right. The court determined that the transfer of custody did not deprive the parents of *all* rights to "rear" their children and thus did not result in a wholesale relinquishment of their fundamental right. The court noted that although the parents relinquished day-to-day supervision of their children, they had not surrendered permanent custody and they had not only the right but the obligation to visit the child and to plan for the child's future. Further, the agency was obligated to apprise the parents of their continuing rights and obligations with respect to "rearing" the child.[83]

In addition, the court stressed that the purpose of this system was not to infringe upon or deprive parents of their right to rear their child but to keep the natural family together. The court cited the agency's obligation before accepting custody to determine whether less disruptive needed services could be provided, including "day services;" responsibility to initiate a visitation plan, with the state required to provide transportation or other assistance to enable the parent to make the visits; and inability to limit or terminate visitation rights without an amendment of the VPA or a court order.[84]

Finally, the court stressed the voluntary nature of this relinquishment and stated that parents who want their children to enjoy the benefits of a voluntary state-subsidized program do not retain a right to dictate how the service should be administered. As a result, the state was not obligated to consult and satisfy the individual concerns of each recipient of the service. The court noted the U.S. Supreme Court has established that indigent persons do not have a constitutional entitlement to subsidized welfare programs and that any severing of family ties here was the result of the parents' actions, not those of the state.[85]

The third step of this analysis was to examine whether the state's interest justified the infringement. Because the court concluded that a significant infringement had not occurred, it did not address this question.

The Second Circuit did leave an opening for the plaintiffs. Although it found the program did not violate the constitution on its face, the program could be found to infringe the parents' due process rights if they could establish that it was administered in an inappropriate manner. Such a ruling could be based on a finding that the agency (1) unduly refused to return children to their parents, (2) in constructing the VPA did not allow parents to negotiate important issues such as the return of the child and the child's placement and treatment, (3) retained ultimate decision-making power as to the child's placement, medical care, and rehabilitative treatment, and (4) strictly controlled visitation thereby isolating the child and straining familial bonds.

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[80] Joyner v. Dumpson, 533 F. Supp. 233 (S.D.N.Y. 1982).
[81] Joyner v. Dumpson, 712 F.2d 770, 772 (2d Cir. 1983).
[82] *Id.* at 777-78.
[83] *Id.* at 778-79.
[84] *Id.* at 778-80.
[85] *Id.* at 780-81.

The court remanded the case to the lower court for a trial on these possible issues.[86]

Collins *ex rel.* Collins v. Hamilton. A second ruling that rejected the argument that parents' constitutional rights were violated by having to give up custody of their children to receive mental health services from the state was issued some 19 years later by an Indiana federal district court.[87] This court applied essentially the same analytical scheme employed by the Second Circuit in *Joyner* and reached much the same result.

One of the named plaintiffs in this class action lawsuit was hospitalized four times over a six-month period due to violent behavior at the age of five. He was diagnosed with Bipolar Disorder, Oppositional Defiant Disorder, Organic Personality Syndrome, and Attention Deficit Hyperactivity Disorder, and was born addicted to Vicoden, a pain medication. The child had been living with his grandmother, who had become his adoptive mother.[88]

The hospital where the child was receiving acute care informed his grandmother that Medicaid would no longer pay for the services they were providing to the child and she would have to take him to her home. However, the hospital also recommended that she contact the local CPS agency for assistance in finding a placement for him.[89]

The CPS agency required the grandmother to complete documents indicating that the child should be designated a Child in Need of Services (CHINS) and subsequently be made a ward of a local child welfare agency to obtain Medicaid coverage for necessary mental health services. Shortly thereafter a juvenile court judge found that the child was a CHINS and made him a ward of the state due to his grandmother's inability to care for him given his mental health disabilities. Once the child became a ward of the state, he was sent to a residential treatment program in Wisconsin, apparently because there was no long-term residential psychiatric treatment facility that provided Medicaid coverage for children in Indiana.[90]

A few months later he was returned to his grandmother's home for a trial period, but while there the only services he could receive were designed to assist in the placement transition, not to treat his mental disorders. At his grandmother's home, he suffered from severe violent behavioral problems, such as physical abuse of the household dog and threats to bring guns to his kindergarten class. He was temporarily placed in a psychiatric hospital, and then returned to the Wisconsin residential treatment program, where he was still residing at the time of the lawsuit.[91]

The plaintiffs argued that their constitutional right to family association under the Fourteenth Amendment was violated by the state's requirement that children be made wards of the state via a CHINS action to obtain payment for necessary residential placement for children with a mental illness.

Using the same three-part test employed by the Second Circuit in *Joyner*, the federal district court first agreed that the right to family association is a fundamental constitutional right. However, it noted that there were seven dispositional alternatives available for a child found to be in need of services and only one of them involved making the child a ward of the state and none of them required that parental rights be terminated. Citing *Joyner*, the court concluded that this type of voluntary transfer did not deprive parents of the rights to

[86] *Id.* at 782-83.
[87] Collins *ex rel.* Collins v. Hamilton, 231 F. Supp. 2d 840 (S.D. Ind. 2002).
[88] *Id.* at 843-44.
[89] *Id.* at 844.

[90] *Id.* Although the plaintiffs were unsuccessful in pursuing their constitutional claim, the court ultimately ruled that Indiana's failure to provide long-term residential treatment to Medicaid-eligible children for whom a required screening found such placement medically necessary violated the federal Medicaid Act and ordered these services be provided them. *Id.* at 846-49.
[91] *Id.* at 844-45.

"rear" their children. The court added, like *Joyner*, that the statutory scheme governing the choice of CHINS' dispositions was focused on minimizing the intrusion into family autonomy and family life and dictated that parents have a reasonable opportunity to participate in whatever disposition was chosen.[92]

Promising Interventions

Although these lawsuits were unsuccessful in establishing a constitutional claim,[93] the plight of these parents has led legislators across the country to introduce a number of bills to provide better means for them to access needed services for their children.

Federal Legislation. A number of federal legislative initiatives have sought to (1) help address parents' inability to use their health insurance coverage to finance needed treatment for children suffering from an emotional or behavioral disorder or (2) expand their ability to access public sector programs. Perhaps reflecting Congressional reluctance to expand federal obligations to fund this relatively expensive treatment, the former has thus far been the primary legislation enacted.

Because there is little evidence that this approach has alleviated the factors that have led parents to relinquish custody of their children to obtain needed mental health treatment and because attention continues to be focused on this problem, there is some indication that support may be growing in Congress to expand parents' ability to access relevant public sector programs. At the same time, neither of these approaches will directly help to address the paucity of services available to address these children's mental health needs and the fragmented nature of the related service delivery system, although arguably greater funds for these services will encourage more mental health practitioners and facilities to provide such services.

Mental Health Parity Act. In 1996, Congress sought to alleviate the profound inequalities in insurance coverage for mental disorders by implementing the Mental Health Parity Act (MHPA).[94] One of the goals of the MPHA was to assist parents of children with emotional and behavioral disorders by requiring that group health plans employ the same aggregate lifetime and annual dollar limits for mental health benefits as for medical and surgical benefits.[95]

While the MHPA was intended to relieve the pressing financial needs of parents of children with emotional and behavioral disorders, in practice it has fallen far short of its goal because of permitted exceptions that reduce its overall impact. For example, the MHPA did not apply to individual insurance plans or plans provided by employers with 50 or fewer employees. The MHPA allowed employers that were encompassed to refuse to offer mental health benefits altogether if they chose to do so. If employers decided to provide mental health benefits, they could define covered conditions and associated benefits as they liked and exclude entirely certain categories of mental illness from coverage. Substance abuse and chemical dependency benefits were explicitly exempt.[96]

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[92] *Id.* at 850-51.

[93] Parents and their children can still pursue judicial claims that they should be able to access needed services without relinquishing custody as a matter of federal or state statutory right. For example, a federal claim could be filed pursuant to IDEA, Medicaid, or the Americans with Disabilities Act. There may also be a right as a matter of state law. For a Virginia example, see Fauquier County Dep't of Soc. Servs. v. Robinson, 455 S.E.2d 734 (Va. Ct. App. 1995). For a discussion of how to pursue these claims, see BAZELON CENTER, LITIGATION STRATEGIES TO PREVENT CUSTODY LITIGATION, *at* http://www.bazelon.org/issues/children/custody/litigation.htm (last visited July 10, 2005).

[94] Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701-03, 110 Stat. 2944-50 (1996) (codified at 29 U.S.C. § 1185a and 45 U.S.C. § 300gg-5). *See also* Beth Mellen Harrison, *Recent Development: Mental Health Parity*, 39 HARV. J. ON LEGIS. 255 (2002).

[95] Harrison, *supra* note 94, at 256.

[96] *Id.* at 258-59.

There were also no restrictions on the co-payments or deductibles that a plan could impose when an employee obtained mental health services. Furthermore, plans could limit without restriction the number of covered outpatient visits or inpatient days. Finally, employers could apply for an exemption if they could demonstrate that compliance with the MHPA would increase their overall group health plan costs by at least 1%.[97]

The law became effective on January 1, 1998, but was scheduled to expire on September 30, 2001.[98] The MHPA has thus far been renewed since then on a yearly basis, but it has provided limited relief to parents who find that their health insurance plans fail to adequately cover the extensive costs associated with obtaining mental health treatment for their children.

The Paul Wellstone Mental Health Equitable Treatment Act of 2005. For several years legislation has been introduced in Congress to heighten the parity in health insurance plans between the coverage provided for mental disorders and other health care needs by closing or limiting some of the exemptions in the MHPA.[99] This legislation has thus far not been enacted but on March 17, 2005, it was reintroduced into the House of Representatives as the Paul Wellstone Mental Health Equitable Treatment Act of 2005 (MHETA).[100]

MHETA would require that group health plans not impose any treatment limitations or financial requirements on the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical services. The bill specifically includes within this requirement deductibles, coinsurance, co-payments, other cost sharing, and annual and lifetime limitations. Under this bill, equal coverage must be applied to all mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR) if related services are part of an authorized treatment plan that meets the health plan's medical necessity criteria.[101]

If an existing state law provides greater protections than MHETA, the state law will not be pre-empted.[102] MHETA also requires that a post-implementation GAO study examine the bill's effects on cost, quality of care, and access to care.[103]

However, MHETA is not without its own shortcomings. Like MHPA, MHETA has a small employer exemption that will exclude from these requirements any employer who employed an average of not more than 50 employees during the preceding calendar year. MHETA would continue the MHPA's practice of not requiring health plans to offer mental health benefits at all, and, like MHPA, when they are offered, MHETA permits the health plan to create restrictions in coverage of mental health benefits as long as they apply equally to medical and surgical benefits.[104]

Also as is the case with MHPA, no group health plan will be required to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.[105] MHETA would also exclude out-of-network mental health benefits from the parity requirement.[106]

Health plans are also permitted to use managed care techniques when providing mental health services, including concurrent and retrospective utilization review,

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[97] *Id.* at 259.
[98] *Id.*
[99] *See id.* at 255.
[100] *See* Paul Wellstone Mental Health Equitable Treatment Act of 2005, H.R. 1402, 109th Cong. (2005).

[101] *Id.* §§ 2, 3.
[102] *Id.* § 4.
[103] *Id.* § 5.
[104] *Id.* §§ 2, 3.
[105] *Id.*
[106] *Id.*

preauthorization, and the application of medical necessity and appropriateness criteria specifically applicable to behavioral health, and there is no requirement that these techniques apply equally to medical and surgical benefits.[107]

While MHETA will achieve a greater degree of parity between mental health and medical and surgical benefits, it will fail to alleviate the financial barriers that parents without health care insurance face when they seek mental health treatment for their children. In addition, it will not address barriers to accessing treatment that result from a lack of needed services and a fragmented mental health care delivery system.

Family Opportunity Act of 2005. Another piece of legislation currently before Congress that could directly help parents of children with a mental disorder with their financial needs, promote home and community treatment alternatives, and provide parents with help in navigating their way through the mental health care delivery system and recognizing alternatives to custody relinquishment is the Family Opportunity Act of 2005 (also known as the Dylan Lee James Act).[108]

Introduced in the Senate on January 26, 2005, this bill would amend Title XIX of the Social Security Act to give families of children with a disability the opportunity to buy their way into the Medicaid program, thus providing families with incomes above the Medicaid eligibility threshold the opportunity to access Medicaid funding for services.[109] This bill has received bipartisan support as it was co-introduced by a Republican, Sen. Charles Grassley of Iowa, and a Democrat, Sen. Edward Kennedy of Massachusetts.

This bill would allow middle-income families with children with severe disabilities to obtain Medicaid coverage through a buy-in program and would alleviate the pressure on families to remain below the poverty level so that their children with a mental disorder can obtain or continue to receive benefits under Medicaid. To purchase coverage under this bill, the child must be under the age of 19 and meet the definition of disabled under the Social Security Disability Insurance (SSDI) program, and the child's family income must be above the limit for receipt of SSDI but not above 300% of the Federal Poverty Level. In addition, a state may waive payment of a premium in any case where the state determines that requiring a payment would create an undue hardship.[110]

The bill would also provide funds for demonstration projects in ten states to test the effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment facilities for Medicaid-enrolled children.[111]

In addition, the bill provides funds for the development and support of "family-to-family health information centers" to "assist families of children with disabilities or special health care needs to make informed choices about health care." This provision has the capacity to alert parents of treatment alternatives and minimize the relinquishment of the custody of their children. These centers will be charged with providing information regarding the health care needs of these children, as well as the resources available for them. They are also to (1) identify successful health delivery models for these children, (2) develop models for collaboration between families of these children and health care professionals, (3) provide training and guidance regarding how to care for such children, and (4) conduct outreach activities to the families of these children, health professionals, schools, and other appropriate entities and individuals. The centers are to be jointly staffed by family members who have expertise in federal and

[107] *Id.* §§ 2, 3.
[108] S. 183, 109th Cong. (2005). *See also* Goodman, *supra* note 76, at 326-28 (describing this bill's initial introduction).
[109] S. 183, 109th Cong. (2005).
[110] *Id.* at § 3.
[111] *Id.* at § 4.

state public and private health care systems and health professionals.[112]

This bill does not focus on revamping insurer providers' approaches to the coverage of mental health benefits and avoids concerns that enhancing these benefits will add to the cost of health care insurance, currently a widely-shared concern. Furthermore, it has the potential to promote a more cohesive public sector treatment program, or at least help parents better negotiate its elements. Also, by providing greater funding for services, it may encourage more mental health practitioners and facilities to provide needed services. However, at a time when Congress is already seeking to significantly limit Medicaid funding in general, any expansion of the program's coverage may be a tough sell.

The Keeping Families Together Act. The Keeping Families Together Act is another pending bill and is the one that most specifically addresses the parental relinquishment of custody issue. Introduced in the House on February 15, 2005, also with bipartisan support, this bill would amend the Public Health Service Act to establish a "State family support grant program."[113]

The specified purpose of the bill is "to assist States in eliminating the practice of parents giving custody of their seriously emotionally disturbed children to State agencies for the purpose of securing mental health care for these children."[114] The federal government would provide matching grants to states to establish systems of treatment and care for children in need of mental health services.[115]

The bill targets all children who are in the custody of a state or at-risk of entering the custody of a state for the purpose of receiving mental health services. To receive matching federal funds, a state must have in place laws or policies that ensure that children receive appropriate mental health services so that parents do not have to relinquish legal custody of these children. Also, the state must provide a description of the system of care it intends to establish to ensure that eligible children and their families receive appropriate individualized mental health treatment and family support services necessary to keep these families together. The state must provide outreach services to these families and expand its public health insurance programs to cover a comprehensive array of community-based mental health and family support services.[116]

Under the bill, the state must also have a procedure for the early identification, assessment, and referral for care of all eligible children by health care providers, mental health agencies, child-serving entities, and the child welfare and juvenile justice systems. All youths entering the juvenile justice and child welfare systems must be screened for mental health problems, and those identified as having a significant mental health problem must be tracked and reported. Child welfare, juvenile justice, and child mental health agencies must provide coordinated services for eligible children.[117]

In addition, the Keeping Families Together Act would require the establishment of a task force by a number of federal agencies to examine problems of mental health in the child welfare and juvenile justice systems, determine what prevents children from accessing mental health services, and identify strategies to improve the delivery of mental health services to youth with serious emotional disturbances.[118]

In contrast to the Family Opportunity Act of 2005, there are no limitations on participation based on family income associated with this bill, which enhances its ability to reach the full range of children and families for whom parental relinquishment may be relevant. It

[112] *Id.* at § 5.
[113] H.R. 823, 109th Cong. (2005).
[114] *Id.* at § 2.
[115] *Id.* at § 3.
[116] *Id.*
[117] *Id.*
[118] *Id.*

would also provide a more systemic approach to addressing these issues, specifically recognizing the role of the child welfare and juvenile justice systems in these relinquishments. It also places significant responsibility on participating states to shape their policies and practices in a way that diminishes custody relinquishments intended to obtain mental health services. To the extent a state's mental health care delivery system is fragmented and contributing to this problem, this bill has the potential to promote efforts by the state to directly redress it.

At the same time, because it requires states to provide matching funds and to assume what may be a relatively expensive responsibility to shape and reshape its mental health care delivery system, states may be reluctant to participate in this program, particularly those who already feel overwhelmed by the costs of their public health obligations. State officials may join federal officials in balking at the potential cost of this program.

IDEA. Although not a new federal legislative initiative, IDEA remains, notwithstanding its shortcomings, an important tool that can help parents obtain needed treatment for children with a mental disorder without relinquishing custody. It has the advantage of already being in place and its costs and impact are relatively well understood. In addition, IDEA does not contain income or similar restrictions. As a result, all eligible children qualify for needed services regardless of the financial status of their parents or the nature of the health care coverage available through their parents.

Also, school is an ideal venue for identification and intervention because attendance is compulsory and most children spend a large part of their day in school.[119] In addition, when children in rural areas receive services through their schools, the necessity that their parents travel long distances to access care may be reduced. Finally, because IDEA requires schools to provide a coordinated services plan, it can provide a means to more systematically and thus more effectively address the mental health needs of the child.[120] Suggestions have been provided on how IDEA can be used more effectively to provide needed services to children with mental and emotional disorders and thereby reduce the burden on their parents.[121]

State Interventions. Various states have also pioneered distinct responses to address the needs of mentally ill children and their families and to reduce the custody crisis. The programs instituted focus on three aspects of this crisis: finding new ways to reduce costs or fund services, consolidating services in a single location, and expanding community mental health services and family support.[122]

Development of Tailored Programs. The first measure states have employed is developing mental health programs that better match the child's need with the appropriate level of service. This prevents valuable mental health resources from being devoted to children who could be effectively treated with a less expensive modality.

New Jersey's Systems of Care initiative is an example of such a program. Under this approach, the state contracts with private, non-profit organizations for a variety of mental health services aimed at the needs of children. In each county, standardized measures are used to assess children's mental health needs and uniform protocols are employed to determine appropriate levels of care. Children with lesser needs are referred to community based providers, while children requiring a higher level of care will receive their services from local Care Management Organizations specifically created to serve them.[123] In this manner, the more expensive treatment modalities are

[119] TEAMING UP, *supra* note 37, at 4.

[120] *Id.* at 5.

[121] FAILING TO QUALIFY, *supra* note 45, at 12-14; TEAMING UP, *supra* note 37, at 4-13.

[122] *See* GAO Report, *supra* note 2, at 24.

[123] *Id.*

reserved for the children who most need them.

There are several other methods that state and local officials are using to contain costs. These include employing less expensive mental health care providers, such as using nurses to distribute medicines and bachelors-level workers for case management, usually under the supervision of a masters-level clinician.[124]

Another measure used to reduce the cost of mental health care is the blending of funds from multiple sources, working around agencies' limitations on the types of services and placement settings each can fund.[125] Spreading the costs of treatment avoids placing sole responsibility for these costs on any single organization.

Finally, states are using flexible funds, which have few restrictions, to pay for nontraditional services that are generally not allowable under state guidelines. These services include in-home counseling, community activities, mentoring, and respite care.[126]

Concentration of Services in a Single Location. The second measure states have employed to help children with mental disorders and their families is the concentration of mental health services in a single location. This goal is achieved by creating a single point of entry into the mental health system where children can be evaluated using a standardized measure and then provided or referred to the appropriate service. The children can access this facility regardless of which agency had primary responsibility for the child.[127]

States have created similar central locations for services in their school systems to help children with a mental disorder and their families access needed services. A Maryland program has collected services at an elementary school and provides a range of providers and programs.[128]

In addition, parents are also provided with information regarding treatment and funding resources in their area. This system is useful because most children with a mental illness and their parents must come in contact with the school system on a daily basis, while it might be more difficult for them to locate an appropriate mental health facility in their area to perform the same initial referral service.

Expansion of Services. A third response of the states is to expand the number and range of available community-based services for these children, as well as to enhance support services for their families. States are seeking to develop a continuum of care that includes early intervention, diversion, transitional services, and crisis intervention. States are also encouraging parental involvement in their child's care. Families are being seen more as partners in this care and are receiving help to enhance their ability to fulfill this role.[129]

The Medicaid Home and Community Based Services Waiver and the Katie Beckett Option. The Medicaid Home and Community Based Services Waiver provides more flexible community mental health services to children with mental disorders as an alternative to institutional care. Although technically a federal initiative, it is ultimately dependent on state participation. The three states that have taken advantage of the waiver, Vermont, New York and Kansas, have found that the costs of serving children with emotional and behavioral problems in the community is about half of what would be spent on institutional care.[130]

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[124] *Id.*
[125] *Id.* at 25
[126] *Id.*
[127] *Id.*
[128] *Id.* at 26.
[129] *Id.* at 27-29.
[130] *Keeping Families Together: Removing Barriers That Force Parents to Relinquish Custody of their Children to Secure Mental Health Services: Hearing Before the Senate Comm. on Governmental Affairs* 4 (July 15, 2003) (statement of Tammy Seltzer, Staff Attorney, Bazelon Center For Mental Health Law), *available at* http://www.

Waiver programs give states the discretion to limit the number of slots or apply the program to certain geographic regions. Also, the cost of services under the program can be offset by institutional savings. Waiver programs enable children with emotional and behavioral disorders to receive the intensive treatment they require in their homes, negating the need for parents to relinquish custody to obtain needed services. Efforts are now aimed at modifying the waiver program to include children receiving or at risk of receiving services in a residential treatment facility.[131]

The Katie Beckett (or TEFRA 134) option allows states to cover home and community-based services for children with disabilities who would otherwise require institutional care. So far 20 states have selected this option to assist children with disabilities. However, half of the 20 states have failed to enroll children with mental or emotional disorders even though nothing in the option's requirements necessitates this exclusion. Participating states have failed to indicate in their materials that parents of children with mental and emotional disorders are eligible for enrollment. It has been recommended that Congress exercise greater oversight of this program to ensure that states are more aware of this program and that, when states participate, children with mental and emotional disorders are fully included.[132]

Conclusion

Parents have a fundamental constitutional right to direct the upbringing of their children in the manner that they see fit. However, thousands of parents must make the heartrending decision to transfer custody of their children to the state when they are unable to afford their child's mental health treatment, access necessary services, or surmount the emotional challenge associated with caring for these children.

While many states have enacted laws that make it illegal to require the surrender of all parental rights as a condition for mental health treatment, the temporary voluntary relinquishment of parental rights has been upheld as acceptable. Courts have reasoned that this temporary relinquishment is an acceptable burden to bear for the opportunity to access services that the state is not required to provide. However, when parents are bereft of other alternatives, the voluntary nature of this relinquishment is questionable.

Although federal, state, and local governments have begun to explore possible means of redressing this problem, the lack of emotional support, funding, and access to mental health services for the parents of these children is a multi-layered problem that will require a multifaceted and comprehensive resolution across governmental levels if it is to be successfully ameliorated.

With the estimated rate of serious emotional disturbance among juveniles in the general population placed between 9% and 13%, and with considerable research documenting the importance of early intervention to address the mental health treatment needs of juveniles, it is imperative that children received this treatment in a timely fashion.[133] A failure to provide treatment has both immediate and life-long consequences. Parents should not be forced to choose between obtaining needed treatment and giving up custody of their children. That is not a choice. It is a tragedy, both for the families involved and any society that necessitates this choice.

[Ed.: As this article went to press, a bill was introduced into the Senate entitled "The Lifespan Respite Care Act of 2005" (s. 283). It targets all families caring for individuals with a disability in their home and would promote the availability of respite care programs for them.]

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bazelon.org/issues/children/custody/7-15-03seltzer testimony.htm.

[131] *Id.* at 4-5.

[132] *Id.* at 6.

[133] Thomas L. Hafemeister, *Parameters and Implementation of a Right to Mental Health Treatment for Juvenile Offenders*, 12 VA. J. SOC. POL'Y & L. 61, 66 (2004).

Cases in the United States Supreme Court

Death Penalty for Juveniles Convicted of Murder Held to Be Unconstitutional Because a National Consensus Opposes Its Use and Juvenile Offenders Are Less Culpable Than Adults

The Supreme Court ruled in a 5-to-4 decision that it is unconstitutional to impose the death penalty on convicted murderers who were younger than 18 at the time of the crime. The Court concluded that such executions violate the Eighth Amendment's prohibition of "cruel and unusual punishments."

In reversing its earlier decision in *Stanford v. Kentucky* (1989), which had upheld the execution of juveniles who were 16 or 17 at the time of the crime, the Court stated that punishments for a criminal offense are not permitted if they "are so disproportionate as to be cruel and unusual" and in making that determination reference must be made to "the evolving standards of decency that mark the progress of a maturing society." In reaching its conclusion, the Court relied heavily on its decision three years ago in *Atkins v. Virginia* (2002), which held that it is unconstitutional to execute a mentally retarded person, and noted three lines of evidence that supported the result.

First, the Court ascertained that there is now a national consensus opposing the death penalty for juveniles. The Court noted that 30 states prohibit the juvenile death penalty and, in those states that do not prohibit its use, the practice is infrequent. The Court found that only three states (Oklahoma, Texas, and Virginia) in the past 10 years have executed prisoners for crimes committed as juveniles. The Court added that, notwithstanding a recent trend to crack down on juvenile crime in other contexts, since *Stanford* no state that had previously prohibited capital punishment for juveniles had reinstated it.

Second, the Court reasoned that the death penalty is reserved for "the worst offenders" where there is "evidence of irretrievably depraved character" and that this did not encompass juvenile offenders because they are less culpable than adult offenders. The Court highlighted three general differences. The Court observed that (1) juveniles are more immature and irresponsible, noting that they are "overrepresented statistically in virtually every category of reckless behavior"; (2) they are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure, which is in part due to the fact that they "have less control, or less experience with control, over their own environment;" and (3) the character of a juvenile is not as well formed as that of an adult, with personality traits more transitory and less fixed.

As a result, the Court determined that juveniles' irresponsible conduct is not as morally reprehensible, they have a greater claim to be forgiven for failing to escape negative influences, and there is a greater possibility that their character deficiencies will be reformed. The Court added that the two primary social purposes served by the death penalty, retribution and deterrence of prospective offenders, would not be served by imposing the death penalty on offenders who were juveniles at the time of the crime. The Court concluded that the evidence regarding juvenile culpability was sufficient to justify a categorical rule that prohibits executions for crimes committed by offenders under the age of 18.

Third, the Court noted that the United States was the only country in the world that "continues to give official sanction to the juvenile death penalty." Although not controlling, the Court asserted that the laws of other countries and the conclusions of international authorities are instructive when interpreting the Eighth Amendment's prohibition of "cruel and unusual punishments."

The dissenters to this ruling vigorously disputed the majority's reasoning and holding. They (1) contested the majority's conclusion that there was a national consensus against this use of the death penalty and argued that this ruling inappropriately undercut the prerogative of state legislators and their constituents to determine its use, (2) asserted that the evidence was insufficient to justify a categorical prohibition of the application of the death penalty to juveniles and contended instead that a case-by-case approach should be employed to determine a given juvenile offender's culpability, and (3) argued that foreign and international law on this issue was of limited, if any, relevance. Roper v. Simmons, 125 S. Ct. 1183 (2005), *at* http://www.supremecourtus.gov/opinions/04pdf/03-633.pdf.

For a discussion of the impact of the opinion and an assertion that the next challenge to the use of the death penalty will focus on its application to offenders who were mentally ill at the time of the crime but who were not entitled to an insanity defense, see Adam Liptak, *News Analysis: Reshaping Capital Punishment*, N.Y. TIMES (Mar. 2, 2005), *at* http://www.nytimes.com/2005/03/02/politics/02juvenile.html?ex=1110430800&en=b04b905e038d9946&ei=5018&partner=BRITANNICA.

Child Sexual Abuse Victims Can Be Required to Undergo a Mental Health Evaluation to Determine Credibility of the Report of Abuse; Ruling Not Disturbed

Because criminal charges of sexual assault often center on the reports of the purported victim, the credibility of these reports is often critical. Defendants in such cases may seek a mental health evaluation of the victim to determine whether there is reason to question the credibility of the report. Victims' advocates, concerned that such evaluations may place the victims and their mental state "on trial," often object to these court-ordered mental health evaluations. The courts have wrestled with how to resolve this conflict, particularly when the purported victim is a minor.

In South Carolina, a juvenile was charged with criminal sexual conduct with a minor. At the time of the incident, the juvenile was 13 years old and developmentally impaired, and the alleged victim was 5 years old. The younger child often played at the juvenile's house where the two would sometimes shower together.

After watching a TV program discussing a man arrested for indecent exposure, the younger child told his mother he had been raped in the shower by the older child. During a subsequent investigation, the younger child informed a clinical psychologist that he had been hearing voices in his head. Based on this information, the older child's attorney filed a motion that would require the younger child to undergo a psychological evaluation to determine the credibility of his report.

The South Carolina Supreme Court in reviewing this request noted that other jurisdictions have split on the question. The court ultimately ruled that six factors employed by the West Virginia Supreme Court should be considered when weighing such requests: (1) the nature and intrusiveness of the examination requested, (2) the victim's age, (3) the effects of the exam on the victim, (4) the probative value of the exam, (5) the remoteness in time of the exam to the alleged criminal act, and (6) the evidence already available for the defendant's use.

The court asserted that because the defendant and the purported victim may be the only two witnesses to an alleged sexual assault and a young child may not have the capacity to give an accurate account of the facts, fundamental fairness dictated that the defendant be entitled to request a psychological evaluation of a child complainant when there is a compelling reason to question the child's psychological status. The court added that because these factors generally weigh against such orders, evaluations would be rare and unlikely to discourage victims from reporting sex crimes.

In the case before it, the court said an evaluation was justified because the victim was undergoing counseling, spoke freely of the incident (suggesting that he would not be further traumatized by another examination), was very young, and may have been hearing voices at the time of the alleged assault.

A dissenting opinion argued that the ruling contravened a recent statewide movement to protect the rights of sexual abuse victims and that existing trial procedures adequately protected the rights of defendants in these cases. The U.S. Supreme Court declined to review this decision. *In re* Michael H., 602 S.E.2d 729 (S.C. 2004), *at* http://www.judicial.state.sc.us/opinions/displayOpinion.cfm?caseNo=25529, *cert. denied*, 125 S. Ct. 1644 (2005).

Force Used by Police in Detaining Individuals with a Mental Disorder Found to Be Excessive in Three Cases; Rulings Not Disturbed

It has been estimated that 15-20 million American adults have a serious mental illness and that 25-40% of the individuals with a mental illness in this country will come into contact with the criminal justice system at some point in their lives. This contact may occur as a result of efforts to ensure that such individuals receive mental health care.

In light of the sheer frequency of these encounters, it is perhaps not surprising that a number of incidents have occurred that resulted in claims that police officers used excessive force in taking a person with a mental disorder into custody. Under the federal constitution, officers are not permitted to use excessive force in making an arrest or in taking a person into custody for purposes of transporting him or her to obtain needed mental health care.

Three cases in which police officers were found to have employed excessive force were appealed recently to the U.S. Supreme Court. In each case, officers responded to a call that an individual in the community was acting in an erratic or agitated manner and it was apparent that the behavior was the result of a mental disorder. Although initial efforts to restrain the individuals were considered appropriate, the officers' subsequent actions were found to involve excessive force.

Appellate courts reviewing these cases determined that special attention should be given to the individual's mental disorder in determining whether excessive force was applied. The U.S. Supreme Court declined to review all three cases.

California Case. In one case, the Ninth Circuit noted that when attempting to detain individuals with a mental illness it is ordinarily advisable that officers trained in the art of counseling be used or that officers be assisted by individuals who have receiving such training. The use of force, the court added, may exacerbate existing tensions.

In this case, police officers had responded on two consecutive days to calls that a man with a history of mental illness (bipolar disorder and schizophrenia) had run out of medication and was hallucinating and paranoid. On the first day, the officers concluded the man was not a danger to himself or others and did not meet the criterion for involuntary psychiatric detention.

On the second day, finding the man to be agitated, the officers decided to take him into custody "for his own safety." The man was placed on the ground and his arms were handcuffed behind his back. According to witnesses, two officers placed their knees on the man's back and neck, even though the man repeatedly told the officers that he could not breathe. After 20 minutes the man lost consciousness, sustained brain damage, and is now in a permanent vegetative state.

The Ninth Circuit held that this level of force was constitutionally excessive. The court focused on the nature of the force applied, which it characterized as severe, and the need for the force, which it found to be minimal. Because no underlying crime was at

issue, the use of force could not be justified as necessary to protect the safety of the officers or others. Although some degree of physical restraint may have been necessary to prevent the man from injuring himself initially, that justification ended when the man was knocked to the ground and handcuffed and did not resist the officers.

The court acknowledged that officers must often make decisions in circumstances that are tense, uncertain, and rapidly evolving, but concluded that any reasonable officer would have understood that the force employed here was unwarranted and constitutionally excessive. Drummond v. City of Anaheim, 343 F.3d 1052 (9th Cir. 2003), *at* http://www.ca9.uscourts.gov/coa/newopinions.nsf/375152B9CEC0B95988256D9D00517CF7/$file/0255320.pdf?openelement, *cert. denied*, 124 S. Ct. 2871 (2004).

Tennessee Case. In a second case, the Sixth Circuit upheld a jury award of $900,000. A 32-year-old autistic man, who was nonresponsive and unable to speak, had been taken to a store by his caregiver when the man became very agitated and began to hit himself in the face and bite his hand. When a police officer responded to a 911 call, the caregiver informed her that the man was mentally ill, but did not tell her that the man was nonverbal and nonresponsive.

The officer approached the man, asking for his name and the reason for his agitation. The man, in turn, while hitting and biting himself, began to approach the officer. When the man grabbed the officer's shirt, she delivered a short burst of pepper spray to his face. Joined by two other officers, who were informed that the man was mentally ill, the three of them took the man to the ground to arrest him.

The man continued to struggle and the officers first applied handcuffs and then a "hobble device" that bound his ankles together. According to five witnesses, the officers sat or otherwise put pressure on the man's back and continued to use pepper spray on him after he had stopped resisting. After several minutes on the ground, the man began to vomit, went into cardiac arrest, and subsequently died.

In reviewing the jury's verdict, the Sixth Circuit found that the officers' use of pepper spray after the man was handcuffed and hobbled was excessive force. The court also determined that putting substantial or significant pressure on a suspect's back while the suspect is in a face-down prone position after being subdued and/or incapacitated constitutes excessive force.

The court emphasized that the police knew they were confronting an individual who was mentally ill or retarded, even though they may not have known the full extent of his disorder, and that the diminished capacity of an unarmed detainee must be taken into account when assessing the amount of force exerted. Although the court acknowledged that the officers may not have intended to harm the man and may have believed that they were helping him, the court ruled that the motive of the officers was irrelevant.

The court also determined that a verdict of $900,000 for pain and suffering for the 17-minute period involved was not excessive. The court noted the panic associated with being unable to breathe because of exerted external pressure, and added that the man's pain and suffering were magnified by his likely inability to comprehend what was happening. Champion v. Outlook Nashville, Inc., 380 F.3d 893 (6th Cir. 2004), *at* http://www.ca6.uscourts.gov/opinions.pdf/04a0270p-06.pdf, *cert. denied sub nom.*, Dickhaus v. Champion, 125 S. Ct. 1837 (2005).

Florida Case. In a third case, an officer received a report that a man was walking on the interstate. When the officer arrived, he found the man crossing traffic but apparently unaware of the traffic around him. The man told the officer that he had diabetes and high blood pressure, was not feeling well, and was walking to the hospital.

While waiting for an ambulance to arrive, the man indicated he believed the officer and another officer who had joined them wanted to hurt him. Despite efforts to reassure him, the man started to walk away. The officers chased him and, following a struggle, got the man face down on the ground and lay on top of him.

Other officers arrived, the man was handcuffed, and his legs were bound with rope. Two of the officers continued to lie across the man's shoulders until he lost consciousness. The man experienced cardiac and respiratory arrest and is now in a persistent vegetative state.

A Florida Court of Appeal ruled that the officers' actions constituted excessive use of force. The court acknowledged that the officers' intentions were laudable, but found their intentions to be irrelevant. The court ascertained that the force used must be reasonably proportionate to the need for that force and concluded that the use of force in this case was unreasonable based on the information the officers had. The court emphasized that the man had not been suspected of committing any crime that would subject him to detention and determined that the absence of a crime militates against the use of any force, much less the force used in this case.

Because force was not justified, the fact that the man was a "big guy" was irrelevant. The court also stressed that the man did not pose an immediate threat to either the officers or others. Speculation that he might be heading back to the interstate where he might cause an accident or the possibility that he might subsequently fall into a diabetic coma did not establish he posed an immediate threat to either others or himself. Finally, the man's initial resistance did not justify the amount of force used after he had been handcuffed and bound. Thompson v. Douds, 852 So. 2d 299 (Fla. Ct. App. 2003), *at* http://www.2dca.org/opinion/July%2018,%202003/2D02-3972.pdf, *cert. denied*, 125 S. Ct. 59 (2004).

Mentally Retarded Defendant Incompetent to Waive *Miranda* Rights and Confess to Murders; Ruling Not Disturbed

The Illinois Supreme Court reversed the conviction of a criminal defendant who was mentally retarded after it found that she was incompetent to waive her *Miranda* rights. As a result, the confessions she had given the police were suppressed and a new trial was required if the state wished to continue to prosecute her for a pair of murders that occurred in a Chicago apartment where she was present.

The court determined that there were two primary issues that must be resolved. First, was this a "custodial interrogation"? The court noted that only if the defendant was in the custody of the police at the time of the confession was the 5th Amendment's privilege against self-incrimination applicable. Second, was the defendant's waiver of her *Miranda* rights made voluntarily, knowingly, and intelligently?

The focus of the first question, the court decided, is whether a reasonable person would have felt he or she was not at liberty to terminate the interrogation and leave. Factors the court found applicable to this question were the "age, intelligence, and mental makeup of the accused—and an investigating officer's awareness and exploitation of those characteristics."

The court reasoned that because it is "now firmly established legal principle that 'juvenile defendants are, in general, more susceptible to police coercion than adults'" and thus a "reasonable-juvenile standard" is now applied to a determination of whether an interrogation of a juvenile is custodial, a similar modification of the reasonable person standard should apply when mentally retarded defendants are involved. The court cited "their limited communication skills, their predisposition to answer questions so as to please the questioner rather than to answer the question accurately, and their tendency to be submissive" as the bases for finding that

mentally retarded defendants are more susceptible to police coercion during a custodial interrogation.

The court added that mentally retarded defendants are also more susceptible to the impression that they are in custody in the first place. In this case, the court emphasized that the defendant had been questioned by the police six times before she was formally arrested. Also noted was that for the questioning the police enlisted the help of a woman who said she was the defendant's sister and legal guardian, that this woman facilitated the interrogation by conveying the questions of the police after it became apparent that the defendant would not respond to the police, and that this woman did not fill the role of a family member concerned with the defendant's welfare.

Finally, the court observed that two officers were always present during questioning, that an officer had expressed disbelief at the defendant's version of events and had asked her to take a polygraph examination, and that at one point the police read the defendant her *Miranda* rights when they had not done so previously. The court concluded that under these circumstances, a reasonable person with defendant's mental capacity would not have felt free to leave and thus the defendant was in custody when she gave an inculpatory statement.

Turning to the second question, namely, whether the defendant knowingly and intelligently waived her *Miranda* rights, the court noted "it is generally recognized" that individuals that are mentally retarded are more susceptible to police coercion or pressure, are predisposed to answer questions so as to please the questioner rather than to answer accurately, are more likely to confess to crimes they did not commit, tend to be submissive, and are less likely to understand their rights.

While limited mental capacity alone did not establish that a defendant is incapable of waiving *Miranda* rights, the court determined that it is one of several factors to be considered. The court cautioned that it was not necessary for the defendant to understand the far-reaching legal and strategic effects of waiving such rights or appreciate how widely or deeply an interrogation may probe, but concluded that the defendant must at least understand basically what these rights encompass and minimally understand what their waiver will entail.

In this case, the court found that the defendant was given her *Miranda* warnings from a standard form without additional explanation; made no verbal response, but merely nodded her head in an affirmative manner; never verbally indicated that she understood the warnings and did not sign a waiver form; may not have directly responded to or communicated with the police officer; and may have been subjected to suggestive or leading questions by the police. The court also noted that five psychiatrists concluded that the defendant was incapable of understanding *Miranda* warnings.

As a result, the court concluded the defendant did not knowingly and intelligently waive her *Miranda* rights and her statements to the police should have been suppressed. The U.S. Supreme Court declined to review this decision. Illinois v. Braggs, 810 N.E.2d 472 (Ill. 2004), *at* http://www.state.il.us/court/Opinions/SupremeCourt/2004/April/Opinions/Html/95350.htm, *cert. denied*, 125 S. Ct. 862 (2005).

Teacher Claimed Constitutional Rights Violated When Arresting Police Officers Failed to Adequately Question Credibility of Special Needs Student Who Asserted Teacher Sexually Fondled Him in the Classroom; Teacher's Lawsuit Dismissed; Ruling Not Disturbed

In Rhode Island, a high school special education teacher was arrested for the alleged sexual assault of a 15-year-old male student during class. On the day of the purported incident, the student had gone to the principal's office and claimed that the teacher

had touched him in a sexual manner during class. That evening the student and his mother went to the local police department and filed a complaint against the teacher. Police officers interviewed and reinterviewed the student and his mother, as well as the school principal, who confirmed that the student had come to his office with his complaint.

Based on this information, the police arrested the teacher and charged him with second degree sexual assault. A subsequent investigation by the school system found there "was no credible evidence" that the teacher had sexually fondled the student in class, the Rhode Island Attorney General's office declined to prosecute the matter, and the case was ultimately dismissed.

The teacher, who had been a full-time special education teacher at the high school for 30 years, complained that the police officers inappropriately failed to interview his teaching assistant or any of the other students present in the classroom at the time of the alleged incident and should have questioned the credibility of the student because he was a special needs student taking Ritalin for his Attention Deficit Hyperactivity Disorder. He filed a lawsuit for damages against the police officers asserting that he had been arrested without probable cause in violation of his constitutional rights.

The First Circuit of the U.S. Court of Appeals dismissed the teacher's lawsuit after determining that there was probable cause for the arrest. The court noted that the student had not claimed that the teacher had molested him in clear view of the others in the classroom and that the nature of the reported inappropriate touching would not necessarily have been recognized by even an eye witness.

The court also found that there was no evidence that the student's condition of Attention Deficit and Hyperactivity Disorder, and his prescription of Ritalin, had any effect on his credibility. The court added that one of the police officers involved had made an independent determination that the student was "fairly intelligent and credible" and was not mentally incapacitated in any relevant manner.

The court observed that the police had conducted an investigation and once presented with probable cause to support an arrest, the police were not required to undertake a further investigation at that point. The U.S. Supreme Court declined to review this decision. Forest v. Pawtucket Police Dep't, 377 F.3d 52 (1st Cir. 2004), *at* http://www.ca1.uscourts.gov/, *cert. denied*, 125 S. Ct. 1315 (U.S. 2005).

Death Sentence Reversed Because Prosecution Failed to Provide Defense with a Parole File Containing Exculpatory Mental Health Evidence; Ruling Not Disturbed

In *Brady v. Maryland* (1963), the U.S. Supreme Court established that the prosecution has a responsibility to provide the defense with material, exculpatory evidence in its possession and that a failure to do so is grounds for overturning a conviction. Questions have periodically arisen over when this responsibility to disclose extends to evidence pertaining to the defendant's mental status.

The Georgia Supreme Court vacated a defendant's death sentence after finding that the State had violated *Brady* by suppressing parole records that supported the defendant's claim of mental retardation. The court noted that the file would have established that State officials and his mother had characterized him as mentally retarded in the 1970s, which would have refuted the prosecutor's claim that the defense had recently concocted his alleged mental retardation.

The court also determined that the file indicated that a State official had described a relatively high IQ test score of the defendant's as being "questionable," which would have undercut the prosecutor's reliance on this test

as direct evidence of his intelligence level. The court added that reference in the file to the existence of a sub-70 score on an IQ test taken by the defendant when he was 16 years old would have provided direct support for the defendant's position.

The court concluded that had this evidence been disclosed to the defendant, there was a reasonable probability that the outcome of his trial would have been different. The court rejected the prosecution's argument that the suppression of the file was justified because a Georgia statute makes parole files confidential, reasoning that such a statute cannot trump a capital defendant's constitutional rights. The U.S. Supreme Court declined to review this decision. Head v. Stripling, 590 S.E.2d 122 (Ga. 2003), *at* http://www2.state.ga.us/Courts/Supreme/pdf/s03a0525.pdf, *cert. denied*, 124 S. Ct. 2400 (2004).

Privatization by Puerto Rico of Prison Inmates' Medical and Mental Health Services Upheld for the Time Being; Ruling Not Disturbed

Since the 1970s, class action lawsuits have been brought against many states challenging the medical and mental health care provided in their correctional systems. In part because many of these lawsuits deeply enmeshed the federal courts in the supervision of prisons and jails for an extended period of time, Congress enacted the Prison Litigation Reform Act (PLRA) in 1996 to curb the involvement of the federal courts in day-to-day prison management.

One of the lengthiest ongoing lawsuits has focused on prison conditions in the Commonwealth of Puerto Rico. After roughly 20 years of litigation, prison conditions in general improved but medical and mental health care lagged behind. In 1997, the parties to the lawsuit agreed as part of a consent decree to privatize this care.

A non-profit entity, the Correctional Health Services Corporation (CHSC), was formed to provide these services. Although expected to be fully functional by the end of 1998, by 2003 the CHSC had not yet treated any patients, despite an infusion of $55 million.

In addition, a new administration representing a different political party took office in Puerto Rico in November of 2000. In October of 2003, the Commonwealth filed a motion under the PLRA to vacate the privatization component of the consent decree.

On appeal, the First Circuit rejected this motion. The court determined that (1) the health and mental health care provided remained constitutionally unacceptable, (2) the privatization remedy held promise of being able to correct this deficiency, and (3) this litigation, for the time being, was not in violation of PLRA. At the same time, the court warned that it expected accelerated efforts so that federal judicial involvement could cease.

The court rejected an assertion that privatization was an inherently improper remedy for responding to the unconstitutional level of health and mental health care services. It also noted, however, that the justification for its use was based on the failure of other possible remedies and "[d]rastic times call for drastic measures."

In addition, the court cited the CHSC's development of a functional information technology system and believed that this platform seemed likely to "contribute measurably to the long-term success" of the prison health care system because it would provide a means of maintaining accurate records and create accountability. The U.S. Supreme Court declined to review this decision. Feliciano v. Rullán, 378 F.3d 42 (1st Cir. 2004), *at* http://caselaw.lp.findlaw.com/scripts/printer_friendly.pl?page=1st/041300.html, *cert. denied*, 125 S. Ct. 910 (2005).

For an article on the use of privatized prison health care that notes that "[a]s governments try to shed the burden of soaring medical costs—driven by the exploding problems of AIDS and mental illness among inmates—this field [of privatization of jail and prison health

care] has become a $2 billion-a-year industry," see Paul von Zielbauer, *Private Health Care in Jails Can Be a Death Sentence*, N.Y. TIMES (Feb. 27, 2005), *at* http://www.nytimes.com/2005/02/27/nyregion/27jail.html?hp&ex=1109566800&en=f814d917b2991c35&ei=5094&partner=homepage.

Dismissal of a Lawsuit Asserting That Licensure Testing Procedure for Professionals Violated the ADA for Failing to Reasonably Accommodate an Examinee's Mental Disability Is Reversed and Remanded for Further Consideration

Many professionals, including physicians, nurses, psychologists, social workers, and attorneys, are required to be licensed in the state in which they desire to provide services. Title II of the Americans with Disabilities Act (ADA) prohibits states from discriminating on the basis of a disability in providing access to their services, programs, or activities.

Complaints periodically arise that a state has discriminated against an individual with a mental disability who has sought professional licensure, with the individual subsequently suing the state under the ADA for damages incurred as a result of this discrimination. At the same time, the 11th Amendment to the Constitution ordinarily bars private lawsuits seeking monetary damages from a state. The question has arisen whether these ADA lawsuits for damages are barred by the 11th Amendment, with complainants limited to seeking injunctive relief under the ADA.

In Florida, an applicant failed the state's nursing licensure examination. She had suffered a "closed head injury" in 1998 that resulted in a mental impairment that she claimed diminished her "ability to perform tasks that measure attention such as examinations." Nevertheless, she subsequently completed a Registered Nurse degree program.

The licensing exam, however, was given in a room with a dozen people taking other exams and people coming in and out to test on the computers. She claimed that this environment was noisy and distracting and caused her to fail the exam. She asked for a "reasonable accommodation" for her impairment during the exam, but this request was refused. In response, she filed a suit under Title II of the ADA seeking monetary damages from the State of Florida for its failure to provide her with a reasonable accommodation during her nursing licensure exam.

This lawsuit was dismissed by the Florida trial court in which it was filed on the basis that it was barred by the 11th Amendment, a ruling that was subsequently affirmed by a Florida intermediate court of appeal. The U.S. Supreme Court, however, vacated the judgment and remanded it for further consideration in light of its recent decision in *Tennessee v. Lane* (2004).

In *Lane*, the Supreme Court ruled that six disabled residents of Tennessee, including one who refused to crawl or be carried up to a second-floor courtroom to answer a traffic complaint, could pursue a lawsuit against that state under Title II of the ADA. The decision in *Lane*, however, was limited to where access to a court of law was denied. *Lane* necessitates a case-by-case approach in other Title II suits that will focus on whether the act of discrimination impinges on "basic constitutional guarantees" and whether there is a significant history of official mistreatment of individuals with a disability in the context under review.

The Supreme Court in *Lane* indicated that when these elements are met, private lawsuits against a state seeking damages under the ADA for a failure to provide reasonable accommodations to enhance accessibility to its services, programs, or activities will be permitted to proceed, notwithstanding the 11th Amendment. At the same time, the Court cautioned that the ADA does not require states to compromise their essential eligibility criteria for public programs.

The remanding of the Florida lawsuit involving the candidate for nursing licensure indicates

that the Court expects a review of whether professional licensing exams have an impact on basic constitutional guarantees and have a history of mistreating individuals with a disability. If so, states may then be required under the ADA to pay monetary damages for discriminating against and failing to provide reasonable accommodations to applicants with a mental disability seeking to obtain a professional license. Feaster v. Florida, 846 So. 2d 1238 (Fla. Dist. Ct. App. 2003), *vacated & remanded for further consideration in light of Tennessee v. Lane* (2005). Tennessee v. Lane, 124 S. Ct. 1978 (2005), *at* http://a257.g.akamaitech.net/7/257/2422/17may20041215/www.supremecourtus.gov/opinions/03pdf/02-1667.pdf.

State Board Can Insist as a Condition for Reinstating a License to Practice Medicine That a Physician Submit to a Psychiatric Exam by a Medical Professional Pre-Approved by the Board; Ruling Not Disturbed

A Rhode Island court upheld a decision by that state's Board of Medical Licensure and Discipline (Board) that a physician was not fit for practice and could only apply for reinstatement after she had undergone a psychiatric examination by a medical professional pre-approved by the Board. The physician had argued that she was willing to be examined by a psychiatrist, but not one who was subject to the Board's control. The court rejected this argument and concluded that she was required to comply with the Board's order and that her license could be suspended until she satisfied the Board's requirement.

Among the findings of unprofessional conduct that the court upheld was that the physician had made an anonymous phone call to the Department of Children, Youth and Their Families (DCYF) suggesting child abuse by the parents of four of her patients. The court determined that while the general public could file a complaint regarding abuse by this means, under Rhode Island law a physician has a higher duty when reporting a case of suspected child abuse, which necessitates that a written report be filed.

The court also upheld the Board's finding that the physician's treatment of patients outdoors constituted unprofessional conduct, notwithstanding that the physician had asserted that this outdoor treatment had been necessitated by the contamination of each of the four buildings in which her offices were located over the course of five years. The court also upheld a finding of unprofessional conduct related to the physician's refusal to transfer patient records to the patient's new physician in a timely manner following a dispute over a bill.

The U.S. Supreme Court declined to review this decision. Mills v. Nolan, No. PC 01-4153 (R.I. Super. Ct. Nov. 13, 2003), *at* http://www.courts.state.ri.us/superior/pdf/01-4153.pdf#search='Geraldine%20Mills,%20M.D.', *cert. denied*, 125 S. Ct. 1304 (U.S. 2005).

Ruling that Enhanced the Sentence of a Psychiatrist and His Office Manager for Testifying Falsely at Their Medicaid and Medicare Fraud Trial, Without a Jury Having Made This Factual Finding, Is Reversed and Remanded for Further Consideration

Under the Federal Sentencing Guidelines, the sentence authorized by a jury verdict could be enhanced by.the presiding judge at the sentencing hearing if the judge found that additional facts delineated by the guidelines existed. In *United States v. Booker* (2005), the Supreme Court struck down these guidelines to the extent that they imposed binding requirements on sentencing judges but were based on facts that had not been determined by a jury.

A number of lower court decisions were vacated and remanded for further consideration in light of this ruling. One such decision involved the conviction of a psychiatrist and his office manager for Medicaid and Medicare fraud.

The defendants had been convicted of billing for services provided by others but declaring that the psychiatrist had provided the services. The challenged services included the use of unlicensed individuals to co-direct a therapy group for the survivors of sexual abuse. After a jury had found the defendants guilty, the presiding judge concluded that both defendants had testified falsely at their trial, and imposed a two-level obstruction of justice enhancement under the federal guidelines.

By vacating and remanding this decision, the Supreme Court requires that these defendants be re-sentenced. United States v. Mitrione, 357 F.3d 712 (7th Cir. 2004), *vacated & remanded for further consideration in light of United States v. Booker* (2005). United States v. Booker, 125 S. Ct. 738 (2005), *at* http://www.supremecourtus.gov/opinions/04pdf/04-104.pdf.

Florida Guardianship Proceedings in Schiavo Case Did Not Violate Federal Law; Efforts to Override Judicial Order Discontinuing Life-Sustaining Nutrition and Hydration Also Struck Down; Rulings Not Disturbed

A series of closely-watched judicial rulings and legislative enactments were issued that addressed the withdrawal of the nutrition and hydration tube of Theresa (Terri) Schiavo, a severely brain-damaged woman in Florida. On several occasions the U.S. Supreme Court declined to intervene, the nutrition and hydration tube was ultimately withdrawn, and Schiavo died on March 31, 2005.

Schiavo experienced cardiac arrest in 1990 after she collapsed in her home. Her heart was believed to have stopped beating for ten minutes before paramedics arrived. She suffered from an undiagnosed potassium deficiency, possibly due to extreme weight loss. Her husband later speculated that she suffered from bulimia. Schiavo's cardiac arrest left her unconscious and reliant on a nutrition and hydration tube for sustenance. Her husband sought from a guardianship court in 1998 an order authorizing the withdrawal of the nutrition and hydration tube. This petition was opposed by Schiavo's parents. The guardianship court determined that clear and convincing evidence existed that Schiavo was in a persistent vegetative state and would elect to cease life-prolonging procedures if she was competent to make her own decision.

Following an extensive series of judicial appeals, this order was affirmed and Schiavo's nutrition and hydration tube was removed on October 15, 2003. Six days later, the Florida legislature enacted a law that effectively allowed the governor of Florida to order the reinsertion of the nutrition and hydration tube for Schiavo, but not for anyone else. The governor subsequently issued such an order.

Upon review, the Florida Supreme Court ruled that this legislative act constituted an impermissible encroachment on the judicial branch and a violation of the constitutionally mandated separation of powers. The court concluded that the legislature was not permitted to reverse a properly rendered final judgment by the courts. The court also determined that because the legislation provided no guidelines or standards directing the governor's actions and failed to guarantee that an incompetent patient's right to withdraw life-prolonging procedures would be honored, it represented an unconstitutional delegation of legislative authority to the governor. Bush v. Schiavo, 885 So. 2d 321 (Fla. 2004), *at* http://www.floridasupremecourt.org/decisions/2004/ops/sc04-925.pdf, *cert. denied*, 125 S. Ct. 1086 (2005).

Following additional judicial review, the order authorizing withdrawal of Schiavo's nutrition and hydration tube was affirmed and it was again removed on March 18, 2005. Three days later Congress enacted and President Bush signed legislation that assigned jurisdiction over any questions regarding possible violations of the federal rights of Schiavo to the federal district court of the

Middle District of Florida. Pub. L. No. 109-3, *at* http://news.findlaw.com.hdocs/docs/schiavo/bill31905.html.

On March 22, the federal district court ruled that the parents had failed to show "a substantial likelihood of success on the merits," a requirement for the issuance of a temporary restraining order to reestablish nutrition and hydration for Schiavo. Among the arguments rejected were that there had been a failure to appoint a guardian *ad litem* during the guardianship proceedings, a failure to appoint an independent attorney to represent Schiavo's legal rights, and a denial of "access to court" because the guardianship judge did not meet Schiavo "personally" and personally assess her level of cognition and responsiveness.

The federal district court determined that (1) not only had a guardian *ad litem* been appointed, but three of them had been appointed to represent Schiavo's interests over the course of the litigation, (2) the appointment of an independent attorney to represent Schiavo's interests was not required when, as here, the case had been exhaustively litigated and appealed and the parties, represented by counsel, had advanced what they believed to be Schiavo's intentions, and (3) there is no federal requirement that a state trial judge personally assess the cognition and responsiveness of the ward in a guardianship proceeding. Schiavo ex rel. Schindler v. Schiavo, 357 F. Supp. 2d 1378 (M.D. Fla. 2005), *at* http://www.aapsonline.org/judicial/districtdecision.htm.

In a later ruling, issued March 25, the court added, among other things, that Title II of the Americans with Disabilities Act (ADA), which protects qualified individuals with a disability from being denied the benefits of the services, programs, or activities of a public entity by reason of their disability was not applicable here because neither her husband, as court appointed guardian, or the hospice where Schiavo resided were "public entities" as required for the ADA to be applicable. Schiavo ex rel. Schindler v. Schiavo, 358 F. Supp. 2d 1161 (M.D. Fla. 2005), *at* http://www.flmd.uscourts.gov/.

The May 22 ruling by the federal district court was appealed to the 11th Circuit. The parents argued in part that the district court had violated a requirement of the recently enacted federal legislation (Public Law No. 109-3) that the federal court determine *de novo* any claim of a violation of Schiavo's federal rights by considering the procedural history of the state court litigation associated with this case.

The 11th Circuit responded that the complaint filed in federal district court had essentially asserted a lack of procedural due process by the state courts. As a result, the 11th Circuit concluded, the district court had to consider these prior state proceedings to ascertain whether there was a violation of the federal constitution. The appellate court ruled that, ultimately, the district court had made its own independent, *de novo* evaluation of the relevant federal constitutional claims. The 11th Circuit also agreed with the district court holding that the parents had failed to demonstrate a substantial case on the merits of any of their claims. Schiavo ex rel. Schindler v. Schiavo ex rel. Schiavo, 403 F.3d 1223 (11th Cir. 2005), *at* http://www.ca11.uscourts.gov/ opinions/ops/200511628.pdf.

On March 24, 2005, the U.S. Supreme Court denied an application for an emergency stay to reinsert the feeding tube pending the filing and disposition of a petition for a writ of certiorari. Schiavo ex rel. Schindler v. Schiavo, 125 S. Ct. 1692 (2005). On March 30, the 11th Circuit refused to reconsider the case. Schiavo ex rel. Schindler v. Schiavo ex rel. Schiavo, 404 F.3d 1282 (11th Cir. 2005). Later that same day, the U.S. Supreme Court again declined to intervene. Schiavo ex rel. Schindler v. Schiavo, 125 S. Ct. 1722 (2005).

Schiavo died on March 31. William Yardley & Maria Newman, *Schiavo Dies Nearly Two Weeks After Removal of Feeding Tube*, N.Y. TIMES (Mar. 31, 2005), *at* http://www.nytimes.com/2005/03/31/national/31cnd-schiavo.html?

hp&ex=1112331600&en=9a3735df723459c0&ei=5094&partner=homepage.

Grandparent Visitation Order Based on Diagnostic Evaluation of Parent, Children, and Grandparents Upheld; Ruling Not Disturbed

Historically, grandparents had no legal right to petition for court-ordered visitation with their grandchildren. Today, every state has enacted legislation that authorizes such orders under certain circumstances despite the objection of the children's parents. Although the U.S. Supreme Court in *Troxel v. Granville* (2000) struck down what it characterized as the "breathtakingly broad" grandparent visitation statute enacted by the State of Washington, it did not find such statutes to be inherently unconstitutional and its deeply splintered opinion provided little guidance to courts reviewing the enactments of other states.

Although the right of parents to rear their children as they see fit has been identified as a constitutionally protected fundamental liberty interest, the courts have generally upheld grandparent visitation statutes. These rulings can be roughly divided into two camps. The supreme courts of Georgia, Oklahoma, Tennessee, and Virginia have upheld statutes authorizing grandparent visitation orders provided there is a required threshold showing that the child's health or welfare will be harmed without such visitation. Other courts, including appellate courts in Maine, Wyoming, Arizona, California, Louisiana, Missouri, and West Virginia, have tended to agree that that a judge cannot overrule a fit parent's decision to deny grandparent visitation simply because a judge decides that visitation would be in the child's best interests, but have not articulated what more is needed.

Under either approach, mental health professionals often play a pivotal role when grandparents seek visitation rights by providing an evaluation of the impact of the proposed visitation or its absence on a grandchild.

In a New Jersey case, the father of two children had obtained a divorce from his wife and received sole custody of the children after his wife was proven to be a habitual drug user. The maternal grandparents initially saw the children routinely in conjunction with their daughter's court-ordered visitation. Animosity developed between the children's father and the grandparents after one child suffered second- and third-degree burns during a visit with his grandparents. Six years after the divorce the wife died of an apparent medication overdose.

The grandparents then sought court-mandated visitation rights. Diagnostic evaluations of the father, the grandparents, and the children were ordered and an evaluation team determined that the grandparents could "serve as a conduit with the children's deceased mother and can be a positive resource for the children in many ways." The trial court subsequently ordered monthly grandparent visitation.

On appeal, the New Jersey Supreme Court ruled that New Jersey's grandparent visitation statute was constitutional, but determined that grandparents must show by a preponderance of the evidence that visitation is necessary to avoid harm to the child. It also noted 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.

The court concluded that visitation with the grandparents was necessary to avoid harm to the children and upheld the ordered visitation. The U.S. Supreme Court declined to review this decision. Moriarty v. Bradt, 827 A.2d 203 (N.J. 2003), *at* http://lawlibrary.rutgers.edu/courts/supreme/a-145-01.opn.html, *cert. denied*, 124 S. Ct. 1408 (2004).

Suit Dismissed Against Therapist for Alleged Role in Conspiracy to Deny Child Custody to Mother; Ruling Not Disturbed

Child custody disputes are frequently bitterly contested. Mental health professionals may

be asked to play a pivotal role by formulating and submitting a report regarding who should be assigned custody. A disappointed party may subsequently file a lawsuit alleging improper behavior by the mental health professional in reaching his or her opinion.

In a case before the Ninth Circuit, the court was asked to review the dismissal of a lawsuit that alleged that a therapist had participated in a conspiracy to deprive a mother of the custody of her children.

The mother's complaint asserted that the therapist had joined with the fathers of her children and the social workers involved in the case in devising a plan to deprive her of the custody of her children. The mother claimed that the fathers of her children had made false claims of child abuse against her to punish her for leaving them, that the social workers had become involved to punish her for challenging their authority, and that the therapist's false report had been decisive in the judicial decision to deprive her of custody.

In affirming the dismissal of the complaint, the Ninth Circuit ruled that the mother had to show more than just that the therapist wrote reports upon which the social workers relied or that the therapist's actions ultimately resulted in the loss of custody. The court determined that there was no basis for inferring that the therapist was part of a conspiracy to violate the mother's constitutional rights. The U.S. Supreme Court declined to review this decision. Elwood v. Morin, 84 Fed. Appx. 964 (9th Cir. 2004), *cert. denied* 125 S. Ct. 271 (2004).

Cases in Virginia State and Federal Courts

Virginia Supreme Court

Virginia Supreme Court Clarifies Scope and Operation of Sexually Violent Predator Commitment Law

Legislation that permits prison inmates to be involuntarily hospitalized as a sexually violent predator (SVP) upon the completion of their prison term has been widely enacted across the country. Courts asked to review this legislation have generally upheld it. On the few occasions in which a court has read this legislation in such a way that its scope and impact is narrowed, legislators have tended to respond by enacting additional legislation that clarifies that they intended it to have a broader reach.

Virginia's Sexually Violent Predator Act (SVPA) became effective during the summer of 2003. With three separate rulings, the Virginia Supreme Court provided its first examination of the SVPA, which was subsequently followed by the enactment of additional SVP legislation.

Qualifying "Sexually Violent Offense." In one ruling, the court held that under the SVPA an inmate could be subjected to civil commitment upon release from prison only if the offense for which the inmate is *currently* serving time is a qualifying "sexually violent offense."

In the case before the court, the inmate had initially been imprisoned for statutory rape, a qualifying "sexually violent offense." After 18 years, the inmate had completed serving the sentence for this crime, but because he had been convicted for other crimes he committed while in prison, he remained in prison for several more years. However, none of these subsequent crimes were sexually violent offenses.

Prior to release, a petition was filed for his commitment as a sexually violent predator (SVP). The trial court ordered him committed after it determined that (1) he suffered from an antisocial personality disorder that made it difficult for him to control his predatory behavior and (2) this lack of control made it likely he would engage in sexually violent acts in the future.

The Virginia Supreme Court reversed this ruling. The court determined that "a person subjected to an involuntary civil commitment proceeding has a substantial liberty interest in avoiding confinement in a mental hospital." As a result, any statute that permits an involuntary commitment process to be initiated by the Commonwealth must be strictly construed.

Guided by this principle, the court concluded that the SVPA requires that a prisoner must be serving an active sentence for a sexually violent offense to be subject to commitment. Because this inmate was no longer incarcerated for a sexually violent offense at the time he was identified as a candidate for civil commitment, the court ruled he was not subject to the provisions of the SVPA. Townes v. Commonwealth, 609 S.E.2d 1 (Va. 2005), *at* http://www.courts.state.va.us/opinions/opnscvwp/1040979.pdf.

The Virginia General Assembly during its 2005 legislative session modified the language of the SVPA to encompass inmates who are either (i) incarcerated for sexually violent offenses or (ii) serving concurrent or consecutive time for other offenses in addition to time for a sexually violent offense. 2005 Va. Acts ch. 914. This change and other modifications to the SVPA can be found at http://leg1.state.va.us/cgi-bin/legp504.exe?051+ful+CHAP0914.

Qualified Mental Health Professionals; Evidentiary Standard. In a second ruling, the court held that it is permissible to rely on testimony from a mental health professional who evaluated the person for whom SVP

commitment was sought even though the professional is not licensed to practice in Virginia. The court determined first that the SVPA did not establish that the mental health expert must be licensed in Virginia.

The court then examined the general rules applicable to expert testimony in other civil cases. The court noted that the sole purpose of permitting expert testimony is to help the trier of fact understand the evidence presented or determine a fact in issue. A witness is qualified to testify as an expert, it concluded, when the witness possesses sufficient knowledge, skill, or experience on the relevant subject matter to fulfill this function.

The mental health professional in question, a psychologist, was licensed in Pennsylvania and New Jersey, had previously evaluated approximately 250 sexually violent predators and testified in over 200 such cases, was currently employed by federal district courts in both Pennsylvania and New Jersey to assess and treat sexual offenders, had supervised the sexual offender program at a Pennsylvania state prison, and had published numerous articles concerning the treatment of sexual offenders.

The court found that "without question" this professional was qualified to render an opinion on the identification and treatment of sexually violent offenders and that the trial record did not establish that he lacked a sufficient appreciation of the Virginia requirements for finding an individual a SVP.

The court also refused to disturb a trial court ruling that refused to commit the individual before the court as a SVP because there was not clear and convincing evidence that the individual was a SVP likely to commit sexually violent acts in the future. The Virginia Supreme Court stated that the clear and convincing standard was required both by the SVPA and by the federal constitution and that this burden of proof "places a heavy burden" on the Commonwealth. The court noted that the Commonwealth was not required to prove that the individual would be unable to control his sexual impulses, but determined that the Commonwealth was required to show that the individual would be *likely* to commit a sexually violent offense.

When there is supporting expert testimony presented by both sides and a resulting "battle of experts," which was the case here, the Supreme Court concluded that it should defer to the trial court's judgment regarding the weight and credibility to be given this testimony.

In dissent, two members of the court engaged in a relatively extensive discussion of the evidence and concluded that the clear and convincing standard had been met and the individual should have been committed. Commonwealth v. Allen, 609 S.E.2d 4 (Va. 2005), *at* http://www.courts. state.va.us/ opinions/opnscvwp/1041454.pdf.

The Virginia General Assembly during its 2005 legislative session modified the language of the SVPA with another enactment that specified that "[a]ny expert employed to assist the person [for whom commitment as a SVP is sought] on matters relating to the person's mental health shall be a licensed psychiatrist or licensed clinical psychologist who is skilled in the diagnosis and treatment of mental abnormalities and disorders associated with violent sex offenders." 2005 Va. Acts ch. 716. This change and other modifications to the SVPA can be found at http://leg1.state.va.us/cgi-bin/legp504.exe? 051+ful+CHAP0716.

Relevant Evidence, Exploration of Alternatives. In a third ruling, the court addressed (1) whether evidence of criminal convictions or prison disciplinary actions that did not involve sexually violent acts could be admitted into evidence at a SVP hearing and (2) the degree to which alternatives to involuntary confinement must be explored.

The Commonwealth had argued that it should be allowed to introduce evidence of 82 institutional infractions that occurred over a

period of years even though they did not involve prohibited sexual behavior. The Commonwealth contended that this was the best evidence available to establish whether someone who is incarcerated has the ability to control his predatory impulses or is likely to re-offend when returned to free society.

The Supreme Court refused to admit this evidence as it ruled it could not be reasonably concluded that a prisoner who violates an institutional rule while incarcerated (such as disregarding a direct order or being in an unauthorized area) is likely to commit a sexually violent offense or other criminal offense upon release from prison.

However, the court did determine that convictions for offenses that occurred in proximity to other convictions for sexual offenses, even though they did not involve sexually violent acts, were admissible if they could demonstrate the individual's predatory behavior or inability to control his impulsive sexual behavior. In this case, the individual had been convicted of an abduction related to a rape and around the same time had been convicted for indecent liberties. The court ruled that the convictions for abduction and indecent liberties were admissible in addition to the rape conviction.

As for exploring alternatives to involuntary confinement, the court held that when the Commonwealth has demonstrated that alternatives to confinement have been investigated and found unsuitable, it is not necessary to also propose and discount specific alternatives to commitment. The court added, however, that the Commonwealth has the initial burden of proving that there is no suitable less restrictive alternative to involuntary confinement and that the inmate is not required to produce a specific conditional release plan.

The court concluded that when the Commonwealth produces evidence sufficient to satisfy the trial court that involuntary confinement is necessary and, thus, less restrictive alternatives are unsuitable, then the prisoner has the burden of rebutting this evidence. The court found that in the case before it, a sufficient basis for confinement was established after the Commonwealth's expert indicated specific concerns regarding the inmate's (1) ability to comply with rules and (2) lack of insight into his personality disorder, which would limit his amenability to treatment unless he was in a setting where his behavior was controlled and monitored. McCloud v. Commonwealth, 609 S.E.2d 16 (Va. 2005), *at* http://www.courts.state.va.us/opinions/opnscvwp/1041200.pdf.

Conviction of Legal Guardian for Felonious Neglect of the Medical Treatment of an Incapacitated Person Upheld

The Virginia Supreme Court upheld the conviction of a woman for violating a statutory provision that makes it a felony for any "responsible person" to abuse or neglect an incapacitated person when that abuse or neglect results in serious bodily injury or disease to the incapacitated adult. VA. CODE § 18.2-369. This provision defines "neglect" as the "knowing and willful failure" to provide treatment, care, goods, or services that results in injury to the health or endangers the safety of the incapacitated adult. The court relied on the definition of "willful" as applied to a parallel criminal statute governing child abuse and neglect and determined that it "contemplates an intentional, purposeful act or omission in the care of an incapacitated adult by one responsible for that adult's care."

The court concluded that in this case the woman knowingly and willfully failed to provide medical treatment to her incapacitated 83-year-old mother. In 1997, the woman had been appointed as her mother's legal guardian.

During a January 2000 examination, the mother's condition was diagnosed as "advanced Parkinsonism, multi-infarct dementia, hypertension, atrial fibrillation, osteoarthritis, along with early stage 2 decubiti" (i.e., bedsores). The examining physician did not observe indications of

malnourishment at the time but informed the daughter to return to his office with her mother in six months or sooner if her mother's condition deteriorated.

The follow-up appointment was not kept and in September 2000 the mother was admitted to an emergency room in a severely hydrated and undernourished state with early stage 4 decubiti that had not been treated properly.

In reviewing the case, the court found that the mother was clearly incapacitated and totally dependent upon her daughter. The court acknowledged that the mother's severe dehydration and chronic starvation may have been caused by a number of factors, including the mother's refusal to eat.

However, it determined that it was unlikely that this condition developed during the course of two days, as claimed by the daughter, and that the daughter failed to seek treatment for her mother even though she had been instructed by the physician to bring her mother to his office for treatment if she experienced any problems. The court also noted that the mother's decubiti existed for at least a month before medical assistance was sought and it would not heal because the mother had not received adequate nutrition.

The court concluded that the daughter, as her mother's court-appointment legal guardian, had a duty to seek medical treatment and failed to do so. The court added that the mother's chronic starvation, dehydration, and infected decubiti constituted a serious threat to her health and safety and her subsequent death from pneumonia was a foreseeable and expected consequence of chronic starvation.

Consequently, the daughter's conduct resulted in the mother suffering "serious bodily injury or disease" within the meaning of the Virginia statute. Correll v. Commonwealth, 607 S.E.2d 119 (Va. 2005), *at* http://www.courts.state.va.us/opinions/opnscvwp/1040746.pdf.

Virginia Court of Appeals

Judge Cannot Compel Medical Exam and Evaluation of Depressed Woman When She Is Capable of Exercising Informed Consent

A Virginia law authorizes judicial orders compelling individuals to submit to a medical examination and evaluation (VA. CODE § 37.1-134.21). A circuit court judge issued such an order for a fifty-one-year-old woman who was suffering from morbid obesity and depression and who had been bedridden for more than two years, following a fire in the house in which she and her husband resided.

The Department of Social Services (DSS), after determining that the woman was in need of adult protective services, had obtained initially an emergency court order committing the woman involuntarily to a nursing home. As the maximum period of time for this emergency commitment neared, the DSS sought a court order authorizing placement of the woman in a nursing home to provide her with care and treatment pursuant to § 37.1-134.21.

The DSS asserted that because of her depression the woman was incapable of making informed health care decisions and was incapable of properly caring for herself. However, a psychosocial evaluation of the woman resulted in testimony that the woman's depression did not impair her ability to make informed decisions concerning her health.

The circuit court judge agreed with this finding, but nevertheless ordered the woman hospitalized for a period of one day to a month to undergo a comprehensive examination and evaluation of her depression and obesity and noted that the woman had "to lose weight to get better."

In one of the few published opinions reviewing the use of such judicial orders, the Virginia Court of Appeals ruled that this order exceeded the circuit court judge's authority. First, the appellate court determined that

before an order mandating a medical examination and evaluation can be issued under § 37.1-134.21, the statute requires that there must not only be a finding that the proposed action is in the individual's best interest, but also that the person is unable to give informed consent to the proposed action.

The court added that it did not matter whether the proposed action involved medical treatment or a medical evaluation or examination, as both may involve intrusive procedures. Because the woman was capable of making and communicating an informed decision, the court concluded that this order could not be issued pursuant to § 37.1-134.21.

Second, the appellate court rejected the assertion that the trial court had the inherent authority to order the woman to undergo a comprehensive medical examination under its general equity jurisdiction. The court ruled that the authority to order such an examination was limited to that established by § 37.1-134.21. The court added that to grant courts such authority under their general equity powers would eviscerate the narrowly drawn statutory scheme designed to balance the state's interest in protecting its citizens against the constitutional right of competent adults to refuse medical procedures. Cavuoto v. Buchanan County Dep't Soc. Servs., 605 S.E.2d 287 (Va. Ct. App. 2004), *at* http://www.courts.state.va.us/opinions/opncavwp/0596043.pdf.

Parental Rights Terminated for Failure to Remedy Mental Health, Substance Abuse, and Domestic Violence Issues that Adversely Affected Ability to Properly Parent Children

It is not unusual for mental illness and substance abuse to figure prominently in a decision to remove a child from the custody of a parent, as well as in a decision to ultimately terminate parental rights. The Virginia Court of Appeals ruled that a mother's failure to remedy issues associated with mental health, substance abuse, and domestic violence that adversely affected her ability to properly parent her children provided a sufficient basis for terminating the mother's parental rights. The court indicated that the focus is not whether steps have been taken to remedy these issues, but what has been achieved as a result of these steps.

The court noted that (1) it had been three years since the occurrence of the conditions that necessitated placing the children in foster care, (2) the mother failed to establish that she had benefited from the services she had sought or had remedied the conditions that necessitated the children's removal, and (3) the professional who had conducted a psychological evaluation of her parenting ability determined she still required long-term therapy to remedy her parental deficiencies.

The court concluded there was sufficient evidence the mother was either unable or unwilling to substantially remedy within a reasonable time the conditions that led to foster care placement and more opportunities were not required. Relying on similar grounds, the court also upheld the termination of the parental rights of the father. Carr v. James City County Div. of Soc. Servs., Nos. 0339-04-1, 0499-04-1, 2004 WL 1822374 (Va. Ct. App. 2004), *at* http://www.courts.state.va.us/opinions/ opncavtx/0339041.txt.

U.S. Court of Appeals, Fourth Circuit

Defendant Facing Capital Punishment Can Argue That "Flynn Effect" and Standard Error of Measurement Should Be Taken Into Account When Determining Whether IQ Score Established That He Is Mentally Retarded

The U.S. Supreme Court ruled in *Atkins v. Virginia* (2002) that it is unconstitutional to impose the death penalty on a defendant who is mentally retarded. However, the Supreme Court left it to the states to define what constitutes mental retardation in this context. Virginia responded by enacting legislation that requires the defendant to establish that the disability originated before the age of 18, that

it is characterized by a score two standard deviations below the mean on an approved standardized test, and significant limitations exist in the defendant's adaptive behavior. VA. CODE § 19.2-264.3:1.1.

Before *Atkins* was decided, Darick Walker was convicted in Virginia of capital murder for killing two individuals within a three-year period. After *Atkins* was issued, Walker asserted for the first time that he is mentally retarded. A federal district court ruled that the facts alleged in Walker's petition were not sufficient to establish that he is mentally retarded under the Virginia definition and dismissed the case.

On appeal, the Fourth Circuit of the U.S. Court of Appeals reversed this ruling, holding that if Walker can prove that the facts he asserted are true, he could establish that he is mentally retarded. As a result, he was entitled to an evidentiary hearing addressing his assertions.

In his petition, Walker presented the test results from the Wechsler Intelligence Scale for Children-Revised (WISC), administered to him at the age of 11, in which he received a score of 76. The district court had determined that only scores of 70 or lower on this test are the required two standard deviations below the mean. However, the Fourth Circuit rejected this conclusion.

The Fourth Circuit noted Walker's experts had described the "Flynn Effect," which posits that IQ scores in general rise over time and that IQ tests that are not "re-normed" to adjust for rising IQ levels will overstate an individual's IQ. Because the WISC had last been re-normed in 1972, Walker's experts asserted that when the test was given to Walker in 1984, it overstated his IQ by over 4 points (1/3 of a point per year). As a result, they argued, his IQ score should be viewed as a 72.

In addition, Walker's experts contended that the standard error of measurement must be taken into account when evaluating the IQ score obtained. Because it has been recognized that IQ tests have a measurement error of plus or minus five points, they maintained that individuals who have a measured IQ of 65 to 75 or lower may be considered to be mentally retarded if there is evidence of poor adaptive functioning.

The Fourth Circuit ruled that although Walker's position might be rejected following a hearing, it was sufficient at this preliminary stage to justify further proceedings. The court also noted Walker cited a 2003 IQ test that generated a score that was "indisputably" more than two standard deviations below the mean, while the Commonwealth pointed to a 2000 test score showing the contrary, which further necessitated the need for a hearing to determine which IQ scores are dispositive. Walker v. True, 399 F.3d 315 (4th Cir. 2005), *at* http://pacer.ca4.uscourts.gov/opinion.pdf/0416.P.pdf.

Virginia School Board's Offer of Educational Placement That Employs the TEACCH Method Found to Be Inadequate for Young Boy Diagnosed as Severely Autistic

Under the federal Individuals with Disabilities Education Act (IDEA), all states receiving federal funds for education are required to provide disabled schoolchildren with a "free appropriate public education" (FAPE). To meet this requirement, educational instruction must be specially designed to meet the unique needs of the handicapped child, supported by such services as are necessary to permit the child to benefit from the instruction. However, states are not required to provide the best possible education. The adequacy of a program offered by a school system to meet the FAPE requirement is oftentimes the subject of litigation.

In Virginia, a boy was diagnosed as severely autistic when he was two. His parents enrolled him in a private school when he was not quite three years old that uses the "applied behavioral analysis" (ABA) approach to teaching autistic children, which is an iteration of the Lovaas method. The Lovaas method breaks down the child's activities into discrete

tasks and rewards a child's accomplishments. One of its characteristics is the use of intensive, one-on-one training 30-40 hours per week. At this school, the child was reported to have made real progress in some areas, and little progress in other areas.

Roughly six months after enrollment in this program, the County School Board of Henrico County (Board) identified the boy as eligible for special education and related services and formulated an individualized education plan (IEP) for the current school year. The parents rejected this IEP, leaving their son in his current placement for that school year.

The following summer, the school board again evaluated the boy and developed an IEP that called for the boy to be placed in the pre-school autism class at Twin Hickory Elementary School (Twin Hickory). This program primarily uses the "TEACCH" method, a program reportedly adopted by many school districts throughout the country. It differs from the ABA method in part because it involves less one-on-one instruction.

The parents were not satisfied with this proposal and, in accord with Virginia's IDEA procedures, requested a hearing to challenge it. The hearing officer found the reduced one-on-one instruction would fail to adequately address the boy's self-stimulatory behavior, which would preclude him from learning in that environment. The hearing officer concluded that the Board's IEP did not provide the boy with a free appropriate public education, and required the Board to pay for his current program.

A federal district court reversed this decision after determining that the hearing officer had failed, as required, to give "great weight" to the testimony of the Board's witnesses on the adequacy of the Board's proposed program.

The Fourth Circuit of the U.S. Court of Appeals reversed the district court, siding with the boy's parents. The Fourth Circuit determined that the hearing officer did give careful consideration to the opinions of the Board's witnesses, but nevertheless had been persuaded that the boy's problems are so severe that he would not be able to benefit from Twin Hickory's program. The court acknowledged that the opinions of the professional educators were entitled to respect, but ruled that the hearing officer could accept the evidence of the parents over that of the Board. The Fourth Circuit added that it was not a matter that the alternative program was better than the Twin Hickory program, but that the Twin Hickory program was not appropriate for this particular child.

A dissenting judge argued that the hearing officer failed to give the required appropriate deference to the Board's witnesses as professional educators and that the evidence had not established that the boy's autism is more severe or significantly different than the other children that have received educational benefit at Twin Hickory. The dissent added that under the IDEA, the student is "only entitled to *some* educational benefit; the benefit need not be maximized to be adequate." County Sch. Bd. v. Z.P., 399 F.3d 298 (4th Cir. 2005), *at* http://pacer.ca4.uscourts.gov/opinion.pdf/032338.P.pdf.

Federal District Court, W.D. Virginia

Employer Provided Reasonable Accommodation to Call Center Employee Who Has a Bipolar Disorder; ADA Claim Rejected

The Americans with Disabilities Act (ADA) generally prohibits an employer from discriminating against an employee because of the employee's disability. In addition, an employer must grant a requested accommodation for the disability if the accommodation is reasonable and would allow the employee to perform the essential functions of the position.

An employee in Virginia who worked as a customer service and sales associate at her employer's call center, answering customer calls and promoting products and services, was diagnosed with bipolar II disorder. The

employee claimed her disorder caused severe mood swings, limited her ability to control her emotions, and made it difficult for her to perform her job duties. The employee filed suit under the ADA, claiming that her employer discriminated against her by disciplining her because of her disorder.

A federal district court in Virginia ruled that an employer is not required to accommodate an employee's disability if doing so would cause the employer undue hardship. The court added that the ADA does not require an employer to allow an employee to work only when illness permits, to automatically grant time off on demand, nor to give time off when doing so would cause an undue hardship. The court concluded that the employer had taken the required steps to accommodate the employee and rejected the employee's lawsuit. Rush v. Verizon Virginia, Inc., 7:04CV00093, 2004 WL 2900654 (W.D. Va. Dec. 9, 2004), *at* http://www.vawd.uscourts.gov/opinions/wilson/704cv00093.pdf.

Circuit Courts of Virginia

Lawsuits Against Law School for Student Shootings Settled

Four lawsuits brought against the Appalachian School of Law in the wake of the 2002 shooting spree by Peter Odighizuwa, a student who went on a rampage shortly after being asked to withdraw from school due to his poor academic performance, have been settled for $1 million.

The suits, brought on behalf of four students, one of whom died in the shooting, alleged that the school had been negligent in failing to warn students of the danger posed by Odighizuwa and had sought a total of $22.8 million in damages. The plaintiffs alleged that the defendants had knowledge of numerous warning signs exhibited by Odighizuwa, including "numerous incidents of irrational, paranoid, bizarre, psychotic, crazy and violent behavior toward the staff, administration, and students," had repeatedly ignored these warning signs, and failed to properly warn others of the danger posed by Odighizuwa or take appropriate disciplinary or security measures.

School officials denied liability for the shootings but said that the settlement permitted "the parties to this tragic episode to move ahead without protracted and expensive litigation." An attorney who represents the plaintiffs said the matter had been settled in the hope of bringing closure to the suffering endured by the plaintiffs since the shootings and that there were concerns that the law school would go bankrupt if a larger judgment were obtained. The school's commercial general liability policy provided for $1 million in coverage per incident. Odighizuwa pled guilty in February of 2004 to three counts of capital murder and three counts of attempted murder. Dara McLeod, *Lawsuits over Appalachian School of Law Shootings Settled*, 19(32) VA. LAW. WKLY. 1 (Jan. 10, 2005).

Proceedings Begin to Determine Whether Daryl Atkins Is Mentally Retarded and Thus Not Subject to the Death Penalty; Questions Arise About Increasing IQ Score

In Atkins v. Virginia (2002), the U.S. Supreme Court established that it is unconstitutional to issue the death penalty to a mentally retarded offender, but provided limited guidance to states attempting to implement this mandate. The Virginia General Assembly established in 2003 that the criteria for establishing mental retardation in capital murder trials are that the mental retardation originate before the age of 18, that the defendant have the equivalent of a tested IQ of 70 or below, and demonstrate significant limitations in adaptive behavior. VA. CODE § 19.2-264.3:1.1. The defense is assigned the burden of proof to show that the defendant is mentally retarded.

In what will be one of the first jury trials to determine whether a death row inmate is mentally retarded, initial proceedings have begun in York County Circuit Court regarding Daryl R. Atkins, the focus of the 2002 U.S. Supreme Court opinion. On February 2, 2005, the Virginia Supreme Court refused to

review the trial court's rulings that jurors should be told that Atkins was originally sentenced to death and that prosecutors will be allowed to dismiss jurors who say they oppose the death penalty in all circumstances.

In subsequent circuit court proceedings, prosecutors said their latest IQ test of Atkins yielded a score of 76. The prosecution argues Atkins has never been mentally retarded and that his recent IQ scores, as well as the cognitive skills necessary to complete the alleged crime, establish this. The U.S. Supreme Court in its ruling, which did not decide whether Atkins was mentally retarded, noted Atkins scored 59 on a 1998 IQ test.

A defense expert, who tested Atkins in 1998 and 2004, said that he found Atkins' IQ to be 74 last year. His report asserted that this change reflected the increased intellectual stimulation Atkins received from his constant contact with the many lawyers working on his case and concluded that Atkins' true IQ score is somewhere in the mid-to-upper 60s. Among the reasons given for why an IQ score may rise are that IQ scores often drift by five points up or down, practice drives scores higher, and scores tend to rise over time by about three points a decade.

Because Atkins was not given an IQ test as a youth, the jury will have to decide how to use these later IQ scores in assessing his intelligence before the age of 18. The jury trial is expected to begin this summer. Adam Liptak, *Inmate's Rising I.Q. Score Could Mean His Death*, N.Y. TIMES (Feb. 6, 2005), *at* http://www.nytimes.com/2005/02/06/national/06atkins.html?ei=5090&en=772135e21774ddd7&ex=1265346000&adxnnl=1&partner=rssuserland&pagewanted=all&adxnnlx=1107882180-GKaE65FU6Jc 5X7R6KtOOhg.

Pedophilia with a Personality Disorder Sufficient Basis for Involuntary Commitment as a Sexually Violent Predator

A Virginia Circuit Court judge ruled that an individual fit the definition of a sexually violent predator provided by the Virginia Code and ordered his involuntary confinement. Under the relevant statute, confinement as a sexually violent predator is limited to an individual who "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." VA. CODE § 37.1-70.1.

The court noted that the single expert providing testimony at the hearing had found that the individual is "afflicted with pedophilia with a personality disorder with antisocial traits," that he should be placed in the designated secure facility for sexually violent predators, and that alternatives to involuntary confinement were unsuitable and lacking or unavailable. This testimony was found to outweigh the willingness of the individual's former employer to hire him again and his wife to accept him in the home. Kilgore v. Garris, No. LS-1224-1, 2004 WL 3001162 (Va. Cir. Ct. 2004).

Virginia General Assembly

Virginia Enacts Law That Prevents Expressions of Sympathy by Health Care Providers from Being Used in Subsequent Lawsuits; Coalition Seeks to Go Further

Virginia joined a number of states that have enacted legislation that permits health care providers to express sympathy to a patient or a relative or representative of the patient without that expression being admissible in a civil action brought by the alleged victim of an unanticipated health care outcome.

In Virginia, a "relative" is defined to include "any person who has a family-type relationship with the patient." A "representative" is defined to include a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent. Unlike some states, however, the Virginia legislation does not protect from subsequent use in litigation a statement of

fault that was included with the expression of sympathy. VA. CODE §§ 8.01-52.1, 8.01-581.20:1 (2005).

A national advocacy group called the "Sorry Works! Coalition" has developed a model that goes beyond such efforts. Under this approach, (1) hospitals and physicians review every adverse incident, (2) hospital administrators and physicians sit down with patients and families to explain what happened, and (3) the hospital and doctor apologize if a mistake was made, offer the patient or family fair compensation if the investigation finds that there was a medical error, and explain how any such error will be corrected in the future. Its proponents argue that this approach will result in fewer lawsuits and reduced liability costs, will enable victims of inappropriate care to receive justice more quickly, and will reduce medical errors because medical providers and patients can more openly discuss mistakes and how to prevent them from happening again.

Pilot programs are operating in Johns Hopkins, Children's Hospitals and Clinics in Minneapolis, the Veterans Affairs Medical Center in Lexington, Kentucky, and the University of Michigan Health System. The approach was developed in response to claims that plaintiffs in malpractice actions are motivated primarily by a desire to find out what happened following an unexpected adverse outcome and that a lawsuit would not have been filed had this information been provided. Tanya Albert, *Preventing Lawsuits: Coalition Pushes Apologies and Cash Up-front,* AM. MED. NEWS (Feb. 7, 2005), *at* http://www.ama-assn.org/amednews/2005/02/07/prl20207.htm.

Virginia Department of Social Services

Information on Virginia Assisted Living Facilities Now Available Online; Information Includes the License Status, Complaints, Violations, and Required Remedial Actions

Information on more than 600 licensed assisted living facilities in Virginia is now being posted online. These facilities are non-medical residential settings that provide personal and health care services, 24-hour supervision, and assistance for the care of four or more adults who are aged, infirm, or disabled. They provide care for more than 34,000 residents who are not so ill that they qualify for nursing home care.

This website is operated by the Virginia Department of Social Services. The information dates back to July 2003 and includes license status, dates of inspections, whether the inspection was generated by a complaint, violations of state law found by regulators, inspectors' notes, and actions required to be taken by the facility.

The agency's commissioner, Maurice A. Jones, said that while the agency has long wanted to make the records readily available to the public, it was prompted to move more quickly after a series of articles appearing in The Washington Post revealed problems in the industry and with regulation of the facilities. *Virginia Places Records on Assisted Living Facilities Online*, 19 VA. LAW. WKLY. 847 (Jan. 24, 2005). The web site can be found at http://www.dss.state.va.us/facility/search/alf.cgi.

Cases in Other Federal Courts & Federal Legislation

Second Circuit/ D. Conn.

Peer Review Records Must Be Given to P&A Investigating Possible Incidents of Abuse and Neglect Notwithstanding a State Law That Prohibits Their Disclosure

Congress enacted in 1986 the Protection and Advocacy for Mentally Ill Individuals Act (PAMII) because of concerns that (1) individuals with a mental illness are vulnerable to abuse, neglect, and serious injury and (2) state systems for monitoring the rights of these individuals varied widely and were frequently inadequate. To receive federal funds supporting the care of such individuals, states are required to have in place an independent protection and advocacy system (P&A) that investigates reported or likely incidents of abuse and neglect. PAMII provides the agency with access to "all records of . . . any individual," including "reports prepared by any staff of a facility rendering care and treatment."

However, to encourage internal facility review of incidents of potential inappropriate treatment, many states have enacted laws that protect from discovery the proceedings of medical review committees conducting a peer review. Peer review typically involves an evaluation by health care professionals of the quality and efficiency of the services ordered or performed by another health care professional. It is hoped that by preventing disclosure of these proceedings a more candid and meaningful review of the health care professional's conduct will occur.

In a handful of suits, P&As have sought peer review documents following reports of patient abuse. A federal district court in Connecticut has joined the Third and the Tenth Circuits of the U.S. Court of Appeals in ruling that PAMII provides P&As with access to peer review records, notwithstanding a state law that shields these documents from disclosure.

In the Connecticut case, a P&A sought peer review records following the deaths of two state facility residents. The one resident died while being physically restrained, while the other died after choking while eating her breakfast.

The Connecticut court ruled that the "plain meaning" of the language in PAMII established that P&As are entitled to access peer review records, notwithstanding a subsequent 1991 U.S. Senate Committee report, regulations of the Department of Health and Human Services, and an opinion by the New Hampshire Supreme Court, all of which indicated otherwise. Conn. Office of Prot. & Advocacy for Persons with Disabilities v. Kirk, 354 F. Supp. 2d 196 (D. Conn. 2005), *at* http: //www.ctd.uscourts.gov/Opinions/ 021605.DJS.OPA.pdf.

Seventh Circuit

Requiring an Employee to Undergo a Psychological Test as a Condition of Employment Does Not Violate the Fourth Amendment Because Such Tests Do Not Constitute a "Search"

Psychological examinations are required as a condition of employment in a number of fields. Because the exams may explore relatively private and sensitive matters, various employees have filed lawsuits to exempt them from such requirements. In Indiana, a research analyst objected when officials with the Indiana Department of Corrections told her that to keep her job she would have to submit to a psychological exam. The test lasted two hours and was acknowledged to inquire into details of her personal life. The research analyst filed a federal claim that the test by state officers violated her Fourth Amendment right to be free from unreasonable searches and seizures by the government.

The Seventh Circuit of the U.S. Court of Appeals dismissed the employee's claim. The

court acknowledged that the employee had no contact with prisoners, was not armed, was not privy to state secrets, and had no other powers or opportunities that have been established as warranting in general a psychological test as a condition of employment. The court also granted that what constitutes a "search" encompasses a broad range of tests, including breathalyzer and urine tests and that the physical contact associated with these other tests may be minimal or nonexistent, while the invasion of privacy associated with a psychological test may be more profound.

Nevertheless, the court concluded that a psychological test is not a "search" that is subject to Fourth Amendment protections. The court concluded that the Fourth Amendment does not reach the mere "putting of questions to a person, even when the questions are skillfully designed to elicit what most people would regard as highly personal private information."

The court expressed concern that such an extension would ultimately encompass police inquiries or a government lawyer conducting a cross-examination at trial, and necessitate the obtaining of a search warrant before such questions were permitted. The court reasoned that the Fourth Amendment is not intended to encompass interrogations.

The court also opined that individuals such as this research analyst might still be able to pursue a number of state-law claims, including a tort claim for an invasion of her right of privacy, although the court noted that such remedies appeared limited in Indiana. The court added, without deciding the issue, that the administration by public officers of a "particularly intrusive, and gratuitously humiliating, psychological test" might constitute a deprivation of liberty without due process of law in violation of the Fifth and Fourteenth Amendments. Greenawalt v. Indiana Dep't of Corr., 397 F.3d 587 (7th Cir. 2005), *at* http://caselaw.lp.findlaw.com/data2/circs/7th/041997p.pdf.

Ninth Circuit

Mandatory Disclosure of Sexual History in Conjunction with a Treatment Program for a Convicted Sexual Offender as a Condition of Probation Struck Down

The courts continue to wrestle with the nature of the conditions that can be placed on sexual offenders who are permitted to return to the community. An individual convicted of possessing child pornography after he ordered a child pornography video over the Internet was initially sentenced to five years probation.

One of the terms of the probation required him to participate in a sex treatment program, which in turn required him to provide a complete sexual history autobiography. After being told that any past criminal offenses he revealed in the course of the program could be released to the authorities and that any information regarding offenses involving victims under 18 must be disclosed, the individual refused to complete the autobiography because he asserted it violated his Fifth Amendment right against compelled self-incrimination. Because of this refusal, his probation was suspended and he was sentenced to 30 months in prison.

The Ninth Circuit of the U.S. Court of Appeals reversed this sanction. The court did not dispute that the treatment program's policy of requiring convicted sex offenders to give a sexual history and to admit responsibility for past misconduct to counselors served an important rehabilitative purpose. The court noted that "[o]ften sex offenders repeat their past offenses, and informed counseling can only help protect them, their potential victims, and society."

However, the court determined that even though the disclosures sought might serve a valid rehabilitative purpose, they were also "starkly incriminating." As a result, the court ruled that revocation of the individual's probation violated his Fifth Amendment right against self-incrimination and the individual

was entitled to refuse to answer the sexual history question until he was assured that his answers would be protected by immunity.

The court also struck down a provision of his supervised release that prohibited him from possessing "any pornographic, sexually oriented or sexually stimulating materials" as impermissibly vague. However, the court upheld a requirement that prohibited him from possessing or using a computer with access to any "on-line computer service" at any location, including employment, without the prior approval of the probation department because the Internet was essential to the commission of his crime, there was evidence that his crime was "one step on a path towards more serious transgressions," and this provision was likely to protect the public from further crimes by the defendant. United States v. Antelope, 395 F.3d 1128 (9th Cir. 2005), http://caselaw.lp.findlaw.com/data2/circs/9th/0330334p.pdf.

Tenth Circuit/ D. Kansas

Mandatory Child Abuse Reporting Requirements in Kansas Do Not Apply to Sex Between Age-Mates When Injury Is Not Suspected

Kansas, like all states, mandates that suspected child abuse or neglect, including sexual abuse, be reported to a designated state agency. Under the relevant Kansas statute, a wide range of professional groups, including mental health professionals, must file a report if there is reason to suspect that a child has been injured as the result of sexual abuse, as well as physical, mental, or emotional abuse or neglect. A failure to submit a required report is punishable as a misdemeanor.

In 2003, the Kansas Attorney General issued an opinion that a report should be generated any time a juvenile under the age of 16 becomes pregnant, concluding that such activity is inherently injurious. This opinion has been construed to require reports whenever professionals suspect that patients and clients under the age of 16 have been sexually active with juveniles of a similar age, even when injury is not reasonably suspected.

This position was challenged by a number of professionals, including physicians, nurses, social workers, and a clinical psychologist. They argued that reporting all sexual activity between age-mates would not protect adolescents from actual abuse, but would instead threaten their professional relationships with health care providers and deter adolescents from obtaining needed health care.

A federal district court judge in Kansas determined that minors possess a right to informational privacy concerning personal sexual matters and that requiring reports of all sexual activity by juveniles under 16 would infringe this right. The court noted that approximately 30% of the adolescents in the United States engage in sexual intercourse by the age of 16, most sexual activity by adolescents under the age of 16 consists of sexual activity with peers, and consensual sexual activity between an adolescent under 16 and a person of a similar age is not inherently injurious to the adolescent.

The court determined that if sexually active adolescents are unable to obtain medical and psychological care without their sexual conduct being reported to state officials for investigation, they will be deterred from seeking such care and that such deterrence will be detrimental to their health. As a result, the court ruled that professionals are not required to report the non-injurious sexual activity of juveniles under 16. Aid for Women v. Foulston, 327 F. Supp. 2d 1273 (D. Kan. 2004), *at* http://www.ksd.uscourts.gov/opinions/031353-71.pdf.

District of Columbia Circuit

Army Veteran Can Pursue a Claim for Alleged Failure to Tell Him He Had Been Diagnosed as Having Schizophrenia

A U.S. Army veteran claimed the Department

of Veterans Affairs (VA) was aware that a physician had diagnosed him as having schizophrenia during an examination, but that the VA failed to inform him of this diagnosis for eight years and thus should be held liable for the damages he incurred as a result. A trial court dismissed the lawsuit after concluding that federal law dictates that all questions regarding the awarding of veterans' benefits are to be decided by the Secretary for Veterans Affairs.

The District of Columbia Circuit of the U.S. Court of Appeals reversed this ruling after concluding that this was not a claim that the VA had acted improperly in handling a request for benefits. The appellate court determined that the veteran's complaints of medical malpractice and intentional infliction of emotional distress associated with his "failure-to-inform" allegations did not suggest that the VA failed to pay for his treatment. As a result, he did not have to pursue his complaints through the administrative process created by Congress to resolve benefits disputes involving veterans, but could instead pursue them in federal court. Thomas v. Principi, 394 F.3d 970 (D.C. Cir. 2005), http://caselaw.lp.findlaw.com/data2/circs/dc/035182a.pdf.

Federal Legislation

On October 4, 2004, President Bush signed into law the Working Families Tax Relief Act of 2004 (Pub. L. 108-311). This law further extends the original sunset date for the Mental Health Parity Act (MHPA), originally enacted on September 26, 1996, to December 31, 2005. In recent years, this extension has been authorized on a year-to-year basis. The MHPA applies to group health plans that provide both medical/surgical benefits and mental health benefits. The MHPA requires parity between these benefits with regard to annual and lifetime dollar limits. Efforts, thus far unsuccessful, have been made to enact federal legislation to extend this parity to the number of covered hospital days, outpatient visits, co-pays, deductibles, and maximum out-of-pocket costs for in-network services. This enactment can be found at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:publ311.108.pdf.

Cases in Other State Courts and the District of Columbia

Connecticut

Connecticut Physicians Who Submitted Reports About the Competence of a Psychiatrist to Practice Safely Were Not Entitled to Absolute Immunity

State licensing boards or a corresponding legislatively designated agency typically have the authority to investigate licensed practitioners and to discipline them for unprofessional conduct. However, these boards and agencies generally have limited resources to engage in routine surveillance of the activities of licensed practitioners and generally do not undertake an investigation unless a report of unprofessional conduct has been filed with them.

One important source of such reports is other licensed practitioners. To encourage the filing of these reports, the persons who file them are often afforded immunity from lawsuits that might be later filed by a targeted practitioner (e.g., a lawsuit asserting that the report was defamatory).

At the same time, investigations triggered by these reports can have significant consequences for the targeted practitioner (e.g., any disciplinary action must be submitted to the National Practitioner Data Bank and may result in the loss of clinical privileges). Concerns have been raised that the reports may not have been made in good faith (e.g., that they were filed out of spite or to gain a competitive advantage).

The Supreme Court of Connecticut was asked whether these reports should be entitled to absolute immunity from subsequent lawsuits by the targeted practitioner or only qualified immunity. The latter would not provide protection if it can be shown that the report was false and malicious.

In the case before the court, a psychiatrist, whose license to practice had been suspended, sued four other physicians for alleged malicious submission of false reports about him to the Connecticut Department of Public Health. The four physicians had expressed concerns about the psychiatrist's ability to practice psychiatry safely.

The court ruled that such reports are only entitled to qualified immunity because the Connecticut legislature in creating this supervisory structure abolished the previously existing common law rule that statements made in conjunction with judicial or quasi-judicial proceedings are entitled to absolute immunity. Therefore, if malice could be proven, the physicians who made the statements would not be protected from subsequent lawsuits.

The court reasoned that the legislature was free to eliminate the absolute immunity protection, even though this protection encouraged participation and candor by eliminating the threat of a lawsuit. The court found that the legislature had indicated that it did not want to provide insulation from lawsuits to those reports that were based on malice or "any sort of jealousy." The court noted that the same outcome had been reached in New Mexico and other courts concerned about the potential for abuse in the filing of these reports. The court added, however, that "the burden of establishing malice is a difficult one." Chadha v. Charlotte Hungerford Hosp., 865 A.2d 1163 (Conn. 2005), *at* http://www.jud.state.ct.us/external/supapp/Cases/AROcr/CR272/272CR157.pdf.

Georgia & Kentucky

Medical Board Complaints Against Physicians for Their Involvement in the Executions of Criminal Offenders Are Dismissed

Complaints filed against a pair of physicians with their respective state medical boards for their involvement in the executions of criminal

offenders have been dismissed. The American Medical Association, through its Council on Ethical and Judicial Affairs, has issued an ethical opinion (E-2.06) that states, "A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution." Physician participation is defined generally as "(1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner." This opinion also states that "[w]hen a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins." The AMA ethical opinion can be found at http://www. ama-assn.org/ama/pub/category/ 8419.html.

One complaint, filed with the Kentucky Board of Medical Licensure, asserted that the Governor of Kentucky, Gov. Ernie Fletcher, who is also a physician, violated his ethical obligations when he signed a death warrant for a convicted murderer. On January 13, 2005, the Kentucky Board ruled that there was no merit to this complaint.

Another complaint, filed with Georgia's Composite State Board of Medical Examiners, argued that a physician in that state violated medical ethics when he inserted a catheter into a prisoner to start a lethal injection. The Georgia Board on December 15, 2004, ruled that Dr. Hothur V. Sanjeeva Rao's actions did not violate the state's medical practice act. The internist said he was unaware of the ethical prohibitions on physician involvement in executions and that because the government had approved the execution, he thought his actions were "OK."

An Ohio pediatric surgeon, Jonathan I. Groner, who was involved in the filing of both complaints, indicated that the coalition with which he was working hoped to make physicians involved in executions "uncomfortable" and to thereby end their involvement in these executions. Andis Robeznieks, *Ethics Charges Related to Executions Dropped: A Georgia Internist Said He Didn't Know His Participation Violated Medical Ethics*, AM. MED. NEWS (Jan. 31, 2005), *at* http://www.ama-assn.org/ amednews/ 2005/01/31/prsg0131.htm.

Louisiana

Time Period for Woman to File Malpractice Claim Asserting She Was Not Warned Her Mental Illness Medication Might Cause Birth Defects Begins at Time of Child's Birth, Not When Ultrasound First Showed Existence of Birth Defects

Every jurisdiction imposes a limit on how long individuals can wait to file a lawsuit that claims they were injured as the result of the malpractice of a health care provider. This limit, which is typically one or two years in length, generally runs from the time individuals discover they have been injured. If they wait beyond this time, they are generally precluded from pursuing their claim.

A Louisiana woman with a long history of treatment and hospitalization for a bipolar disorder was prescribed Depakote. Depakote has been linked to birth defects among children exposed to it in the womb. Several months after she started taking this medication, the woman learned from a nurse at a mental health center that she was pregnant with her third child and was advised to discontinue all medications. At a subsequent meeting with an obstetrician, the woman was told that there was a particular risk that her child would suffer birth defects as the result of using Depakote during her pregnancy.

An ultrasound conducted a month later revealed that the fetus had a neural tube defect and the woman was told that the condition had probably resulted from her use of Depakote. The child was ultimately born

with a number of defects, including spina bifida and hydrocephalus. The woman claimed that the physicians who prescribed the Depakote had not warned her of the dangers of birth defects arising from its use during pregnancy and that the failure to warn her of these known side effects constituted medical malpractice.

In Louisiana, however, a medical malpractice claim must be filed within a year from the date on which the individual discovers the alleged negligence. The woman filed her claim within a year of the birth of her child, but it had been more than a year from the date when she had been informed that the ultrasound confirmed the existence of the birth defects (some six months before the birth of her child).

The Louisiana Supreme Court ruled that the woman could proceed with her claim, even though a Louisiana statute establishes that an unborn child who is later born alive is considered a natural person from the time of its conception. The physicians had argued that, as a result of this statute, the time for filing this claim began to run when the injury was confirmed in the course of the ultrasound.

The court, however, concluded that this statute applies only when its application works to the benefit of the child and that using it to preclude a malpractice suit would be detrimental to the child. The court added that waiting until after the child was born before starting the "clock" on when such claims must be filed relieves a pregnant individual of the burden of worrying about the need to pursue potential legal claims during a difficult pregnancy. Bailey v. Khoury, 891 So. 2d 1268 (La. 2005), *at* http://www.lasc.org/opinions/2005/04cc0620.opn.pdf.

New Orleans Police Shooting Could Lead to Changes in Information Provided to Louisiana Police When Responding to Requests to Take Individuals with a Mental Illness into Custody for Evaluation

A judge or a parish coroner in Louisiana can issue a protective custody order directing a person to be taken into custody and transported to a treatment facility for immediate examination if a "credible person" has signed a statement that the person is mentally ill or suffering from substance abuse and is in need of immediate treatment to protect the person or others from physical harm.

The application may include, among other things, a statement that the person is dangerous to himself or others, the date and place of any dangerous acts or threats, and the name of any other person who is in danger. The order is supposed to include a description of the acts or threats that led to the belief that the person is mentally ill or suffering from substance abuse and in need of immediate hospitalization to protect the person or others from physical harm. LA. REV. STAT. ANN. § 28:53.2(A), (B) (2004).

A shootout left a New Orleans police officer and two men dead. The police officer, who was attempting to implement a protective custody order, was unaware that the mentally ill man she was seeking was armed. The man and his half-brother were also killed in the gun battle that ensued after the police officer opened the door to the man's bedroom.

Police and mental health professionals have since met in an effort to determine the best way to get information that might prevent such tragedies to police before they implement protective custody orders. It has been suggested that additional information be requested on the form that applicants are required to complete, including whether the person is likely to be armed, has a history of drug abuse or violence, has served in the armed forces, or has martial arts training, so that such information can be conveyed to the police executing the orders.

In the case of the shooting of the New Orleans police officer, however, it is unclear that such information would have resulted in a different outcome. The protective custody request had been filed by the 78-year-old mother of the 38-

year-old man after he stole her medication and locked himself in his room. She was reportedly unaware that he was armed and kept guns in his room. In addition, according to family members, the man was not prone to violence. John Pope, *Police Shooting Could Spark Changes; Form for Mentally Ill Would State Dangers*, The Times-Picayune (Aug. 22, 2004), *at* http://www.nola.com/news/t-p/metro/index.ssf?/base/news-4/10931527574410.xml; Jeffrey Meitrodt & John Pope, *Mentally Ill Man's Weapons Caught Officers Unaware; Police Backup Was Already on the Way*, The Times-Picayune (Aug. 13, 2004), *at* http://www.nola.com/news/t-p/frontpage/index.ssf?/base/news-2/109239130431100.xml.

Massachusetts

Recovered Memories of Sexual Abuse Play Decisive Role in ex-Priest's Conviction

In a case that may trigger a resurgence in the use of recovered memories of sexual abuse in criminal prosecutions, Paul R. Shanley, a 74-year-old defrocked priest, was convicted of raping a boy when he was a parish priest in suburban Boston in the 1980s and was sentenced to 12 to 15 years in prison.

The trial focused on the uncorroborated accusations of a single individual who is now 27 years old. He claimed he repressed the memory of being molested from age six through nine, and only regained that memory when he read three years ago a newspaper article about other accusations of abuse by Shanley.

The jury was apparently unswayed by the only witness called by the defense, Dr. Elizabeth Loftus, who has conducted extensive research on recovered memories. Loftus testified that there is no credible scientific evidence for the notion that memories of years of brutalization can be massively repressed; that research has shown that memories, including memories for events that never happened, can be implanted in individuals; and that people can hold false memories with a lot of emotion and have a lot of confidence in and provide a lot of detail about their memories.

On cross-examination, however, Loftus agreed that people can forget traumatic events and remember them later. One juror interviewed after the verdict indicated he was not persuaded by this testimony and characterized it as "contradictory." Pam Belluck, *Ex-Priest Convicted in Rape of Boy in Boston*, N.Y. TIMES (Feb. 8, 2005), *at* http://www.nytimes.com/2005/02/08/national/08shanley.html?ex=1265518800&en=e51aaca6766ddd2f&ei=5088&partner=rssnyt.

Minnesota

First Report of Adverse Health Events in Minnesota Hospitals Issued

The Minnesota Department of Health in January of 2005 released its first annual public report of adverse health events in Minnesota hospitals. This document notes that the Institute of Medicine (IOM) released in 2000 a landmark report entitled "To Err is Human," which indicated that medical errors in American hospitals kill between 44,000 and 98,000 people each year. The IOM report concluded that "[t]he problem is not bad people; the problem is that the system needs to be made safer" and recommended that a mandatory reporting system be implemented where the most serious events would be reported, persistent safety problems identified, and action taken to prevent these errors.

In response to this recommendation, the National Quality Forum (NQF) developed a list of 27 events that should never happen in health care facilities (the "never events" list).

The Minnesota legislature, in turn, in 2003 enacted a law that mandated the reporting of the "never events" by Minnesota hospitals. The report by the Minnesota Department of Health summarizes the event reports provided during a transition period from July 2003 to October 2004. The report includes a compilation of (1) state-wide reports by category of event and (2) the adverse health

events that occurred at the 30 reporting health care facilities (which together have a total of 11,434 beds).

In all, 99 events were reported, which were linked to 20 patient deaths and 4 cases of serious disability. The reports were categorized as surgical, environmental, patient protection, care management, criminal, or product or device events. A total of 52 events were attributed to surgical errors, including 2 deaths.

The category with the next highest number of reports was care management events, of which there were 31 events, including 6 deaths or disability due to a medication error. There were 9 environmental events, which included 8 deaths associated with a fall (there were no deaths or disability associated with restraints, an event that was required to be reported if it occurred).

There were 4 products or devices events and 2 patient protection events. The latter consisted of 2 suicides or suicide attempts, with both events resulting in a serious disability (only suicide attempts that resulted in a serious disability or death were required to be reported).

Finally, there was 1 report of a criminal event, which involved the physical assault of a patient or staff that resulted in an injury (this category also included events involving the impersonation of a health care provider, the abduction of a patient, and the sexual assault of a patient).

Minnesota has been joined by Connecticut and New Jersey in requiring the reporting of the NQF list of "never events." These reporting laws establish that these reports are immune from legal discovery, a provision included in the hope that such reports will not be withheld because of a fear that they might lead to civil liability. Minnesota Department of Health, *Adverse Health Events in Minnesota Hospitals: First Annual Public Report* (Jan. 2005), *at* http://www.health.state.mn.us/ patientsafety/aereport0105.pdf.

Speculation Arises Following Red Lake High School Shooting on Role of Antidepressant Medication

In the wake of the shootings at Red Lake High School in Minnesota on March 21 in which a 16-year-old high school student shot nine people and then himself, family members speculated that the antidepressant Prozac may have played a role. The niece of the teenager, who lived in the same house with him, said he had been prescribed the medication following a suicide attempt and 72-hour hospitalization a year earlier. Another relative said that his medication had been increased a few weeks before the shootings. At the same time, a number of other risk factors that might be linked to the shootings have been identified.

A federal panel of experts in 2004 said antidepressants could cause children and teenagers to become suicidal. While acknowledging that depression and other psychiatric disorders in pediatric patients can have significant consequences if not appropriately treated, the Food and Drug Administration subsequently required the makers of antidepressants to warn of this danger on their labels for the medications and has cautioned that suicide risk is particularly acute when therapy starts or a dosage changes. However, the FDA warning does not indicate a link between these medications and violence towards other individuals.

In Canada, on the other hand, these medications are required to include a warning indicating that patients of all ages taking these drugs may experience behavioral and/or emotional changes that may put them at increased risk of self-harm or harm to others. Monica Davey & Gardiner Harris, *Family Wonders if Prozac Prompted School Shootings,* N.Y. TIMES (Mar. 26, 2005), *at* http://www.nytimes.com/2005/03/26/national/ 26shoot.html?ex=1112072400&en=fbda84485 6317c93&ei=5070; Monica Davey & Jodi Wilgoren, *Signs of Danger Were Missed in a Troubled Teenager's Life,* N.Y. TIMES (Mar. 24, 2005), *at* http://www.nytimes.com/ 2005/

03/24/national/24shoot.html?ex=1269320400&en=2aec88003fa16dd5&ei=5088&partner=rssnyt.

The FDA's advisory warning can be found at http://www.fda.gov/cder/drug/antidepressants/SSRIPHA200410.htm. The Health Canada advisory warning can be found at http://news.gc.ca/cfmx/CCP/view/en/index.cfm?articleid=87789&.

New Jersey

Employment Contract Intended to Limit Psychologist's Ability to Compete with a Group Practice After Employment Relationship Ends Is Not Enforceable

When mental health professionals join a group practice, their employment contract may include a restrictive covenant that is intended to limit their ability to compete with the group practice for a period of time should the employment relationship end. In New Jersey, a corporation providing neuropsychological services to clients sued one of its former employees, a licensed psychologist, to enforce a restrictive covenant in their employment contract. The restrictive covenant stated that after the termination of employment the psychologist could not practice his profession within ten miles of the corporation's facility and not solicit any of the corporation's patients for two years.

The Appellate Division of the Superior Court of New Jersey concluded that these restrictions interfered with the right of patients to receive continued treatment from the psychologist and refused to enforce them.

The court acknowledged that restrictive covenants in employment contracts involving physicians are enforceable under existing New Jersey law if they protect a legitimate interest of the employer, impose no undue hardship on the employee, and are not injurious to the public. The court determined, however, that this precedent was inapplicable to psychologists because the New Jersey State Board of Psychological Examiners has adopted a regulation restricting psychologists from entering into restrictive covenants.

In addition, the court asserted that the nature of the practice of psychology and the uniquely personal patient-psychologist relationship dictate against any restrictions that might interfere with an ongoing course of treatment. The court reasoned that psychologists who change their office location, voluntarily or involuntarily, have a duty to inform patients of the change, as well as the new location and phone number, and to do otherwise may be akin to abandonment. Comprehensive Psychology Sys. v. Prince, 867 A.2d 1187 (N.J. Super. Ct. App. Div. 2005), *at* http://lawlibrary.rutgers.edu/courts/appellate/a2761-03.opn.html.

New York

State-Issued Report Proclaims New York's Kendra's Law Mandating Outpatient Treatment a Success During Its First Five Years; Critics Dispute Analysis

The Office of Mental Health for the State of New York has issued a five-year evaluation of that state's assisted outpatient treatment (AOT) law. Widely known as Kendra's Law, it was enacted in 1999 in response to the death of a woman pushed in front of a subway train by a man with a history of mental illness. The law created a procedure for obtaining a court order to mandate outpatient treatment for individuals with a mental illness. It also required that local mental health systems give these individuals priority access to case management and other community services.

The report found that 10,078 individuals were referred for an AOT assessment during the law's first five years, of which 37% received a court order and another 28% received service enhancements without a court order. Almost 60% of the court orders and service enhancements occurred in New York City.

The average length of time recipients remained under court order was 16 months, two-thirds were male, the average age was

37, 71% had a diagnosis of schizophrenia, and 52% had a co-existing alcohol or substance abuse disorder. In the three years prior to a court order, 97% of the recipients had at least one psychiatric hospitalization, 30% had been arrested, 23% had been incarcerated, and 19% had been homeless at one point.

After six months, AOT recipients were more likely to participate in case management, substance abuse services, and individual or group therapy. They were also more likely to receive housing or housing support services. Their case managers rated their medication adherence, service engagement, and community and social functioning as significantly improved. AOT recipients were also found to demonstrate improvements in handling conflict and managing assertiveness and to be less likely to exhibit behaviors harmful to themselves or others.

The report also determined that large decreases occurred in the incidence of psychiatric hospitalization, alcohol and substance abuse, homelessness, arrest, and incarceration while under court order. Roughly half of AOT recipients interviewed reported feeling angry at being court-ordered into treatment, although 62% of them stated that being court-ordered into treatment had been good for them.

The report also includes a copy of the law and a description of various court challenges that the law has survived. The law is scheduled to expire on June 30, although efforts to make the law permanent have been initiated. Office of Mental Health, New York State, *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* (March 2005), *at* http://www.omh.state.ny.us/omhweb/Kendra_web/finalreport/.

In response to this report, The New York Lawyers for the Public Interest (NYLPI), a group opposed to the compulsory-treatment provisions in the law, argues that the law is used mainly on people with multiple psychiatric hospitalizations but no histories of hurting others. This group also asserts that it has been disproportionately applied to black New Yorkers, with black individuals almost five times as likely as white individuals to be subjected to the law, and Hispanic individuals almost two-and-a-half times more likely than non-Hispanic whites. A spokesperson for the state's Office of Mental Health responded that the proportions are similar to those for adults receiving intensive care in urban areas. Michael Cooper, *Racial Disproportion Seen in Applying 'Kendra's Law'*, N.Y. TIMES (Apr. 7, 2005), http://www.nytimes.com/2005/04/07/nyregion/07kendra.html. The NYLPI response can be found at http://www.nylpi.org/pub/Kendras_Law_04-07-05.pdf.

South Carolina

Jury Rejects "Zoloft Defense" in Murder Trial Focused on 12-Year-Old Boy's Killing of His Grandparents

In South Carolina, a jury found Christopher Pittman guilty of the killing of his grandparents. Pittman, who is now 15, was sentenced to 30 years in prison for the killings that occurred when he was 12 years old. Pittman had come to live with his grandparents in South Carolina after he began having trouble at home in Florida.

At trial, the prosecution argued that Pittman had grown angry because his grandfather had disciplined him, waited for his grandparents to go to bed, shot each of them once in the head with a shotgun, and then set the house on fire. The defense argued that Pittman was "involuntarily intoxicated" by the antidepressant Zoloft, which he had begun taking less than a month before the killings, and that this medication caused him to experience "command hallucinations" that told him to kill his grandparents.

During 2004, the Food and Drug Administration (FDA) began requiring selective serotonin reuptake inhibitors (SSRIs), like Zoloft, to carry a label that warned of the increased risk of suicidal behavior among young people that take this

medication. However, the FDA warning does not indicate a link between these medications and violence towards other individuals. In Canada, on the other hand, these medications are required to include a warning indicating that patients of all ages taking these drugs may experience behavioral and/or emotional changes that may put them at increased risk of self-harm or harm to others.

A juror who was interviewed after the trial said the jury was convinced that Zoloft could have a negative effect on young people, but did not believe it was enough to cause them to kill someone.

Although a spokesperson for Pfizer, Inc., the maker of Zoloft, said the company was aware of 14 criminal cases in which defendants blamed the medication for their actions, he asserted that in only a single case has the defense been successful. In April 2004, a jury in Santa Cruz, California, acquitted a 28-year-old man of attempted murder and assault following testimony by a neuropsychiatrist that the man struck his longtime friend in the head with a "ninja key ring" four times because of an adverse reaction to Zoloft. Shaila Dewan & Barry Meier, *Boy Who Took Antidepressant Is Convicted in Killings*, N.Y. TIMES (Feb. 16, 2005), *at* http://www.nytimes.com/2005/02/16/national/16zoloft.html. An account of the Santa Cruz jury verdict can be found at http://www.santacruzsentinel.com/archive/2004/April/24/local/stories/05local.htm.

Texas

Yates' Conviction Reversed for State's Use of False Testimony by Mental Health Expert Concerning "Law & Order" Episode

The Court of Appeals of Texas reversed the capital murder conviction of Andrea Yates obtained in connection with the drowning deaths of her young children in a bathtub in their home. At trial, Yates asserted an insanity defense and four psychiatrists and a psychologist testified that, as a result of her mental illness, Yates did not know right from wrong.

The State's sole mental health expert, however, testified that Yates, although psychotic, knew that what she did was wrong. On cross-examination, this expert testified that he had been a consultant for two shows appearing on the television series "Law & Order" and that one of them "was a show of a woman with postpartum depression who drowned her children in the bathtub and was found insane and it was aired shortly before the [Yates] crime occurred."

Subsequently, an expert witness for the defense was asked during cross-examination by the State whether Yates watched "Law & Order" a lot and whether the expert knew about an episode where a woman killed her children by drowning them in a bathtub and was found not guilty by reason of insanity (the defense expert responded no to both questions).

During closing arguments, the prosecutor asserted that thoughts about killing her children came to Yates, that she saw the episode from "Law & Order," a series that she watched regularly, and that she saw this as "a way out."

After the jury returned a guilty verdict, it was discovered that this episode of "Law & Order" did not exist and the State's expert acknowledged that he had erred in his testimony. Notwithstanding this false testimony, the trial court denied the defendant's motion for a mistrial. On appeal, this decision was reversed.

The Texas Court of Appeals determined that the general rule in Texas is that if a witness testifies to material, inculpatory facts against a defendant and, after a verdict is reached, the witness acknowledges that he testified falsely, a new trial should be granted. The court added that the State was not required to know that the testimony was false at the time it was given. It was sufficient that the State used the false testimony and there was a reasonable likelihood that the false testimony could have affected the judgment of the jury.

After reviewing the record, the court concluded that (1) the testimony was false, (2) it was used by the prosecution on two occasions, namely, during the cross-examination of the expert witness for the defense and during its final arguments, and (3) that it was material. In concluding that the testimony was material, the court noted that the defense felt compelled to address it in their closing arguments.

The court added that the State's expert was the only mental health expert to testify that Yates knew right from wrong. As a result, his testimony was critical to establish the State's case and this false testimony, although not an intentional lie, undoubtedly gave greater weight to his opinion. The court concluded that there was a reasonable likelihood that this false testimony could have affected the judgment of the jury and that a motion for a mistrial should have been granted. It remanded the case for further proceedings. Yates v. State, No. 01-02-00462-CR, 2005 WL 20416 (Tex. Ct. App. Jan. 6, 2005), *at* http://www.1stcoa.courts.state.tx.us/opinions/htmlopinion.asp?OpinionId=81308. A press release issued by the State's mental health expert following publication of the court's decision can be found at http://www.darleenclick.com/weblog/archives/Press%20Release%20and%20Stipulation%2C%2001.06.05.pdf#search='Park%20Dietz,%20M.D.,%20Ph.D.'.

Submission Guidelines

Developments in Mental Health Law encourages the submission of articles on timely and interesting topics regarding mental health law. The reading audience typically has legal or mental health training but not necessarily both. We seek articles that are of interest to this diverse audience.

Submissions can be mailed to: Editor, *Developments in Mental Health Law,* P.O. Box 800660, 1107 Main Street, Charlottesville VA 22908-0660. Inquiries can be sent via e-mail to the Editor at th4n@virginia.edu. The quickest way for the editor to contact you is by e-mail, so please include an e-mail address, if possible.

In Memoriam

We honor our colleague in forensic psychiatry at the ILPPP and the University of Virginia

~ Dr. Reuben Stoltzfus ~

who died in an automobile accident July 12, 2006.
We offer our condolences to his wife, four children, and other family and friends.

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